STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455550	A. Building B. Wing	06/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Holiday Nursing & Rehabilitation	280 Moffitt Dr Center, TX 75935

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46436 Based on observation, interview and record review the facility failed to ensure that a resident who needed respiratory care was provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals, and preferences for 1 of 4 residents (Residents #19) reviewed for respiratory care. The facility failed to ensure Resident #19's oxygen tubing was changed per the physician orders. These deficient practices could place residents at risk of developing respiratory infections and complications. Findings include: Record review of a facility face sheet dated 6/03/2024 indicated Resident # 19 was an [AGE] year-old female and readmitted to the facility on [DATE] with -diagnoses of dementia and urinary tract infection (infection of the urine). Record review of a physician ordered dated 5/01/2023 indicated change oxygen tubing every 7 days on Thursday. Record review of a comprehensive care plan dated 3/12/2024 indicated Resident # 19 had oxygen therapy and give as ordered by the physician. Record review of a quarterly MDS assessment dated [DATE] indicated Resident # 19 had a BIMS of 01 indicating severely impaired cognition and required oxygen therapy. During an observation on 06/03/24 at 9:45 am Resident # 19 had oxygen in place at 3 liters per nasal cannula and the oxygen tubing was dated 5/17. During an observation on 06/04/24 at 7:45 am Resident #19 had oxygen in place at 3 liters per nasal cannula and the oxygen tubing was dated 5/17. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 06/04/24 at 9:29 AM LVN A said she had worked at the facility for 6 years. She said the nurses were responsible for changing the oxygen tubing weekly and was normally completed on the night shift. She said that the nurses should be checking oxygen flow rate and tubing on each shift and rounds to ensure the tubing is in date. She said that outdated oxygen tubing could cause an infection or ineffective oxygen delivery . During an interview on 06/05/24 at 7:46 AM the DON said she had been the DON for almost 2 years. She said the nurses on night shift were responsible for changing the oxygen tubing weekly. She said there had not been a specific training for the oxygen tubing and the nurse should be following the physician order. She said there was no monitoring system in place to ensure the tubing was changed. She said if oxygen tubing was not changed it could cause infections or affect the oxygen flow. She said she expected the nurses to follow the oxygen orders and change the tubing per the orders. During an interview on 06/05/24 at 9:33 AM the Administrator said he had been at the facility for 1 year and that the DON was responsible for oversight of the nursing department, but the nurses were responsible and had been trained on oxygen therapy and following orders. He said the oxygen tubing should be changed per the orders and policy to prevent infections and expected the nurses to follow the orders. Record review of a facility policy dated 12/2017 titled Respiratory indicated, .Oxygen therapy is administered as ordered by a physician. 15. replace entire setup every seven days

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NAME OF PROVIDER OR SUPPLIER: Holiday Nursing & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE: 280 Moffitt Dr Center, TX 75935	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50071 Based on observation, interview, and record review the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety in the facility's only kitchen reviewed for food safety requirements and kitchen sanitation 1.The dietary aide failed to effectively wear a hair net to cover all her hair on [DATE] and [DATE]. 2. The facility failed to ensure foods stored in the refrigerator and freezer were labeled, dated, and not kept past their expiration dates. 3. The cook and dietary manager failed to properly perform hand washing when performing duties in the kitchen. These failures could place residents at risk of foodborne illness and food contamination. Findings included: During an observation on [DATE] at 9:06 am the dietary aide had hair from under her hairnet on her forehead. During an observation and interview on [DATE] at 9:16 AM one bag of green, purple, and orange shreds was in a bag located in the refrigerator with no date or label. The dietary manager said the bag contained cold slaw. The dietary manager said the cold slaw was delivered on [DATE] and someone had taken it out of its original box. During an observation on [DATE] at 9:20 AM one bag of round small brown balls was in the freezer and expired and two pies with no label or date were in the freezer. During an observation and interview on [DATE] at 9:25 AM one gallon zip lock bag with flat, round, white, hard disc like objects were in the freezer with no date or label. One bag of frozen hash browns was in the freezer and had an expiration date of ,d+[DATE]. During an observation on [DATE] between 9:25 AM to 10:34 AM the cook did not wash her hands between putting food on the steam table and preparing puree food and did not wash her hands when leaving the preparation area and using the dish machine to wash the food processor. The dietary aide did not have her hair fully covered by the hairnet and hair was out on her forehead. During an observation on [DATE] at 10:40 AM the dietary manager entered the kitchen without washing her hands, put gloves on, and helped with prepping the steam table. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on [DATE] at 11:30 AM the dietary aide said all hair should be under the hairnet and if hair was not completely covered hair could fall in the food. The dietary aide said she had received training on hair coverage/nets but was not sure when or how often. She said she did not think about having her bangs in the front sticking out of her hair net. She said all food should be dated, labeled, and stored correctly. She said if food was not stored right the food could spoil, be old and get resident's sick. She said hands must be washed going in and out of the kitchen or when changing chores. She said proper glove use and hand washing was important to control spreading bad germs and bacteria that may cause residents to become ill. During an interview on [DATE] at 11:35 AM the cook said all hair should be covered or it may fall in the food causing contamination. She said she had been trained on proper hair covering regularly. She said if proper hand sanitation was not done correctly the residents may get germs or bacteria causing the residents to get sick. She said proper use of gloves was mandatory and if not used properly food can be contaminated and residents may become ill. She said all food should be dated and labeled as well as expiration dates visible. She said all outdated foods should be discarded immediately and it was the responsibility of all staff to check the refrigerator and freezer for properly labeled and expired foods. During an interview on [DATE] at 11:45 AM the dietary manager said she oversaw all kitchen staff were trained once per month on different policies. She said she provided training on hand washing, glove use, cleaning, dating/labeling, and temperatures. She said she did notice her aide having hair out in the front of her face. She said uncovered hair could get into the food and cross contaminate it. She said improper use of gloves and not washing hands correctly puts residents at risk of food borne illness and make them ill. She said all staff should wash hands when entering the kitchen. She said all food should be dated/labeled and all outdated items should be discarded if not residents may consume the wrong food or spoiled food. During an interview on [DATE] at 9:47 AM the Administrator said the dietary manager was responsible for the oversight of the kitchen. He said all food items should be dated, labeled, and stored properly upon receipt. He said all kitchen staff was responsible for dating, storing and labeling food upon delivery and monitoring for outdated and expired items. He said the dietary manager was responsible for training the kitchen staff. He said hands were to be washed when entering the kitchen, between each change of duty and after handling dirty supplies. He said gloves were to be worn and removed between tasks with proper hand hygiene. He said the risk of poor hand hygiene, not wearing hairnets appropriately and improperly stored food could cause infections, food that was served could be spoiled and residents to become ill. He said he expected the policy was followed, everyone was trained, and the kitchen was maintained daily. Record review of a facility policy dated [DATE] titled Employee Sanitation indicated, .The Nutrition and Food service employees of the facility will practice good sanitation practices in accordance with the stat and US Food Codes in order to minimize the risk of infection and food borne illness;3a. hairnets must be worn to keep hair from food and food contact surfaces, 5a. employees must wash their hands immediately before engaging in food preparation, during food preparation, 6a. gloves are not a substitute for thorough and frequent handwashing. When using gloves, always wash hands before touching or putting on new gloves .

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43994 Based on observations, interviews, and record reviews the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 2 of 6 residents (Resident #34 and #25) and 2 of 4 staff (CNA E and CNA G) reviewed for infection control. The Hospice Aide did not follow enhanced barrier precautions when she provided care to Resident #34 on 6/3/2024. CNA C did not sanitize or wash her hands between glove changes and wiped a female resident from back to front when providing incontinent care to Resident #25 on 6/4/2024. These failures could place residents at risk of exposure to infectious diseases due to improper infection control practices. Findings included: 1. Record review of a face sheet dated 6/4/2024 for Resident #34 indicated he admitted to the facility on [DATE] and was [AGE] years old with diagnoses of heart failure (heart not able to pump effectively), dementia (may cause the inability to remember, think, or make decisions) and atrial fibrillation (an irregular heartbeat). Record review of active physician orders for Resident #34 indicated an order for enhanced barrier precautions due to chronic wounds that started on 4/26/2024. Record review of a Significant Change MDS assessment dated [DATE] for Resident #34 indicated he had severe impairment in thinking with a BIMS score of 7. He had a pressure ulcer/injury with three stage 2 wounds that were partial thickness/loss of dermis (skin) that was present on admission. Record review of a care plan for Resident #34 dated 4/30/2024 indicated he required EBP (Enhanced Barrier Precautions- an approach of targeted gown and glove use to prevent the spread of germs) during contact care related to chronic wounds with interventions for staff to provide/utilize appropriate PPE along with standard precautions while providing resident care for ADL's (dressing, grooming, personal hygiene, transfers, linen changes), incontinent care/toileting, wound care, care to enteral tubes (use of a feeding tube to supply nutrients and fluids to the body if they are unable to safely chew or swallow), IV sites, catheters, tracheostomy (a surgical opening in the windpipe to breathe). Record review of a Quarterly MDS assessment dated [DATE] for Resident #34 was in process. During an observation on 6/3/2024 at 2:13 PM, the Hospice Aide was in the room of Resident #34 providing care that included shaving the resident. She was not wearing a gown and only had gloves on. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 6/3/2024 at 2:24 PM, the Hospice Aide said she saw Resident #34 five days a week and on Mondays, Wednesdays and Fridays were his shower days. She said he had just received a bed bath, skin, foot care and she shaved him. She said she was aware that when care was provided to Resident #34 that she had to wear a gown and gloves. She said she only wore gloves during care provided. She said she did not know why she did not put on a gown today. She said residents could be at risk for making things worse. 2. Record review of a face sheet dated 6/4/2024 for Resident #25 indicated she admitted to the facility on [DATE] and was [AGE] years old with diagnoses of dementia, atherosclerotic heart disease (narrowed arteries that causes limited blood flow to the heart) and osteoporosis (brittle bones). Record review of a care plan revised 6/3/2024 for Resident #25 indicated an ADL self-care performance deficit related to weakness, osteoporosis (a condition that causes bones to become weak and brittle), and cognitive impairment. She required the assist of one direct care staff member for ADL completion for toilet use. Record review of a Quarterly MDS assessment dated [DATE] for Resident #25 indicated she had severe impairment in thinking with a BIMS score of 4. She was occasionally incontinent of bladder and frequently incontinent of bowel. During an observation on 6/4/2024 at 8:55 AM, CNA B and CNA C were in the room of Resident #25 to provide incontinent care. Both washed their hands and put on gloves. Supplies were in a plastic bag on the over bed table. CNA B assisted with positioning and holding the resident. CNA C opened the brief and pulled it down between Resident #25's thighs. CNA C removed a wipe from the plastic bag and wiped the resident's right inner thigh and folded it over and wiped the left inner thigh and placed the wipe in the trash. CNA C removed her gloves and placed gloves on both hands without washing or sanitizing them. CNA C removed a wipe from the plastic bag and wiped down the middle of the vagina from front to back. CNA C removed her gloves and placed them in the trash and sanitized her hands. CNA B rolled Resident #25 onto her left side. CNA C removed wipes from the plastic bag and wiped Resident #25's rectal area from back (buttocks) to front (vagina) and them removed her gloves and placed them in the trash. CNA C placed gloves on her hands without washing or sanitizing them and removed another wipe from the plastic bag and wiped both buttocks in a circular motion and removed the brief, gloves and placed them in the trash. CNA C placed gloves on her hands without washing or sanitizing them. CNA C removed a brief from the plastic bag and placed it underneath the resident's buttocks. Resident #25 was rolled onto her back and the brief was secured and the resident was repositioned in the bed. Both CNAs removed their gloves and washed their hands. During an interview on 6/4/2024 at 11:50 AM, CNA C said she had been employed at the facility for 1 1/2 years and worked on the 6 am-2 pm shift. She said the incontinent care provided to Resident #25 earlier, she should have washed her hands between glove changes and should have wiped her rectal area from front to back instead of back to front. She said she had a check off on skills not long ago by the ADON. She said residents could be at risk of infections if staff did not wash or sanitize their hands between gloves changes and wiping from back to front. Record review of a CNA Proficiency Skills Check dated 1/10/2024 conducted by the ADON for CNA C indicated she was satisfactory in perineal care for a female along with infection control on hand washing. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 6/4/2024 at 4:05 PM, the ADON said that Resident #34 was on enhanced barrier precautions because he had a history of ESBL (a bacteria that is resistant to some antibiotics that is usually found in the bowel). She said staff were required to wear a gown, gloves, and a mask according to their policy when providing care to him. She said staff were aware of the residents in the facility that were on enhanced barrier precautions as they had a yellow dot sticker on their name place as a reminder. She said she was not aware the Hospice Aide did not wear the appropriate PPE when she provided care to him on 6/3/2024. She said she had conducted an in-service with the staff on enhanced barrier precautions but did not in-service any of the hospice staff. She said hand hygiene should be performed before care was started, between glove changes and when care was finished. She said when incontinent care was provided to a female resident, staff should wipe them from front to back. She said residents could be at risk for UTI's and vaginal infections if staff did not wipe appropriately and were at risk for spreading germs if they did not wash or sanitize their hands between glove changes. She said they would plan to in-service staff and would conduct visual spot checks with staff. She said there was a risk of spreading infections to other residents if staff did not follow the enhanced barrier precautions. Record review of a list of residents in the facility listed for EBP undated indicated Resident #34 was on the list and had chronic wounds. During an interview on 6/4/2024 at 9:35 AM, the DON said she had been employed at the facility for 2 years and was the IP and was responsible for all things related to infection control. She said EBP was for any resident that had a history of MDRO's (multi drug resistant organisms), current chronic wounds, feeding tubes, and foley catheters. She said EBP would stay in place for residents that had MDRO's indefinitely. She said Resident # 34 was on EBP. She said staff were supposed to wear a gown and gloves when they are providing care up close and personal, when linens were changes, bathing, incontinent care, and wound care. She said she in-serviced staff in April on EBP. She said staff were aware of the residents that had EBP in place because they had yellow dot stickers by the resident's name plate outside their room door to let them know who was on EBP. She said there was a risk of spreading MDRO's to other residents if staff did not follow EBP. She said hand hygiene should be performed before care, between care, before and after glove changes and after care was provided. She said when incontinent care was provided to a female resident, staff should wipe them from front to back. She said she started an in-service with staff on yesterday 6/4/2024 on incontinent care. She said residents could be a risk of infections if staff did not wash or sanitize their hands and if they did not wipe appropriately when providing care to a female resident. Record review of an in-service training report dated 4/25/2024 on enhanced barrier precautions by the DON to staff. Record review of an in-service training report dated 6/4/2024 on incontinent care by the DON and ADON to staff. Record review of an in-service training report dated 6/4/2024 on enhanced barrier precautions by the DON to staff . (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 6/4/2024 at 9:45 AM, the Administrator said EBP was for residents that had MDRO's, chronic wounds, and implanted devices to prevent spreading of bacteria. He said the facility started the EBP in April 2024 and the IP/DON and ADON started training the staff on the new requirements. He said staff should don (put on) and doff (take off) gown and gloves to prevent cross contamination for residents who were on EBP. He said they started in-servicing staff on yesterday 6/4/2024 to ensure they were following the new requirements. He said staff should wash or sanitize their hands anytime gloves were changed, and female residents should be wiped from front to back. He said there was a risk of contamination and infections if staff did not wipe appropriately when care was provided to female residents and if staff did not wash their hands after glove changes. Record review of a memo dated 3/20/2024 from CMS titled Enhanced Barrier Precautions in Nursing Homes indicated, .EBP recommendations now include use of EBP for residents with chronic wounds. EBP are used in conjunction with standard precautions and expand the use of PPE to donning of gown and glove during high-contact resident care activities that provide opportunities for transfer of MDROs to staff hands and clothing . Record review of a facility policy titled Infection Control-Precautions-Categories and Notices revised 3/2024 indicated, .It is the policy of this home to assure that appropriate precautions will be established to ensure that the necessary isolation techniques are implemented. Precaution notices will be posted when isolation precautions are implemented. Enhanced Barrier Precaution Guidance: 1. For residents for whom EBP are indicated, EBP is employed when performing the following high-contact resident care activities; dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs, or assisting with toileting, and wound care: any skin opening requiring a dressing. 2. Ensure PPE and alcohol-based hand rub are readily accessible to staff. Record review of a facility policy titled Hand Washing dated 12/2017 indicated, .It is the policy of this home that hand hygiene is the primary means to prevent the spread of infection. Employees must wash their hands for at least twenty seconds using antimicrobial or non-antimicrobial soap and water under the following conditions. After removing gloves .

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F 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49017 Based on observation, interview, and record review, the facility failed to ensure bedrooms measured at least 80 square feet per resident, in 5 of 18 resident rooms reviewed for required square footage. (Resident room #s 300, 306, 308, 309 and 310). The facility did not have at least 80 square feet per resident in resident room #s 300, 306, 308, 309, and 310. This failure could place residents at risk of having inadequate space for personal belongings, guests, and limit the resident's ability to move about in the room. Findings included: During an interview on 06/03/24 at 10:30 p.m., the Administrator said there had been no structural changes to the building and he knew there had been a waiver granted in the past for five rooms on the secured unit. The Administrator said he would complete HHSC form 3762 (room size waiver for facilities). During an observation on 06/03/24 from 10:00 a.m. until 10:24 a.m., room [ROOM NUMBER] was used for maintenance, rooms [ROOM NUMBERS] were used for the dining area, room [ROOM NUMBER] was used for an office and room [ROOM NUMBER] was used as a sitting area. The rooms measured approximately as follows: * room [ROOM NUMBER]- 6 x 4 feet at entry and the main area was 13.4 x 10.4 feet; * room [ROOM NUMBER]/308- 25.8 x 12.3 feet; * room [ROOM NUMBER]- 12 x 12.4 feet; and* room [ROOM NUMBER]- 12.8 x 12.3 feet. Record review of a bed classification worksheet, completed by the facility administrator, dated 06/03/2024 indicated there were 18 resident rooms on the secured unit. (Hall 300) Record review of the facility census report dated 06/03/2024 indicated 8 residents resided on the secured unit. Resident room #s 300, 306, 308, 309 and 310 were not occupied by residents.