STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455683	A. Building B. Wing	09/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hendrick Skilled Nursing Facility	1900 Pine Abilene, TX 79601

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30057 Based on observation, interview, and record review, the facility failed to treat each resident with respect and dignity for one (Resident #107) of three residents reviewed for rights, in that: The facility failed to ensure Resident #107's ostomy drainage bag was placed in a privacy bag while performing physical therapy in the facility's hallway area. Ostomy (an opening (stoma) from an area inside the body to the outside). This failure could place residents with catheters at risk for embarrassment and reduced self-esteem. The findings included: Review of Resident #107's electronic record on 9/5/24 revealed she was a [AGE] year-old female admitted to the facility on [DATE] with diagnosis of incarcerated hernia. (An incarcerated hernia is a type of hernia in which a part of the small bowel protrudes into the groin area and cannot be pushed back in). Record review of Resident #107's care plan dated 09/01/24 indicated in part: Patient would like to be able to use regular colostomy after recovery. Will be free from trauma to site and infection. Patient to have less leakage from ostomy. Record review of Resident #107's MDS dated [DATE] indicated in part: BIMS = 15 indicating resident was cognitively intact. Bladder and bowel: Ostomy checked yes. During an observation on 09/04/24 at 10:42 AM, Resident #107 was being assisted by PTA A with ambulating in the hallway with the use of the resident's walker. The resident's ostomy drainage bag was seen hanging on the walker and not covered with a privacy bag exposing the bowel movements in the drainage bag. There were other resident's seen in the hallway as well as several visitors. During an interview on 09/05/24 at 3:02 PM, Resident #107 said she was aware of her ostomy bag not being covered while out in the hallway. The resident said she did not mind it being uncovered. The resident said it did not make any difference to her if it was covered or not and that the facility staff had not asked her if they could cover it. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 09/05/24 at 3:07 PM, RN B said whenever a resident that used for example a urinary catheter bag they would make sure it was kept below the resident's waist to prevent back flow of the urine when being transferred out of bed. RN B said if the resident came out of their room they would also place a linen bag over the catheter bag for privacy. RN B was made aware of Resident #107 observed in the hall with her drainage bag uncovered. RN B said as far as she knew Resident #107 had not asked for a privacy bag nor had she asked the resident if she would like one. RN B said she did not think it was a privacy issues if Resident #107's drainage bag was uncovered while out in the hallway even if other residents and visitors were there unless Resident #107 said so. During an interview on 09/05/24 at 3:25 PM, PTA A said Resident #107 did not use a cover on her drainage bag. PTA A said Are we supposed to use a cover on the drainage bag ?. PTA A said the resident had never requested one be used and as far as he knew Resident #107 was fine with the bag not covered when walking in the hallway. During an interview on 09/05/24 at 3:32 PM, the DON was made aware of the observation of Resident #107 ambulating in the hallway with her ostomy drainage bag uncovered. The DON said the drainage bags were usually not covered as it was a skilled facility. The DON said Resident #107 had not voiced that she wanted her drainage bag covered. The DON said if the resident complained about the bag not being covered then they would offer to cover it. Record review of the facility's document titled Patient rights and responsibilities and dated 12/5/2023 indicated in part: Patients are entitled to dignified and respectful care regardless of age, race, color, national origin, ethnicity, religion, culture, language, physical or mental disability, socioeconomic status, sex, sexual orientation and gender identity or expression.

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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 - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26221 Based on observation, interview, and record review the facility failed to maintain an infection control program designed to prevent the development and transmission of infections for 1 (Resident #59) of 3 residents reviewed for infection control. The facility failed to ensure: PTA B cleaned the counter prior to setting up a barrier for setting up wound care supplies for Resident #59. PTA B used a non-permeable barrier when setting up wound care supplies for Resident #59. PT A cleaned scissors between dirty procedure and clean procedure during wound care for Resident #59. PT A used the same scissors after cutting off Resident #59's dirty [NAME]-boot dressing (plaster dressing used to squeeze fluid out of a closed wound) to cut his clean [NAME]-boot dressing. These failures could place resident's at risk for cross contamination and the spread of infection. The findings included: Review of Resident #59's electronic record on 9/5/24 revealed he was an [AGE] year-old male admitted to the facility on [DATE] with diagnoses including debility and septic discitis of the thoracic region (spine infection). Resident #59 was still in his MDS Assessment period. Review of Resident #59's care plan dated 8/23/24 revealed: Problem/ Need Problems: hospitalization abscess to leg Resident will exhibit: Be free from infection during hospital stay; verbalize how to prevent disease. Interventions: Teach patient about handwashing; assess every shift for signs and symptoms of infection; monitor vital signs and lab values; administer medication/ antibiotics as ordered; notify physician of any abnormal values; reinforce hygiene behavior; teach patient signs and symptoms of infection. Wound #1 Right Antero-lateral leg/Venous Ulcer WDL (closed or open, chronic wound that occurs when the veins don't return blood to the heart properly. Resident #59's wounds were closed and seeped fluid) within defined limits, except ulceration, venous, no drainage, dressing in place Review of Resident #59's Order Summary documented Rehab Services: wound care treatment orders: Order date 8/26/24 active. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 9/4/24 at 10:07 a.m., PT A entered Resident #59's room to do wound care. PT A sanitized his hands with alcohol based hand rub (ABHR) and donned gloves. Then after surveyor entered the room, PTA B entered the room and moved Resident #59's belongings to the side and placed a folded towel on the counter without sanitizing the counter and set up the wound care supplies. PT A cut off Resident #59's [NAME]-boot dressing (plaster soaked dressing that compresses as it dries) with a pair of clean scissors. PT A took off the gloves, sanitized hands with ABHR and donned a new pair of gloves. He took measurements of Resident #59's wounds. PT A then applied lotion to Resident #59's leg, then he applied a new [NAME]-boot dressing. When PT A got to the top of Resident #59's calf, PT A used the same, uncleaned scissors to cut the remainder of the [NAME]-boot dressing off. PT A put gauze over the [NAME]-boot dressing, the kerlix (self-adhesive gauze), and put a tube covering over it and left with no hand hygiene. Interview on 9/5/24 at 1:01 p.m., PT A stated he knocked on Resident #59's door, asked about any issues, asked about pain, a student came in to set up supplies and they started the treatment. PT A said Resident #59 had the [NAME]-boot to treat edema. PT A said PTA B was the tech and she moved Resident #59's clothes and put down a clean towel. PT A stated the procedure was clean not sterile so as far as they knew a clean towel was enough. PT A said no one had talked to the PT department about using a non-permeable barrier when setting up wound care. PT A stated after the scissors were used they were considered dirty but they were used for the same resident. PT A said the facility policy was they could use the same instruments. Surveyor requested the policy. PT A stated he did not think it was a formal policy just a facility practice. Interview on 9/5/24 at 1:30 p.m., the ICP stated the expectation for wound care was staff wear the proper PPE which would be gown and gloves. The ICP said she thought a chuck (absorbent pad with plastic on one side to prevent leaks) which was disposable would be acceptable for wound care. The ICP stated she was not sure what the policy stated. The ICP stated once the dressing was cut off the scissors were considered dirty, and the facility did have a spray the PT could have used to clean them. The ICP said hand hygiene was expected before donning PPE, in between glove changes, after touching patient surroundings, and when exiting the room. In an interview on 9/5/24 at 2:21 p.m., the DON stated clean technique could be completed with a towel because the resident was the only person in the room. At this time PT A brought the mandatory in-services by the facility and infection control was completed 2/6/24. In an interview on 09/05/24 at 3:33 p.m., the DON said they did not have a specific policy for wound care.