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	12/05/2025

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 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** Based on observation, interview and record review 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 1 of 3 staff (CNA-A) reviewed for infection control procedures. 1. The facility failed to ensure CNA-A performed proper hand hygiene while performing resident transfer, foley care and incontinent care.2. The facility failed to ensure CNA-A followed EBP during foley catheter care.3. The facility failed to ensure staff were notified of EBP for Resident #10 and failed to have a disposable gown readily accessible to staff outside of Resident #10's room. These failures could place residents at risk for the transmission of communicable diseases.Findings include:Record review of Resident #10's, undated, face sheet reflected a [AGE] year-old female who was admitted to the facility on [DATE].Record review of Resident #10's history and physical, dated 10/1/2025, reflected she was admitted to a hospital on 9/5/2025, after heart catheterization. She was diagnosed with a UTI during the hospital stay on 9/8/2025. Further review reflected the foley catheter was kept in place postoperatively and she was admitted to skilled nursing to continue therapy.Record review of Resident #10's physician orders, dated 10/1/2025, reflected an order, dated 9/18/2025, for follow up appointment with outpatient urology clinic on 10/8/2025 for a trial of void to remove foley catheter. An order, dated 9/19/2025, reflected Indwelling Urinary Catheter Care Orders - Peri Care, using peri care wipes, to be performed on patient every 12 hours, outside of daily bathing, while foley catheter is in place in accordance with policy. Record review of Resident #10's care plan, dated 10/1/2025, reflected Indwelling Catheter Problems/Needs: Potential for urinary tract infection.Resident will: Increase fluid intake to 8 glasses per day.; Show no sign of urinary tract infection.; Be free of urinary tract pain.; Receive no injury secondary to catheter manipulation.; Receive no injury secondary to catheter removal by resident.Personalized Care.Indwelling Catheter Problems/Needs: Potential for urinary tract infection.give perineal care when resident is incontinent.Record review of Resident #10's comprehensive admission MDS, dated [DATE] , reflected a BIMS score of 13, which indicated Resident #10 was cognitively intact. Further review of the MDS, bladder section indicated Resident #10 had an indwelling catheter.Record review of CNA-A's computer-based training record reflected she passed training on infection prevention on 2/6/2025, had passed training on preventing catheter-associated urinary tract infections on 2/6/2025, and passed training on CAUTI - post insertions foley care system for CAUTI prevention on 2/5/2025.During an observation and interview on 9/30/2025 at 1:19 p.m., revealed CNA-A knocked on Resident #10's door and entered the room. There was no EBP sign outside of the room or on the door and were no gowns available on or around Resident #10's door. Resident #10 was sitting in a recliner to the right of the bed with her legs elevated. CNA-A used ABHR on her hands and put on gloves. Resident #10 agreed with getting in bed for foley catheter care. CNA-A took the foley catheter bag from the right of the recliner and secured it to Resident #10's walker. CNA-A grabbed a gait belt and placed it around Resident #10's abdomen and assisted Resident #10 to a standing position. Resident #10 ambulated using a walker to the right side of her bed and sat on the edge of the bed. The privacy curtain was pulled closed by a visitor in (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

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #10's room who stood between the door and the privacy curtain. CNA-A grabbed the two pillows from the recliner and placed them at the head of Resident #10's bed before she assisted Resident #10 with raising her legs into the bed. Resident #10 was lying in bed on a draw sheet and CNA-A moved to the left side of the bed and pulled on the draw sheet to straighten Resident #10 in the bed. CNA-A moved back to the right side of the bed and placed the catheter bag from the walker to the right side of the bed. CNA-A lifted Resident #10's right leg to get the catheter tubing out from underneath it and lowered her leg onto the bed. CNA-A then moved the peri care wipes kit to bedside and moved the trash can to the right of the bed. CNA-A told Resident #10 what to expect from the procedure and then opened the peri wipe kit after lowering the front of Resident #10's brief exposing the foley catheter tube. CNA-A took one wipe from the kit and wiped the foley catheter tubing starting at Resident #10's skin and wiped away from her body. The wipe was disposed into a lined trash can. CNA-A got another wipe from the peri care kit and wiped the right side of the labia then another wipe was used to wipe the left side of labia. Those wipes were disposed of into a lined trash can. CNA-A used the last 2 wipes in the peri care kit to wipe Resident #10's skin from the front (right behind catheter exit site) to the back (rectal area) and both were disposed of into the lined trash can after use. CNA-A stated the brief was soiled and needed to be changed so she went to the area on the other side of the privacy curtain to get incontinent wipes and a clean brief. CNA-A instructed Resident #10 to roll to her left side, and she used the incontinent wipes to clean the gluteal skin disposing of the wipes into a lined trash can after use. CNA-A removed the used brief from under Resident #10 and disposed into the lined trash can. CNA-A placed a clean brief under Resident #10 and asked her to roll onto her back. The clean brief was brought through Resident #10's legs and secured with tabs by CNA-A. CNA-A dated the sticker on the peri care kit with a marker and placed the sticker on the foley catheter bag. CNA-A observed there was urine in the catheter bag and stated she would empty it. CNA-A disposed of the empty peri care kit into the lined trash can. CNA-A went into the restroom and grabbed a urinal. CNA-A emptied the urine from foley catheter bag into the urinal and placed the bag back into the privacy bag on the right side of the bed. CNA-A took the urinal into the restroom and dumped the urine into the toilet then flushed the toilet. CNA-A hung the urinal on the bar in the restroom and exited the restroom. CNA-A used the bed control to adjust Resident #10's bed and handed the control to Resident #10. CNA-A moved the trash can back to the side of the room and took off her gloves for the first time since putting them on after entering Resident #10's room. CNA-A used ABHR on her hands and she removed the trash liner from trash can. CNA-A exited the room with the trash inside of the liner and walked to room behind the nurses' station and put into a larger lined trash bin. Hand hygiene was performed. CNA-A stated she thought she should have replaced her gloves during resident care and would have to ask her supervisor about how to perform hand hygiene during catheter care. She stated she may need a refresher on hand hygiene. She stated not changing gloves and performing hand hygiene at correct times during catheter care could cause CAUTIs.During an interview on 9/30/2025 at 1:53 p.m., RN-B stated gloves should be changed when moving from a contaminated to clean area. RN-B stated she felt CNA-A needed more education on hand hygiene. RN-B stated she did not know CNA-A's training history or how long she had been a CNA. RN-B stated the educators monitored CNAs performed hand hygiene as needed but was unsure of how often the CNAs were monitored. She stated not performing hand hygiene when appropriate could cause infections. During an interview on 9/30/2025 at 2:10 p.m., the DON stated she expected employees to perform hand hygiene and replace gloves when going from one task to another as during foley catheter care. She stated staff were responsible for performing hand hygiene when needed. She stated hand hygiene was needed to prevent infections. She stated the educators monitored staff performed hand hygiene appropriately. She stated there was annual training on hand hygiene instructed by the educators. She stated she had no knowledge of EBP regulation for individuals with indwelling devices.During a follow-up interview on 10/1/2025 at 8:11 a.m., the DON requested information about EBP in long term care. She stated she knew about contact precautions, but she was (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	unable to locate information about EBP in long term care. She stated in acute care, enhanced barrier was for COVID patients. During an interview on 10/1/2025 at 9:29 a.m., the IP stated she expected staff to sanitize hands and change gloves in between tasks and after contact with urine. She stated she anticipated gloves and gowns to be used in wound care but would not expect gowns to be used in foley catheter care. She did not answer if she had known about EBP in long term care but stated there would not be a splash of fluids with catheter care so a gown would not be needed. She stated staff were trained upon hire and annually on hand hygiene. She stated direct care staff had to do a hand hygiene skills check-off prior to being allowed to work with residents . She stated there were also secret shoppers (secret employees that observed staff members for skills then sent a report of what was observed good and bad to the IP) who were responsible for randomly picking direct care staff to perform hand hygiene check off. She stated the DON had a list of secret shoppers. The IP stated she got a report from the secret shoppers after check-off was completed and would check to see if CNA-A had checked off with the secret shopper in the past. She stated the DON was responsible for making sure direct care staff were performing hand hygiene appropriately. She stated the risk to residents from staff not performing hand hygiene appropriately during catheter care could be getting a facility acquired infection or spreading infection from the resident to other residents. During a follow-up interview on 10/1/2025 at 11:09 a.m., the IP stated there was no evidence CNA-A had not been randomly selected by secret staff to observe hand hygiene skill (secret shoppers) since she had been employed at the facility. During a follow-up interview on 10/2/2025 at 9:41 a.m., the DON stated there was no policy for EBP during care for residents with an indwelling device. She stated she could provide policy for contact, droplet, and airborne precautions but none for EBP for indwelling device .Record review of the facility's policy titled Handwashing, Hand Antisepsis and Glove Use, 4.4739 revised on 3/26/2019, reflected: Hand Hygiene 1. Each employee will wash his/her hands at the following times: A. When hands are visibly dirty or contaminated with proteinaceous material or are visibly soiled with blood or other body fluids.2. In addition, all employees with patient contact will decontaminate their hands with the hospital approved alcohol-based hand rub when the hands are not visibly soiled in clinical situations. Note: Alternately wash hands with the hospital approved antimicrobial soap and water in these clinical situations. A. Before having direct contact with patients.D. After contact with a patient's intact skin (e.g., when taking a pulse or lifting a patient). E, After contact with body fluids or excretions, mucous membranes, nonintact skin, and wound dressings if hands are not visibly soiled. F. When moving from a contaminated-body site to a clean-body site during patient care. G. After contact with inanimate objects in the immediate vicinity of the patient. H. After removing gloves. Glove Use 1. Employees will wear gloves in accordance with isolation guidelines and the Exposure Control-Bloodborne Pathogen Standard. 2. Employees will wear gloves when performing any procedures on a patient that could possible expose them to potentially infective material.4. Employees will wear gloves when performing the following nonpatient contact procedures: Cleaning up spills of blood or body fluids Cleaning contaminated equipment Cleaning sanitation facilities Handling contaminated trash, linens, or other potentially contaminated equipment or materials.7. Employees will change gloves and cleanse their hands between patients and between procedures with the potential of cross contaminating the same patient from one site to another (i.e. foley care and trach care).