STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455737	A. Building B. Wing	05/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Concho Health & Rehabilitation Center	613 Eaker St Eden, TX 76837

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26221 Based on observation, interview and record review, the facility failed to ensure each resident received adequate supervision and assistance devices to prevent accidents for 1 of 2 residents reviewed for accident hazards/supervision (Resident #5). The facility failed to ensure CNA E and G demonstrated appropriate transfer techniques while using the mechanical lift for Resident #5. These failures could place residents at risk for injuries. Findings included: Review of Resident #5's Admission Record, dated [DATE], revealed she was an [AGE] year-old female admitted to the facility on [DATE] with diagnoses including fibromyalgia (a condition causing widespread pain and fatigue) and reduced mobility. Review of Resident #5's state MDS assessment dated [DATE] revealed: She had a mental status score of 6 of 15 (indicating severe cognitive impairment) She needed extensive assistance of two or more people to transfer between bed and wheelchair. Observation and interview on [DATE] at 02:34 PM revealed Resident #5 was in her room in her wheelchair. Resident #5 said she was waiting to be transferred to bed. CNA E and CNA G entered the room with the lift . CNA E instructed CNA F to spread the legs of the mechanical lift and lock it. Both aides secured the sling to the mechanical lift. CNA E operated the lift while CNA G steadied Resident #5. Resident #5's wheelchair rolled forward by approximately 6 - 8 inches. Once lifted, CNA E checked Resident #5's wheelchair locks and moved the wheelchair out of the way. CNA E steadied Resident #5 as CNA G moved the lift to the bed. CNA G lowered Resident #5's bed and CNA E positioned Resident #5 in the center of the bed. CNA E told her (CNA G) to lock the lift which CNA G did. Once Resident #5 was lowered into the bed, CNA E immediately took the sling off and CNA G took the mechanical lift out of the room. (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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on [DATE] at 4:24 PM CNA E stated she worked at the facility on and off for 1.5 years as agency staff. CNA E stated she knocked on the door, found out what Resident #5 needed, left and got CNA G. CNA E stated they returned to Resident #5's room and CNA G operated the mechanical lift. CNA E stated they (CNA E and CNA G) got Resident #5 hooked to the lift. CNA E said she had to remind CNA G to spread the legs to the lift and lock it. CNA E said she locked the right side of Resident #5's wheelchair. When informed Resident #5's wheelchair moved easily 6- 8 inches, CNA E stated, it didn't lock. CNA E said she held onto Resident #5 as Resident #5 was lifted into the air and then she had to move Resident #5's wheelchair. CNA E said she remembered she had to tell CNA G to unlock the lift and she (CNA G) started to close the legs to the lift and CNA E had to tell her to stop. CNA E said they got Resident #5 moved to the bed, but the bed was so high and there was a cord in the way, CNA G had to close the legs slightly to push the legs under the bed. CNA E said she told CNA G to lock the lift before lowering Resident #5. CNA E said she remembered having to push Resident #5 to the center of the bed. CNA E said when they got Resident #5 down, they got her unhooked and CNA G took the lift out as quickly as possible. CNA E said she knew the motions and if she was focusing on her instead of trying to help her coworker she would not have messed up. Interview on [DATE] at 09:42 AM the DON said she trained the staff to get a second person. The DON said the operator of the lift, spread the legs of the lift to go around the wheelchair, locked the lift, made sure the sling was on the right way, lifted the resident, unlocked the lift, steered the lift to where it needed to go, locked the lift, lowered the lift and unhooked the resident. The DON stated the spotter made sure the sling was on the resident, held the resident while the resident was being lifted, pulled the wheelchair waly, held onto the resident while the resident was being moved, positioned the resident over the bed, held the resident while the resident was going down, and unhooked the sling. The DON said the wheelchair had to be locked before anything because they did not what the wheelchair moving out from under the resident. The DON said in-services on the lift were done on the facility's computer Inservice program. She did not answer why the therapy department did not do a return demonstration. The DON said the facility did (skill) check-offs upon hire, annually, and as needed. The DON said the aide's surveyor observed were an agency staff and a new aide who had not been a CNA long enough to need an annual check off. Interview on [DATE] at 10:24 AM the Administrator was read the lift observation. The Administrator identified that the wheelchair not being locked was an error and was a risk for injury to the resident. Observation on [DATE] at 10:59 AM of the mechanical lift revealed nothing on the boom about how to operate the mechanical lift. (There were no instructions posted on the lift on how to use it) Review of in-service provided by the facility revealed the facility provided an in-service to the staff on the correct use of the hydraulic lift [DATE]. Review of the facility's policy and procedure on Hydraulic Lift, undated, revealed: The hydraulic lift is a mechanical device used to transfer a resident from and to the bed and chair. It is reserved for those who are paralyzed, obese, or too weak to transfer without complete assistance. The number of staff to provide assistance with the transfer should be determined by the manufacturer recommendations. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Goals. The resident will achieve safe transfer to bed or chair via mechanical lift device. The caregiver will demonstrate safe and correct transfer of the resident to the bed or chair via the hydraulic lift. Procedure: Prepare the lift by setting the adjustable base to its widest position. Lock or unlock the base wheels according to the lift manufacturer's recommendations. Connect the sling. Pump the lift while holding the steering arm until a sitting position is assumed and the buttocks are lifted off the bed. Reassure the resident at this time. Move the lift away from the bed while holding the knees with one hand to guide the movement of the resident in the sling and steadily into the chair until the proper position has been achieved. Guide the resident to the chair and steady the chair to receive the resident. Remove the resident straps. Move the lift away from the resident. To return the resident to bed, reverse the procedure.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 48593 Based on observation, interview, and record review, the facility failed to ensure all controlled drugs and biologicals were stored in separately locked and permanently affixed compartments for 1 of 2 medication carts (Med Cart #1), reviewed for labeling/storage of drugs and biologicals. The facility failed to secure controlled medication in a locked compartment. These failures could place the facility at risk of drug diversion and access to medications. Findings included: Observation of the facility Med Cart #1 on 05/21/24 at 03:27 PM with LVN A revealed one sublingual morphine medication blister pack in the regular section of the chart instead of in the locked narcotic drawer. An interview with LVN A on 05/21/24 at 03:50 PM LVN A stated she did not remember putting the morphine in the regular part of the med cart. LVN A stated she must have just grabbed all the medication packs and put them in the regular section. LVN A stated that she knows all narcotics need to be in the locked part of the medication for safety reasons. LVN A stated at the beginning and end of the shift the oncoming and off going nurse will do a narcotic check on the cart to ensure count is correct. An interview with the DON on 05/23/24 at 03:46 PM the DON stated that all carts should be kept orderly, medication carts should be locked when unattended and all narcotics should be double locked and signed out on narcotic sheet when given. DON stated the nurses or medication aids do a Narcotic count with each shift. A review of the facility policy titled Storage of controlled substance dated 2003, provided by the DON, reads, in part, Controlled drugs (schedule II) .will be kept in a separate, permanently affixed compartment .

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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. 30057 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 in that: The facility failed to ensure kitchen staff wore facial hair restraints during meal preparation. These failures could place residents who received meals prepared in the kitchen at risk for food borne illness and cross-contamination. Findings include: During an observation and interview on 05/21/24 at 10:24 AM Dietary [NAME] D and Dietary Aide C were not wearing facial hair restraints as they each had a moustache and beard. Dietary [NAME] D and Dietary Aide C said they normally wore their facial hair restraints but had forgotten to put them on this morning. There was food set out such as chicken and cake which both staff members were currently preparing when seen without the restraints. During an interview on 05/22/24 at 10:54 AM the Dietary Manager said when staff were in the kitchen, they were supposed to wear hair restraints including facial hair restraints. The DM was made aware of dietary cook and aide not wearing facial hair restraints when they were in the process of preparing food. The DM said the staff were supposed to wear their facial hair restraints when they were in the kitchen and they knew that. The DM said she was not sure why they were not wearing them. The DM said if the staff did not wear their hair restraints that could lead to hair getting on the food. The DM said she would do some training on them wearing their facial hair restraints. During an interview on 05/23/24 at 03:24 PM the Administrator said it was expected for kitchen staff to wear their hair restraints to include facial hair restraints. The Administrator said the DM was responsible for making sure the staff wore their hair restraints. The Administrator said if the staff did not wear their hair restraints, then there was a possibility of hair landing on the food. The Administrator said she believed the failure occurred because the staff forgot to put the restraints on. Record review of the facility's document titled dietary services policy and procedures manual 2012 indicated in part: Sanitation and food handling: All employees receive instruction in sanitation during orientation and through in-services training programs. Hair nets or hats covering the hairline are worn at all times. [NAME] guards are required for facial hair.

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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** 30057 Based on observation, interview, and record review, the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment to help prevent the development and transmission of communicable diseases and infections for 3 (Resident #5, #9 and #31) of 5 residents reviewed for infection control. The facility failed to ensure: CNA E did not turn off the faucet with her bare hands after washing them and before performing personal care for Resident #5. CNA's E and F change their gloves after they became contaminated during incontinent care while assisting Resident #9. CNA B change her gloves after they became contaminated during incontinent care while assisting Resident #31. This failure could place resident's risk for cross contamination and the spread of infection. Finding include: RESIDENT #5 During an observation on 05/21/24 at beginning at 02:46 PM CNA E entered Resident #5's bathroom and rinsed her hands (no soap was used), turned off the faucet with her bare hands and then dried her hands with a paper towel. Immediately after, CNA E entered the bathroom washed her hands with soap but turned off the faucet with her bare hands. During an interview on 05/22/24 at 4:24 p.m. CNA E stated she worked for the facility on and off for 1.5 years. CNA E confirmed she washed her hands after doing performing care for Resident #5. She said she turned on the faucet, soaped her hands, rinsed them, turned the faucet off with a paper towel and then dried her hands with a paper towel. Surveyor read the observation that she turned the faucet off with her bare hands, and CNA E said she was flustered from helping another CNA with care. During an interview on 05/23/24 at 9:42 a.m. the DON and Regional Consultant stated the expectation for handwashing was to wet hands, use soap, wash the entire hand and nails, rinse, dry the hands with a paper towel, and then use a paper towel to turn off the faucet. When asked what the expectation about handwashing was, the DON sighed, let me guess, they turned off the faucet with their hands? The DON said staff were in-serviced on how to wash their hands. During an interview on 05/23/24 at 10:24 a.m. the Administrator was informed of the handwashing observation. The Administrator agreed there was a chance of cross contamination and asked how the investigation was completed. RESIDENT #9 (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #9's admission record dated 05/23/2024 indicated she was a [AGE] year-old female that was initially admitted to facility on 04/02/2022 with medical diagnosis that include muscle weakness, age-related cognitive decline and care provider dependency. Record review of Resident #9's MDS dated [DATE] indicated in part: Bladder and Bowel: Urinary Continence =. 3. Always incontinent. Bowel Continence = 3. Always incontinent. Record review of Resident #9's care plan dated 05/15/2024 indicated in part: Focus: The resident has bladder incontinence. Goal: The resident will remain free from skin breakdown due to incontinence and brief use. Interventions/Task: Notify nursing if incontinent during activities. Apply barrier cream after each incontinent episode. Brief use: the resident uses disposable briefs. Change every 2 hours and prn. During an observation of incontinent care on 05/22/24 at 02:26 PM with CNA E and CNA F for Resident #9. CNA F wiped Resident #9 perineal area from front to back with a clean wipe each time, she did not change her gloves. Resident #9 was rolled to the side to CNA E who then wiped the resident's bottom, removed the old brief, did not change gloves and placed new clean brief. CNA E then placed barrier cream, removed the one glove that had barrier cream and put on one new glove. Both CNA's adjusted the brief, both pulled resident up in bed and without changing her gloves CNA E touched the wipes, the remote, the barrier cream container and the dresser drawer. During an interview with both CNA F and CNA E on 05/22/24 at 2:40 pm. Both CNA's stated they should have changed their gloves and hand sanitized or washed their hands before going from dirty to clean on Resident #9. CNA E stated that changing gloves and hand hygiene were used to help prevent cross contamination. RESIDENT #31 Record review of Resident #31's admission record dated 05/23/2024 indicated she was admitted to the facility on [DATE] with diagnoses which included dementia and muscle weakness. She was [AGE] years of age. Record review of Resident #31's MDS dated [DATE] indicated in part: Bladder and Bowel: Urinary Continence =. 2. Frequently incontinent. Bowel Continence = 3. Always incontinent. Record review of Resident #31's care plan dated 06/01/22 indicated in part: Focus: The resident has bladder incontinence. The resident has bowel incontinence. Goal: The resident will remain free from skin breakdown due to incontinence and brief use through review date. The resident will not have any complications related to bowel incontinence. Interventions: Incontinent care at least every 2 hours and apply moisture barrier after each episode. Apply barrier cream after every incontinent episode. Check resident every two hours and assist with toileting as needed. Provide pericare after each incontinent episode. (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 observation on 05/22/24 at 03:34 PM CNA B performed incontinent care for Resident #31. CNA B entered the resident's room, washed her hands and put on a pair of new gloves. CNA B then undid the resident's brief and it was noted that the brief was wet with urine. CNA B then took some wet wipes and wiped the resident's vaginal area. The CNA then rolled Resident #31 on her right side and took some more wet wipes and wiped the resident's rectal area. While CNA B performed the wiping her gloves came in contact with the resident's vaginal and rectal areas. While still wearing the same gloves CNA B then took the clean brief and fastened it to Resident #31. During an interview on 05/22/24 at 03:46 PM CNA B said she usually changed her gloves before going from clean to dirty but this time she was in a hurry and did not do it. CNA B said not changing her gloves and touching the clean items could lead to cross contamination. During an interview on 05/23/24 at 01:44 PM the DON said it was expected for staff to remove their gloves and wash their hands and install a pair of new gloves once they became contaminated. The DON said staff were supposed to change their gloves to prevent from contaminating other items. The DON believed the failure occurred because the staff got nervous and forgot to change their gloves once they became contaminated. During an interview on 05/23/24 at 03:28 PM the Administrator was made aware of the incontinent observations. The Administrator said staff were supposed to change their gloves and wash their hands once they became contaminated. The Administrator said it was the DON's and ADON's job to monitor staff to make sure those steps were followed. The Administrator said the failure probably occurred because the staff got nervous and forgot to change their gloves at the appropriate time. Record review of the facility's document titled Personal care and dated 05/11/2022 indicated in part: Start: Perform hand hygiene. DON (put on) gloves and all other PPE per standard precautions. Gently perform perineal care wiping from clean urethral area to dirty rectal area to avoid contaminating the urethral area-clean to dirty. DOFF (remove) gloves and PPE, perform hand hygiene. Provide resident comfort and safety by re-clothing (if applicable - incontinence pads and briefs), straightening bedding, adjusting the bed and/or side rails and placing call light within residents reach. Perform hand hygiene. Important points: Doffing and discarding of gloves are required if visibly soiled, always perform hand hygiene before and after glove use.