STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455869	A. Building B. Wing	08/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Guadalupe Valley Nursing Center	1210 Eastwood Dr Seguin, TX 78155

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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39251 Based on observation, interviews, and record reviews the facility failed to ensure each resident had the right to personal privacy for 1 of 2 residents (Resident #2) reviewed for dignity. Resident #2's bedroom door was not closed, and the privacy curtain was not completely drawn during catheter care on 8/29/24. This failure could affect residents by contributing to poor self-esteem, decreased self-worth, and quality of life. Findings included: Record review of Resident #2's Admission Record, dated 8/30/24, revealed the resident was readmitted to the facility on [DATE] with diagnoses that included: UTI, Type 2 Diabetes (chronic condition that affects the way the body processes blood sugar), Morbid Obesity (disorder that involves having too much body fat) , Hemiplegia (paralysis of one side of the body) , Anxiety Disorder (feeling of dread, fear, or uneasiness) , Major Depressive Disorder (mental health disorder characterized by persistently depressed mood or loss of interest in activities), Obstructive and Reflux Uropathy (obstructed urinary flow) , Dysphagia (difficulty swallowing), Congestive Heart Failure (condition in which the heart can't pump blood well enough to meet the body's needs), Hyperlipidemia (high levels of fat in the blood) , and Hypertension (high blood pressure). Record review of Resident #2's quarterly MDS assessment, dated 7/28/24, revealed the resident's cognitive skills for daily decision making was moderately impaired. Further review of this document revealed Resident #2 had an indwelling catheter and was dependent on staff for toileting hygiene. Record review of Resident #2's Care Plan, dated 4/22/23, revealed: [Resident #2] has an ADL self-care performance deficit r/t weakness, obesity, right hemiplegia .requires substantial/maximal assistance for personal hygiene .She requires staff to provide foley catheter care . Observation of catheter care for Resident #2, on 8/29/24 beginning at 2:28 pm, revealed CNA B and CNA C gathered supplies, entered Resident #2's room, completed hand hygiene and donned PPE. CNA B and CNA C introduced themselves and explained the procedure to Resident #2. CNA B and CNA C completed catheter care while Resident #2's bedroom door was left open, and the privacy curtain was not completely drawn. (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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a joint interview on 8/29/24 at 2:50 pm, CNA B and CNA C both said when care was provided to residents the door and curtain should be closed to provide privacy. CNA C said she was very nervous during the observation. During an interview on 8/30/24 at 10:20 am, Resident #2 said she was bothered when the staff left the door and curtain open during catheter care on 8/29/24. Resident #2 further stated this made her feel like an animal. During an interview on 8/30/24 at 10:37 am, LVN B said it was the residents' right to have their privacy and dignity respected. She further stated all staff were expected to provide residents with privacy when providing care. LVN B said this was important because the residents could feel violated. During an interview on 8/30/24 at 11:16 am, LVN C said privacy should always be provided during resident care. LVN C further stated the bedroom door and privacy curtains should be completely closed. LVN C said when privacy was not provided it affected the residents' dignity and might make the resident feel embarrassed. LVN C said all staff were responsible for ensuring residents' dignity was respected. During an interview on 8/30/24 at 12:32 pm, the Administrator said all staff were responsible for ensuring the residents' privacy was maintained. The Administrator further stated when residents' privacy was not maintained residents could feel embarrassed. The Administrator said maintaining resident privacy was important for their dignity and wellbeing. On 8/30/24 a catheter care policy/procedure was requested. The DON was unable to locate a policy but provided the state investigator a CLINICAL COMPETENCY VALIDATION Catheter: Indwelling Urinary - Care of. Review of this document revealed: .4. Explains procedure and provides privacy . Record review of Facility Manual, revised 7/14/2020, revealed: .Statement of Resident Rights .You have a right to .privacy .

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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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39251 Based on observation, interviews, and record reviews, the facility failed to ensure a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible for 1 of 5 residents (Resident #2) reviewed for quality of care. The facility failed to ensure Resident #2 was provided catheter care according to professional standards; keeping the catheter anchored to prevent excessive tension on the catheter, which can lead to trauma due to urethral tears or dislodging the catheter. This failure could place residents at risk for trauma resulting in diminished quality of life. Findings included: Record review of Resident #2's Admission Record, dated 8/30/24, revealed the resident was readmitted to the facility on [DATE] with diagnoses that included: UTI, Type 2 Diabetes (chronic condition that affects the way the body processes blood sugar), Morbid Obesity (disorder that involves having too much body fat) , Hemiplegia (paralysis of one side of the body) , Anxiety Disorder (feeling of dread, fear, or uneasiness) , Major Depressive Disorder (mental health disorder characterized by persistently depressed mood or loss of interest in activities), Obstructive and Reflux Uropathy (obstructed urinary flow) , Dysphagia (difficulty swallowing), Congestive Heart Failure (condition in which the heart can't pump blood well enough to meet the body's needs), Hyperlipidemia (high levels of fat in the blood) , and Hypertension (high blood pressure). Record review of Resident #2's quarterly MDS assessment, dated 7/28/24, revealed the resident's cognitive skills for daily decision making was moderately impaired. Further review of this document revealed Resident #2 had an indwelling catheter and was dependent on staff for toileting hygiene. Record review of Resident #2's Care Plan, dated 4/22/23, revealed: [Resident #2] has an ADL self-care performance deficit r/t weakness, obesity, right hemiplegia .requires substantial/maximal assistance for personal hygiene .She requires staff to provide foley catheter care . Observation of catheter care for Resident #2 , on 8/29/24 beginning at 2:28 pm, revealed CNA B and CNA C gathered supplies, entered Resident #2's room, performed hand hygiene and donned PPE. CNA B and CNA C introduced themselves and explained the procedure to Resident #2. CNA C completed perineal care, then held Resident #2's catheter close to the catheter anchor, located on Resident #2's right thigh (as opposed to holding the catheter close to the resident's urethral meatus (opening that allows urine to exit the body) to avoid trauma), and wiped from the urethral meatus in a downward motion three times. CNA B and CNA C removed gloves, sanitized their hands, placed resident in a comfortable position, removed PPE, and completed hand hygiene. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 8/29/24 at 2:50 pm, CNA C said the catheter should have been held at the insertion site to avoid cross contamination and so the catheter was not pulled out, adding the resident could be hurt because of the balloon. (Indwelling catheters are secured within the bladder with a balloon filled with sterile water. Pulling the catheter while the balloon was filled put the resident at risk for trauma). During an interview on 8/30/24 at 10:37 am, LVN B said not holding an indwelling catheter properly during catheter care put the resident at for trauma due to the inflated balloon. During an interview on 8/30/24 at 11:16 am, LVN C said when catheter care was provided, the catheter should be held 2-3 inches from the urethral meatus and cleaned without pulling on the catheter. LVN C further stated this was done to avoid trauma and infections. LVN C said the floor nurses and ADONs were responsible for ensuring staff followed policies and procedures when care was provided to residents. LVN C further stated all staff were expected to follow procedures during resident care. On 8/30/24 a catheter care policy/procedure was requested. The DON was unable to locate a policy but provided the state investigator a CLINICAL COMPETENCY VALIDATION Catheter: Indwelling Urinary - Care of. Review of this document revealed: .9.Cleanses the proximal third of the catheter .manipulating the catheter as little as possible . Review of Lippincott procedures, indwelling urinary catheter care procedure, revised 12/10/23, accessed 8/30/24, from: https://procedures.lww.com/lnp/view.do?pId=4420099, revealed: .Clean the periurethral area carefully to prevent catheter movement and urethral traction .

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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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39251 Based on observations, interviews, and record reviews the facility failed to ensure nurse aides were able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care for 2 of 2 staff (CNA B and CNA C) reviewed for nurse aide competencies. 1. The facility failed to ensure CNA B performed perineal care for Resident #1, on 8/29/24, according to facility policy. 2. The facility failed to ensure CNA C performed catheter care for Resident #2, on 8/29/24, according to professional standards. This failure could place residents at risk for trauma and/or infection. The findings included: 1. Record review of Resident #1's Admission Record, dated 8/30/24, revealed the resident was admitted to the facility on [DATE] with diagnoses which included: Dementia (group of thinking and social symptoms that interferes with daily functioning), Hyperlipidemia (high levels of fat in the blood), and Hypertension (high blood pressure). Record review of Resident #1's Care Plan, dated 11/10/23, revealed: .The resident is able to perform hygiene tasks with setup and supervision . Record review of Resident #1's quarterly MDS assessment, dated 7/12/24, revealed the resident had a BIMS score of 12, suggesting intact cognition. Further review of this document revealed Resident #1 was continent of bladder. Observation of perineal care (washing the genitals and anal area) for Resident #1 on 8/29/24 beginning at 2:19 pm revealed CNA B and CNA C gathered supplies, entered Resident #1's room and performed hand hygiene. CNA B and CNA C introduced themselves and explained the procedure to Resident #1. During the procedure CNA B clean wiped Resident #1 glans penis five times using the same surface previously used (as opposed to a different/clean surface with each wipe). Further observation revealed CNA B did not clean the shaft of Resident #1's penis or his scrotum. During an interview on 8/29/24 at 2:41 pm, CNA B said she was told not to use the same surface when providing perineal care. CNA B further stated this was important because the surface used to wipe became dirty and reusing the same surface puts the resident at risk for infection or UTI. CNA B said she had been at the facility for 5 months and had not received training regarding perineal care. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Record review of Resident #2's Admission Record, dated 8/30/24, revealed the resident was readmitted to the facility on [DATE] with diagnoses that included: UTI, Type 2 Diabetes (chronic condition that affects the way the body processes blood sugar), Morbid Obesity (disorder that involves having too much body fat) , Hemiplegia (paralysis of one side of the body) , Anxiety Disorder (feeling of dread, fear, or uneasiness) , Major Depressive Disorder (mental health disorder characterized by persistently depressed mood or loss of interest in activities), Obstructive and Reflux Uropathy (obstructed urinary flow) , Dysphagia (difficulty swallowing), Congestive Heart Failure (condition in which the heart can't pump blood well enough to meet the body's needs), Hyperlipidemia (high levels of fat in the blood) , and Hypertension (high blood pressure). Record review of Resident #2's quarterly MDS assessment, dated 7/28/24, revealed the resident's cognitive skills for daily decision making was moderately impaired. Further review of this document revealed Resident #2 had an indwelling catheter and was dependent on staff for toileting hygiene. Record review of Resident #2's Care Plan, dated 4/22/23, revealed: [Resident #2] has an ADL self-care performance deficit r/t weakness, obesity, right hemiplegia .requires substantial/maximal assistance for personal hygiene .She requires staff to provide foley catheter care .Is at risk for infection . Observation of catheter care for Resident #2, on 8/29/24 beginning at 2:28 pm, revealed CNA B and CNA C gathered supplies, entered Resident #2's room, performed hand hygiene and donned PPE. CNA B and CNA C introduced themselves and explained the procedure to Resident #2. CNA C completed perineal care (washing the genitals and anal area), then held Resident #2's catheter close to the catheter anchor, located on Resident #2's right thigh (as opposed to holding the catheter close to the resident's urethral meatus (opening that allows urine to exit the body) to avoid trauma and infection), and wiped from the urethral meatus in a downward motion three times. During an interview on 8/29/24 at 2:50 pm, CNA C said the catheter should have been held at the insertion site to avoid cross contamination and trauma to the resident related to the inflated balloon. During an interview on 8/30/24 at 10:37 am, LVN B said it was important for staff to provide catheter care according to procedure. LVN B further stated not following procedures could affect the residents negatively, putting them at risk for infection, such as UTIs and trauma due to the balloon. LVN B said CNAs were trained by peers during orientation. LVN B further stated there was not a nurse designated to train CNAs, orientation was provided by another CNA. LVN B said she tried to complete skill checkoffs within the first couple of months after CNAs were hired, annually and PRN. LVN B said it was important for staff to be properly trained to ensure the facility provided quality care and policies were followed. LVN B further stated the DON was responsible for ensuring all staff were properly trained and competent. During an interview on 8/30/24 at 11:16 am, LVN C said staff were expected not to wipe using the same surface of the wipe. LVN C further stated not doing so puts residents at risk for infection, such as UTIs, due to cross contamination. LVN C said when perineal care was provided for male residents the shaft of the penis and scrotum should be cleaned. LVN C said when catheter care was provided, the catheter should be held 2-3 inches from the urethral meatus to avoid the risk of infection and trauma. LVN C said LVN B was responsible for reviewing competencies and the nurses on the floor and ADONs were responsible for ensuring CNAs followed procedures when care was provided to residents. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 8/30/24 at 12:32 pm, the Administrator said the DON was responsible for ensuring staff were properly trained. On 8/30/24 the DON was not available for interview. Record review of CLINICAL COMPETENCY VALIDATION Catheter: Indwelling Urinary - Care of, annual review, dated 6/17/24, for CNA C revealed she met all requirements on the check list. Record review of INCONTINENT CARE PROFICIENCY CHECKLIST, dated 8/29/24, for CNA B revealed she met all requirements on the check list. On 8/30/24 a catheter care policy/procedure was requested. The DON was unable to locate a policy but provided the state investigator a CLINICAL COMPETENCY VALIDATION Catheter: Indwelling Urinary - Care of. Review of this document revealed: .9.Cleanses the proximal third of the catheter .manipulating the catheter as little as possible .

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39251 Based on interviews, and record review, the facility failed to ensure resident medical records were kept in accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are complete and accurately documented for 1 of 5 residents (Resident #2) reviewed for clinical records. The facility failed to ensure Resident #2's vital signs were accurately documented in the EMR on 8/28/24. This failure could place residents at risk for improper care due to inaccurate records. Findings included: Record review of Resident #2's Admission Record, dated 8/30/24, revealed the resident was readmitted to the facility on [DATE] with diagnoses that included: UTI, Type 2 Diabetes (chronic condition that affects the way the body processes blood sugar), Morbid Obesity (disorder that involves having too much body fat) , Hemiplegia (paralysis of one side of the body) , Anxiety Disorder (feeling of dread, fear, or uneasiness) , Major Depressive Disorder (mental health disorder characterized by persistently depressed mood or loss of interest in activities), Obstructive and Reflux Uropathy (obstructed urinary flow) , Dysphagia (difficulty swallowing), Congestive Heart Failure (condition in which the heart can't pump blood well enough to meet the body's needs), Hyperlipidemia (high levels of fat in the blood) , and Hypertension (high blood pressure). Record review of Resident #2's quarterly MDS assessment, dated 7/28/24, revealed the resident's cognitive skills for daily decision making was moderately impaired. Record review of Resident #2's Weights and Vitals revealed a heart rate of 37 on 8/28/24 at 8:49 am, documented by MA D. During an interview on 8/30/24 at 10:20 am, Resident #2 said she had been feeling fine and had not experienced any symptoms of low heart rate, such as dizziness or lightheadedness. During a telephone interview on 8/29/24 at 3:54 pm, MA D said the documentation of heart rate of 37 for Resident #2 on 8/28/24 was an error and should have been 87. MA D further stated she did not have her glasses on and entered 37 instead of 87, adding she obtained Resident #2's blood pressure before she administered her blood pressure medication. MA D said she had written the heart rate down on 8/28/24 but had shredded the notes. MA D said as a MA she was unable to correct the error once it was saved in the EMR and only the nurses were able to correct such errors. MA D further stated she forgot to bring the error to the nurse's attention for correction. MA D said Resident #2 was fine on 8/28/24 and did not have any signs/symptoms of low heart rate, such complaints of dizziness or lightheadedness. MA D said it was important resident records were accurately or correction as soon as possible due to safety, such as if the resident needed to be assessed by a nurse. MA D said all staff who documented in resident records were responsible for ensuring documentation was accurate. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 8/30/24 at 10:37 am, LVN B said she reviewed documentation for her assigned residents and reported any inaccuracies to the clinical team in the morning meetings. LVN B further stated when she found inaccuracies in resident records, she followed up with the staff who made the documentation and informed the DON. LVN B said all staff were responsible for ensuring accuracy of resident records. LVN B said she was made aware of the heart rate of 37 documented in Resident #2's EMR on 8/29/24, adding she did not see it because reports were pulled before 8 am. LVN B further stated a heart rate of 37 would be a flag and she would follow up with the staff that documented it. LVN B said MAs did not have the capability to make corrections to documentation in the EMR. During an interview on 8/29/24 at 2:00 pm, the DON said he was told by MA D said the documentation of heart rate of 37 in Resident #2's EMR was made in error and should have been 87. Record review of facility's policy titled Documentation in Medical Record, dated 10/24/22, revealed: Each resident's medical record shall contain an accurate representation of the actual experience of the resident and include enough information to provide a picture of the resident's progress through complete, accurate, and timely documentation .b. Documentation shall be accurate .5. Corrections to a medical record shall be made to clarify inaccurate information .

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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** 39251 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 and to help prevent the development and transmission of communicable diseases and infections for 2 of 2 residents (Residents #1 and Resident #2) reviewed for infection control. 1. The facility failed to ensure CNA B followed proper infection control practices during perineal care for Resident #1 0n 8/29/24. 2. The facility failed to ensure CNA C followed proper infection control practices during catheter care for Resident #2 on 8/29/24. These failures could place residents at risk for exposure to pathogens causing infection resulting in diminished quality of life. Findings included: 1. Record review of Resident #1's Admission Record, dated 8/30/24, revealed the resident was admitted to the facility on [DATE] with diagnoses which included: Dementia (group of thinking and social symptoms that interferes with daily functioning), Hyperlipidemia (high levels of fat in the blood), and Hypertension (high blood pressure). Record review of Resident #1's Care Plan, dated 11/10/23, revealed: .The resident is able to perform hygiene tasks with setup and supervision . Record review of Resident #1's quarterly MDS assessment, dated 7/12/24, revealed the resident had a BIMS score of 12, suggesting intact cognition. Further review of this document revealed Resident #1 was continent of bladder. Observation of perineal care (washing the genitals and anal area) for Resident #1 on 8/29/24 beginning at 2:19 pm revealed CNA B and CNA C gathered supplies but did not remove wipes from the package prior to beginning peri-care. CNA B and CNA C entered Resident #1's room and performed hand hygiene. CNA B and CNA C introduced themselves and explained the procedure to Resident #1. During the procedure CNA B removed a wipe from the package, wiped the right side of Resident #1's perineum, disposed of the wipe, removed another wipe from the package, wiped the left side of Resident #1's perineum, and disposed of the wipe. CNA B removed another wipe from the package and wiped Resident #1's glans penis five times using the same surface previously used (as opposed to a different/clean surface with each wipe). During this observation CNA B did not clean the shaft of Resident #1's penis or his scrotum. CNA B and CNA C removed their gloves and performed hand hygiene. (continued on next page)

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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	During an interview on 8/29/24 at 2:41 pm, CNA B said she had worked at the facility for 5 months. CNA B said, regarding infection control, she was told not to use the same surface when proving perineal care. CNA B further stated this was important because the surface used to wipe became dirty and reusing the same surface puts the resident at risk for infection or UTI. CNA B said not removing wipes from the package prior to providing care and reaching into the package repeatedly during care put the resident at risk for infection due to cross contamination. 2. Record review of Resident #2's Admission Record, dated 8/30/24, revealed the resident was readmitted to the facility on [DATE] with diagnoses that included: UTI, Type 2 Diabetes (chronic condition that affects the way the body processes blood sugar), Morbid Obesity (disorder that involves having too much body fat) , Hemiplegia (paralysis of one side of the body) , Anxiety Disorder (feeling of dread, fear, or uneasiness) , Major Depressive Disorder (mental health disorder characterized by persistently depressed mood or loss of interest in activities), Obstructive and Reflux Uropathy (obstructed urinary flow) , Dysphagia (difficulty swallowing), Congestive Heart Failure (condition in which the heart can't pump blood well enough to meet the body's needs), Hyperlipidemia (high levels of fat in the blood) , and Hypertension (high blood pressure). Record review of Resident #2's quarterly MDS assessment, dated 7/28/24, revealed the resident's cognitive skills for daily decision making was moderately impaired. Further review of this document revealed Resident #2 had an indwelling catheter and was dependent on staff for toileting hygiene. Record review of Resident #2's Care Plan, dated 4/22/23, revealed: [Resident #2] has an ADL self-care performance deficit r/t weakness, obesity, right hemiplegia .requires substantial/maximal assistance for personal hygiene .She requires staff to provide foley catheter care .Is at risk for infection . Observation of catheter care for Resident #2, on 8/29/24 beginning at 2:28 pm, revealed CNA B and CNA C gathered supplies but did not remove wipes from the package prior to beginning catheter care. CNA B and CNA C entered Resident #2's room, performed hand hygiene and donned PPE. CNA B and CNA C introduced themselves and explained the procedure to Resident #2. During the procedure CNA C removed a wipe from the package, wiped the right side of Resident #2's perineum, disposed of the wipe, removed another wipe from the package, wiped the left side of Resident #2's perineum, and disposed of the wipe. CNA C completed perineal care (washing the genitals and anal area), then held Resident #2's catheter close to the catheter anchor, located on Resident #2's right thigh (as opposed to holding the catheter close to the resident's urethral meatus (opening that allows urine to exit the body) to avoid trauma and infection), and wiped from the urethral meatus in a downward motion three times. CNA B and CNA C removed gloves, sanitized their hands, placed resident in a comfortable position, removed PPE, and performed hand hygiene. d During an interview on 8/29/24 at 2:50 pm, CNA C said the catheter should have been held at the insertion site to avoid cross contamination. During an interview on 8/30/24 at 10:37 am, LVN B said it was important for staff to provide catheter care according to procedure. LVN B further stated not following procedures could affect the residents negatively, putting them at risk for infection, such as UTIs. LVN B said LVN C was responsible for ensuring staff followed proper infection control practices. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455869	A. Building B. Wing	08/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Guadalupe Valley Nursing Center	1210 Eastwood Dr Seguin, TX 78155

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	During an interview on 8/30/24 at 11:16 am, LVN C said she tried to provide training within the first 2-3 months after staff were hired and annually, which included infection control. LVN C said staff were expected to remove the number of wipes needed for a procedure prior to proving care to avoid contaminating the entire package of wipes and staff should not wipe using the same surface of the wipe. LVN C further stated not during so puts residents at risk for infection, such as UTIs, due to cross contamination. LVN C said when perineal care was provided for male residents the shaft of the penis and scrotum should be cleaned. LVN C said when catheter care was provided, the catheter should be held 2-3 inches from the urethral meatus to avoid the risk of infection. LVN C said the nurses on the floor and ADONs were responsible for ensuring staff followed proper infection control procedures when care was provided to residents. During an interview on 8/30/24 at 12:32 pm, the Administrator said LVN C was responsible for ensuring all staff followed proper infection control practices. The Administrator further stated when proper infection control practices were not followed it put the resident at risk for negative outcomes, such as infections. Record review of the facility's policy titled Perineal Care, dated 10/24/22, revealed: .It is the practice of this facility to provide perineal care .to promote cleanliness and comfort, prevent infection to the extent possible . 7. Set up supplies .11. Females .c. cleanse perineum .d. Repeat on opposite side using .new disposable wipe with each stroke .12. Males .g. Cleanse the shaft of the penis .Use .new disposable wipe with each stroke. h. Cleanse the scrotum . Record review of the facility's policy titled, Infection Prevention and Control Program, dated 5/13/23, revealed: This facility has established and maintains 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 disease and infections as per accepted national standards and guidelines .2. All staff are responsible for following all policies and procedures related to the program . Review of Lippincott procedures, indwelling urinary catheter care procedure, revised 12/10/23, accessed 8/30/24, from: https://procedures.lww.com/lnp/view.do?pId=4420099, revealed: Clinical alert:?Clean the periurethral area carefully?to prevent catheter movement and urethral traction, which increase the risk of CAUTI (catheter-associated urinary tract infection).