

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455901	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/24/2025
NAME OF PROVIDER OR SUPPLIER Swan Health at Wichita Falls		STREET ADDRESS, CITY, STATE, ZIP CODE 1101 Grace St Wichita Falls, TX 76301	

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)
<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41871</p> <p>Based on observations, interviews and record reviews, the facility failed to establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development of communicable diseases and infections for 4 (Resident #1, Resident #2, Resident #3, Resident #4) of 4 residents reviewed for infection control, in that:</p> <p>The facility failed to implement Enhanced Barrier Precautions for residents requiring ventilation via a tracheostomy tube (a surgically created hole with a tube inserted into the windpipe to provide an alternative airway for breathing) that resided on the vent unit.</p> <p>This failure could affect residents and place them at risk for cross contamination and infections.</p> <p>The findings included:</p> <p>Record review of Resident #1's electronic face sheet dated 12/31/2024 revealed a [AGE] year-old male admitted to the facility on [DATE]. His diagnoses included: Acute and chronic respiratory failure with hypoxia (not enough oxygen in the blood). The resident had a Tracheostomy (a surgically created hole with a tube inserted into the windpipe to provide an alternative airway for breathing).</p> <p>In an observation and interview on 01/23/2025 at 1:46 pm, Resident #1 was sitting inside his room in a wheelchair. The resident had a Tracheostomy. It was observed there was no indication of implementations of Enhanced Barrier Precautions such as signage or PPE. The resident did not know what Enhanced Barrier Precautions were. He said staff does not wear PPE when providing direct care most of the time.</p> <p>Record review of Resident #2's electronic face sheet, dated 12/31/2024 revealed a [AGE] year-old male, with an admitted [DATE]. His diagnosis included: Acute and chronic respiratory failure with hypoxia (not enough oxygen in the blood). The resident had a Tracheostomy (a surgically created hole with a tube inserted into the windpipe to provide an alternative airway for breathing).</p> <p>In an observation and interview on 01/23/2025 at 11:58 am, Resident #2 was sitting inside his room in a wheelchair and just had received peri-care. The resident had a Tracheostomy. It was observed there was no indication of implementations of Enhanced Barrier Precautions such as signage or PPE. The resident did not know what Enhanced Barrier Precautions were. He said staff did not wear PPE when providing peri-care.</p> <p>(continued on next page)</p>

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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 455901
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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Record review of Resident #3's electronic face sheet, dated 12/31/2024 revealed a [AGE] year-old female, with an admitted [DATE]. Her diagnosis included: Chronic respiratory failure with hypoxia (not enough oxygen in the blood). The resident had a Tracheostomy (a surgically created hole with a tube inserted into the windpipe to provide an alternative airway for breathing).</p> <p>In an observation and interview on 01/23/2025 at 1:57 pm, Resident #3 was sitting in a chair in their room. The resident had a Tracheostomy. It was observed there was no indication of implementations of Enhanced Barrier Precautions such as signage or PPE. The resident could not speak but could mouth words with her lips. The resident did not know what Enhanced Barrier Precautions were. She said staff does not wear PPE when providing direct care.</p> <p>Record review of Resident #4's electronic face sheet, dated 12/31/2024 revealed a [AGE] year-old female, with an admitted [DATE]. Her diagnosis included: Chronic respiratory failure with hypercapnia (too much carbon dioxide in the blood). The resident had a Tracheostomy (a surgically created hole with a tube inserted into the windpipe to provide an alternative airway for breathing).</p> <p>In an observation and interview on 01/23/2025 at 1:55 pm, Resident #4 was sitting up in her bed. The resident had a Tracheostomy. It was observed there was no indication of implementations of Enhanced Barrier Precautions such as signage or PPE. The resident could not speak but could mouth her words with her lips. She did not know what Enhanced Barrier Precautions were. She did not know if staff wore PPE while providing direct care.</p> <p>In an interview on 01/23/2025 at 10:45 am, LVN A stated this was her 2nd day on the vent unit. When asked if Enhanced Barrier Precautions were implemented on the vent unit, she said she did not know but was wondering about it. She said she thought it should be due to the resident's having an internal device. She said she was going to seek further clarification.</p> <p>In an interview and observation on 01/23/2025 at 10:50 am, CNA B was observed completing peri-care on Resident #1. CNA B did not have any PPE on except for gloves. The CNA said the resident was not on any precautions. She said there were no residents on the vent unit that was currently on any type of precautions. She said she only wears gloves when providing direct care to residents that have a Tracheostomy.</p> <p>In an interview and observation 1/23/25 at 10:51 am, CNA C was observed completing per-care on Resident #1. CNA C was observed only wearing gloves. CNA C said she did not wear any PPE while providing direct care to Resident #1 because he was not on any type of precautions. She said there were no other residents on the vent unit that were on any type of precautions. She said she only wears gloves while providing care to residents that have a Tracheostomy.</p> <p>In an interview on 01/23/25 at 10:55 am, Respiratory Therapist D said residents that have a Tracheostomy should be on Enhanced Barrier Precautions. Respiratory Therapist D said she wears PPE while providing direct care but she did not know if the Nurses or CNAs wore PPE while providing direct patient care . She did not know why there was no signage or PPE readily available to indicate if a resident was on Enhanced Barrier Precautions.</p> <p>Record review on 01/23/25 at 2:10 pm, of Resident #1, Resident #2, Resident #3, and Resident #4's care plans revealed no care plan for Enhanced Barrier Precautions.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>In an interview on 01/24/25 at 11:00 am, the DON (who is also the Infection Preventionist) said the facility should have implemented Enhanced Barrier Precautions for the resident that have a Tracheostomy but had not done so yet. She said the facility got the supplies in August 2024 but never got it done. She said a possible negative outcome could be the possible spread of infection. She said the facility did not have a policy for Enhanced Barrier Precautions.</p> <p>In an interview on 01/25/25 at 2:30 pm, the Administrator said she purchased the supplies for the facility to implement Enhanced Barrier Precautions last August. Said she was not aware the facility had not implemented Enhanced Barrier Precautions. The Administrator said the facility did not have a policy addressing Enhanced Barrier Precautions.</p> <p>Review of website https://www.cdc.gov/preventmdro on 7/20/24, revealed the following:</p> <p>Multi drug resistant organism transmission is common in skilled nursing facilities, contributing to substantial resident, morbidity and mortality and increased healthcare costs. Enhanced Barrier Precautions are an infection control intervention designed to reduce transmission of resistant organisms that employs targeted gown and glove use during high contact resident activities. EBP may be indicated when contact precautions do not apply for residents with any of the following: wounds or indwelling medical devices regardless of multidrug resistant organism colonization status</p>		