STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455946	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/17/2024
NAME OF PROVIDER OR SUPPLIER: Sweetwater Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 1600 Josephine St Sweetwater, TX 79556	

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 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to organize and participate in resident/family groups in the facility. 49927 Based on observation, interview, and record review, the facility failed to resident or family group, if one exists, with private space, and take responsible steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner for seven of seven anonymous residents reviewed for resident family group and response. The facility did not provide a private space for resident council meetings. This failure could place residents at risk of not being able to exercise their rights of being able to voice their grievances in private, without uninvited staff being present. Findings Included: Observation and interviews on 12/16/2024 at 10:30 AM during a Resident Council meeting held during survey, revealed the following: The Resident Council meeting was held in the dining room. The area had two open doorways that did not have a door closure. The dining room was outside of the nurse's station. There were three staff members observed walking through the dining room during the Resident Council meeting. Residents were seated throughout the large dining room area, which contained approximately twelve round tables that could have possibly seated, approximately, 4-5 residents. The residents in attendance had difficulty hearing each other as well as the State Surveyor during the meeting, despite voices being raised so they could hear. The noise from the hallway was heard in the dining room and caused it to be more difficult to hear during the meeting. Staff were observed entering the far side of the dining area, near the kitchen, which caused a distraction. Residents stated they had Resident Council meetings in the dining room every month, and there was not another, more private, area for residents to meet. Residents stated the area was distracting and difficult to hear during meetings. During an interview with the AD on 12/16/2024 at 11:15 AM; the AD stated she was responsible for scheduling and coordinating Resident Council meetings each month. The AD stated Resident Council meetings were always held in the dining room, and there were no doors on the dining room entry ways for her to close during these meetings. The AD stated she tried to remind staff, when they had a meeting, to prevent staff from entering the dining room. The AD stated she never thought of having the meeting in a different area as this was where the meeting had been held since she started at the facility, a year ago. The AD stated staff often walked through the dining room while residents had Resident Council meetings. (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 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with the ADM on 12/17/2024 at 11:40 AM; the ADM stated he recognized that there was no privacy for the Resident Council meeting that was held during survey. The ADM stated the Resident Council meetings were always held in the dining room. The ADM stated the AD was responsible for scheduling and coordinating Resident Council meetings each month. The ADM stated there were no doors on the dining room to adhere to the facility's policy which indicated Resident Council meetings would be held in a private space. The ADM stated he observed staff walking through the dining room during the Resident Council meeting, and he stated he usually had staff outside of the dining room when residents had Resident Council to redirect staff from entering the dining room. The ADM stated this practice did not promote a private space for Resident Council, as staff could overhear the meeting. The ADM stated that the noise from the hallway, around the nurse's station, could be distracting in the dining room area when Resident Council meetings were held. The ADM stated he would begin having Resident Council meetings in the unused dining area of hallway A, as this area was unused and there were few residents on that hallway. The ADM stated he would block off the back side of the hallway to allow residents to have a private meeting space for Resident Council in the future. Record Review of the facilitiy's undated document titled Grievances, Recording and Investigating, revised February 2021, revealed the following: Policy Statement: The facility supports residents' rights to organize and participate in the resident council. Policy Interpretation and Implementation: 1. The resident council group is provided with space, privacy, and support to conduct meetings.

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. 42515 Based on observation, interviews, and record review, the facility failed to ensure information on how to file a grievance or complaint was available to the residents for 7 of 7 confidential residents reviewed for grievances. The facility failed to provide a prominent posting of the Grievance Procedure, access to Grievance forms, information of who the facility's grievance official was and their contact information, information of how a resident could file an anonymous grievance, and the residents' right to obtain a written decision related to their grievance. This failure could place residents at risk of unresolved grievances and a decreased quality of life. Findings include: During Confidential interviews revealed 7 of 7 confidential residents stated they did not know about the grievance process. They also stated they did not know where to obtain or submit a grievance form. They stated they did not know they could file a Grievance anonymously. They stated they did not know who their grievance officer was. They stated the Grievance procedure had never been discussed in Resident Council or upon admission. They also stated they had not observed a posting of the Grievance procedure anywhere in the facility. Residents did not know how to file a grievance. Residents did not know where to acquire a grievance form, who to turn the form into, and what should happen once a grievance was filed. The Residents did not know they had the right to receive a written decision once their grievance was resolved. Residents did not know they could file anonymous grievances. Observation on 12/16/2024 at 11:30 AM showed there were no visible grievance forms, nor postings with instructions explaining how grievances could be filed, found in any of the areas of the facility accessible to the residents to obtain on their own. (continued on next page)

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F 0585

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Many

During an interview with the AD on 12/16/2024 at 11:15 AM, the AD stated she was responsible for scheduling and coordinating Resident Council meetings each month. The AD stated complaints of missing items were made during Resident Council, and she completed grievance forms for the residents if these complaints were made. The AD stated there were never any other grievances or complaints made during resident council other than missing laundry, at times. The AD stated the grievance forms were not available for residents to obtain without asking a staff for the form. The AD stated the forms were not posted in an area accessible to the residents because she obtained the grievance forms for the residents when needed. The AD stated she felt this was an adequate process for the residents and she did not feel the grievance forms needed to be accessible to the residents to obtain on their own since she stated staff would obtain the forms for the residents. The AD stated she passed the grievance forms on to the laundry personnel to help find the residents' missing laundry, when it was necessary, and the laundry was always found or replaced if it could not be found. The AD stated she obtained the grievance form from the nurses' station or the administrator. The AD stated she was not aware of any location in the facility that the forms were available directly for the residents to obtain themselves. The AD stated the ADM reviews grievances to ensure they were resolved. The AD stated it was important for residents to be able to voice their concerns to ensure their needs were met.

During an interview with the ADM on 12/17/2024 at 11:40 AM, the ADM stated grievances forms were filled out by all staff for the residents when a complaint was made, and the grievance forms were then turned in to the Department manager of the Department that the grievance pertained to, such as laundry. The ADM stated the Department manager would then investigate to resolve the grievance. The ADM stated the grievance forms were then turned in to him, and he would follow up to ensure the grievance was resolved. The ADM stated he was responsible for ensuring each department resolved their grievances. The ADM stated residents were given a copy of the Residents Rights upon admission, but the facility did not have a grievance posting in the facility for residents to review, nor did the facility have a place for residents to obtain a grievance form. The ADM stated there was no process in place for a resident to file an anonymous grievance, as he had never had a resident ask to file an anonymous grievance. The ADM stated grievance forms were available to residents by request via facility staff. The ADM stated it was important for residents to be able to file grievances, so their concerns were resolved timely and to ensure their needs were met. The ADM stated he would establish a grievance location and obtain a box for residents to access going forward, which would allow residents to file grievances anonymously and obtain a grievance form on their own, if they choose.

Record Review of the undated document titled Residents' Rights, revised February 2021, revealed the following:

Policy Interpretation and Implementation:

U. voice grievances to the facility, or other agency that hears grievances, without discrimination or reprisal and without fear of discrimination or reprisal;

V. have the facility respond to his or her grievances;

Record Review of the undated document titled Grievances, Recording and Investigating, revised 1/12/2023, revealed the following:

Policy Statement:

(continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	All grievances filed with the facility will be investigated and corrective actions will be taken to resolve the grievance(s). Policy Interpretation and Implementation: 1. The facility will make information on how to file a grievance available to residents, family, and staff.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49305 Based on observation, interview, and record review the facility failed to ensure that its medication error rate was not 5 percent or greater. The facility had a medication error rate of 7.69% based on 2 errors out of 26 opportunities, which involved 2 of 10 residents (Resident #202 and Resident #2) reviewed for medication administration. 1. LVN A failed to administer Midodrine (given for low blood pressure) to Resident #202, according to physician orders. 2. LVN A failed to administer Tylenol (given for pain) to Resident #2, according to physician orders. These failures could place residents at risk of incomplete therapeutic outcomes, increased negative side effects, and decline in health. Findings included: 1. Record review of Resident #202's face sheet dated 12/16/24 revealed a [AGE] year-old male with an admitted [DATE]. Resident #202 had diagnoses which included: metabolic encephalopathy (brain dysfunction), acute respiratory failure (inability to maintain adequate oxygen level), Gastro-esophageal Reflux Disease (digestive condition), paraplegia (paralysis of arms), and hypotension (low blood pressure). Record review of Resident #202's Admission MDS dated [DATE] revealed a BIMS of 15, which indicated the resident was cognitively intact. Record review of Resident #202's current physicians orders revealed an order with a start date of 12/05/24, for Midodrine 10mg tablet, 1 by mouth three times per day; 08:00 AM, 12:00 PM, 08:00 PM. Special instructions: Hold if systolic is over 130 or diastolic is over 80. During a medication administration observation on 12/16/24 at 11:48 AM for Resident #202, LVN A assessed the resident's blood pressure at 124/88, utilizing a wrist blood pressure cuff. LVN A then dispensed one Midodrine 10mg tablet into a medication cup and administered the medication to Resident #202. Observation of the medication card for Resident #202's medication - Midodrine 10 mg showed: Special instructions: Hold if systolic is over 130 or diastolic is over 80. During an interview on 12/16/24 at 11:51 AM, LVN A stated she did not administer Resident #202's Midodrine 10 mg according to physician's orders. She stated she should have held the medication due to Resident #202's blood pressure reading, which was outside the blood pressure range set by the physician's order. She stated, I don't know why I didn't catch it before I gave the medication? I just made a mistake. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Record review of Resident #2's face sheet dated 12/16/24 revealed a [AGE] year-old female with an original admitted [DATE]. Resident #2 had diagnoses which included: myocardial infarction (heart attack), unspecified pain, cerebral infarction (stroke), dementia, cognitive communication deficit (difficulty in communication), osteoporosis (decreased bone mass). Record review of Resident #2's Annual MDS dated [DATE] revealed a BIMS of 06, which indicated the resident had severe cognitive impairment. Record review of Resident #2's current physicians orders revealed an order with a start date of 01/20/24 for Tylenol Extra Strength (acetaminophen) tablet; 500 mg; amt: one; oral Three Times A Day 08:00 AM, 12:00 PM, 08:00 PM. During a medication administration observation on 12/16/24 at 12:08 PM for Resident #2, LVN A reviewed the order for Tylenol 500 mg in Resident #2's electronic record, then dispensed two Tylenol 500 mg tablets into a medication cup and administered the medication to Resident #2. During an interview on 12/17/24 at 11:17 AM, LVN A stated she did not administer Resident #2's Tylenol 500 mg tablets, according to physicians' orders. She stated she gave 2 tablets to Resident #2 when the order stated to give one tablet. She stated, I'm not sure why I did that-I don't usually make medication errors and I'm usually the one who does med pass every year with the state surveyor. During an interview on 12/17/24 at 11:17 AM, LVN A stated the process for administering medications to a resident was to first, look at the order, then pull the medication card from the cart, match the medication to the order, dispense the medication into the cup, repeat for other medications for the same resident, take vital signs if needed, then administer the medication after identifying the resident and always use the 5 rights of medication administration. LVN A stated she was trained on proper medication administration through yearly skills checks conducted by the facility's Corporate Nurse, who conducted a medication pass observation with nursing staff members. She stated medication administration observations were also conducted approximately every three months by the facility's Pharmacy Consultant. LVN A stated the protocol after making a medication error was to immediately report it to the DON, notify the provider and the family, and monitor the resident for signs of adverse reaction through observations and vital signs checks. She stated the documentation for a medication error would include completing a medication error form in the EMR, which copied to the progress note and added the information to the 24-hour nurses report to pass on to the oncoming shift. LVN A stated she notified the DON at the time of the error and notified the resident's providers and family members of the error. LVN A stated she completed the medication error form after all notifications were made. She stated both residents were monitored following the errors and neither resident exhibited signs of an adverse reaction. LVN A stated a potential negative outcome for failure to administer medications according to physician's orders would be adverse reactions, worsening of condition, and death. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/17/24 at 11:29 AM, the ADM stated he was informed by the DON of medication errors made on observation of medication pass on 12/16/24. He stated the DON was responsible for training staff on proper medication administration. He stated the system for monitoring accuracy of medication administration was medication pass observations conducted with nursing staff several times per year by the Pharmacy Consultant. The ADM stated his expectation of staff for accurate medication administration was that guidelines were always followed. He stated a potential negative outcome for failure to properly administer medications, according to physicians' orders would be adverse effects on the resident. During an interview on 12/17/24 at 11:34 AM, the DON stated she was informed by LVN A of medication errors made on observation of medication pass on 12/16/24. She stated she was responsible for assuring staff were trained on accurate medication administration. She stated medication pass audits conducted by the Corporate RN and Pharmacy Consultant were used to monitor the nursing staff's accuracy of medication administration. She stated she did not have a record of the medication administration audits conducted with LVN A, but the Corporate RN kept records of audits. The DON stated her expectation of staff for proper medication administration was that staff follow policy, which stated medications would be administered accurately, according to physician's orders. The DON stated a potential negative outcome of failure to properly administer medications, according to physicians' orders would be harm to the resident. Record review of the facility-provided policy titled, Specific Medication Administration Procedures, dated 06/01/22, revealed: Oral Medication Administration Purpose To administer oral medications in a safe, accurate and effective manner. Procedures . B. Review and confirm medication orders for each individual resident on the medication administration record prior to administering medications to each resident. Review medication administration record for any test or vital signs that need to be determined prior to preparing the medications. C. For solid medications: 1) Pour or push the correct number of tablets or capsules into the supply cup . . I. Chart medication administration on Medication Administration Record immediately following each resident's medication administration.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 42515 Based on observation, interview, and record review, the facility failed to ensure each resident received and the facility provided food that was palatable, attractive and at a safe, and appetizing temperature for 3 of 3 food forms (Regular, Mechanical Soft, and Pureed) for 1 of 1 meal reviewed for palatability. 1) The facility failed to provide food that was palatable for 3 of 3 food forms served (Regular, Mechanical Soft, and Puree) at 1 of 1 meal observed (12/16/24 lunch). This failure could place residents at risk of decreased food intake, hunger, and unwanted weight loss. The findings included: During confidential individual interviews 4 of 12 residents voiced concerns related to food palatability. One resident stated the food was not good most days. One resident stated the food lacked seasoning and tasted like nothing. One resident stated sometimes the food is good and sometimes it is pretty bad. One resident stated the food was very bland and had little taste. Observation on 12/16/24 at 12:52 PM the test trays arrived at the conference room and sampling began at 12:54 PM with the following results: Regular Meal - Regular Texture Meatballs - no issues White Rice - sticky and very bland, no taste Green Beans - no issues Biscuit - dry/flaky with a burned bottom. Regular Meal - Mechanical Soft Texture Meatballs - no issues White Rice - thick and bland, no taste Green Beans - no issues Biscuit - dry/flaky with a burned bottom. Regular Meal - Puree Meatballs - no issues (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	White Rice - thick and bland, no taste Green Beans - no issues Biscuit - no issues Interview on 12/16/24 at 1:02 PM, the DM was asked to try the test tray and stated the biscuits on the trays were overcooked. The DM stated the white rice tasted bland but she was not allowed to add any salt to the food due to some of the resident's dietary restrictions. Interview on 12/17/24 at 10:55 AM, the DM stated sometimes she tasted the food before serving it to the residents, but not all the time. The DM stated she did not taste the food before serving lunch yesterday, 12/16/24. The DM stated she was nervous, but she had been trained on seasoning the foods and tasting it before it was served. The DM stated sometimes the recipes were good and sometimes they were not. The DM stated none of the residents had complained of the food not tasting good to her. The DM stated she would go around and ask the residents about the food but did not do it all of the time. The DM stated the residents may not want to eat the food if it did not taste good. Interview on 12/17/24 at 11:03 AM, the ADM stated the DM was responsible for food tasting. The ADM stated the dietary staff had been trained on food palatability. The ADM stated the residents did not usually have complaints of the food tasting bad. The ADM stated he was unsure of any negative outcomes to the residents as the facility always had alternates to serve the residents if they did not like the food. Interview on 12/17/24 at 11:23 AM, the ADM stated the policy provided for food palatability was the most relevant policy he could find. Record review of the facility's grievance log from March 2024 to December 2024 revealed no complaints regarding food palatability. Record review of the facility's policy and procedure titled, Alternate Food Choices and Substitutions and Honoring Preferences, dated 2018, reflected the following: Policy: The facility believes that adequate nutrition is essential to each resident's well-being and good health

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 42515 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 1 of 1 kitchen reviewed for dietary services. 1) The facility failed to keep freezer handles clean. 2) The facility failed to properly store food in the freezer and refrigerator. These failures could place residents at risk for food contamination and foodborne illness. The findings included: Observation during a kitchen tour on 12/15/24 beginning at 11:49 AM revealed 5 freezer handles had dry, sticky substances on the inside handles, in the freezer; a box of biscuits that was not properly sealed with an opened date of 12/14/24, in the refrigerator; a bag of turkey sandwich meat that was not properly sealed with an opened date of 12/11/24, a gallon size bag of shredded cheese that was not properly sealed with an opened date of 12/8/24, and a bag of corn tortillas that was not properly sealed with an opened date of 12/12/24. Interview on 12/15/24 at 12:00 PM, the DM stated the freezer handles had not been cleaned today. The DM stated the freezer handles should be cleaned at the end of the day and when they were noticeably dirty. The DM stated the food should be stored fully sealed in the refrigerator and the freezer. Interview on 12/17/24 at 10:55 AM, the DM stated she was mainly responsible for ensuring kitchen foods were stored properly and kitchen items were cleaned. The DM stated the dietary staff were trained on food storage and kitchen cleanliness. The DM stated she gave reminders to dietary staff every few days regarding food storage and kitchen cleanliness. The DM stated the residents could possibly get sick due to food items not being properly stored or the freezer handles not being cleaned. Interview on 12/17/24 at 11:03 AM, the ADM stated all dietary staff were responsible for kitchen sanitation and food storage, but the DM was ultimately the responsible one. The ADM stated he was unsure why the kitchen had concerns as all dietary staff were trained on kitchen sanitation and food storage. The ADM stated the kitchen staff knew their expectations. The ADM stated the concerns to the residents was food borne pathogens. Record review of the facility's policy and procedure title, Food Storage dated 2018, reflected the following: Policy: To ensure all food served by the facility is of good quality and safe for consumption, all food will be stored according to the state, federal and US Food Codes . Procedure: (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	.2. Refrigerators d. Date, label and tightly seal all refrigerated foods using clean, nonabsorbent, covered containers that are approved for food storage . 3. Freezers e. Store frozen foods in moisture-proof wrap or containers Record review of the facility's policy and procedure titled, General Kitchen Sanitation dated 2018, reflected the following: Policy: The facility recognizes that food-borne illness has the potential to harm elderly and frail residents. All Nutrition & Food Service employees will maintain clean, sanitary kitchen facilities in accordance with the state and US Food Codes in order to minimize the risk of infection and food borne illness. Procedure: 1. Clean and sanitize all food preparation areas, food-contact surfaces, dining facilities and equipment. After each use, clean and sanitize .kitchenware and food-contact surfaces of equipment . 6. Clean nonfood-contact surfaces of equipment at intervals as necessary to keep them free of dust, dirt, and food particles and otherwise in a clean and sanitary condition Record review of the facility's policy and procedure titled, Refrigerators, Coolers and Freezers, dated 2018 reflected the following: Policy: The facility will maintain refrigerators, coolers, and freezers in a clean and sanitary manner to minimize the risk of food hazards. Refrigerators, coolers and freezers will be kept clean on a daily basis and will be thoroughly cleaned every month or more often as needed

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NAME OF PROVIDER OR SUPPLIER Sweetwater Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1600 Josephine St Sweetwater, TX 79556	

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** 49305 Based on observation, interview and record review, 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 and transmission of communicable diseases and infections for 1 of 5 residents (Resident #41) and 2 of 5 staff (CNA A, and CNA B) reviewed for infection control. CNA A and CNA B failed to wear proper PPE when providing direct care for Resident #41 who was on Enhanced Barrier Precautions. Findings included: Record review of Resident #41's face sheet dated 12/15/24 revealed a [AGE] year-old female with an admitted [DATE]. Resident #41 had diagnoses which included: dysphagia (difficulty swallowing) following cerebral infarction (stroke), major depressive disorder (persistent depression), unspecified pain, aphasia (inability to communicate), reduced mobility, cognitive communication deficit (difficulty in communication), and Gastro-esophageal Reflux Disease (digestive condition). Record review of Resident #41's MDS dated [DATE] revealed a BIMS of 10, indicating moderate cognitive impairment. Section K - Swallowing/Nutritional Status indicated Resident #41 had a feeding tube while a resident. Record review of Resident #41's current physicians orders revealed an order for ENHANCED BARRIER PRECAUTIONS with a start date of 07/02/24 and an order for Enteral feeding every shift with a start date of 05/07/24. An order for Jevity 1.5 bolus 330 mL 4x times per day (1320 mL total formula) 08:00AM, 12:00 PM, 08:00 PM, 12:00 AM, had a start date of 06/22/24. Observation on 12/15/24 at 12:07 PM, CNA's A and B were observed conducting direct care to resident #41 by performing a transfer of Resident #41 to her Geri-chair and a clothing change. Resident #41 had a feeding tube and was on Enhanced Barrier Precautions, per signage on the outside of the door. CNA A and CNA B failed to put on required PPE (gown and gloves) prior to performing direct care for Resident #41. Enhanced Barrier Precaution signage was noted to the door of Resident #41's room and a storage cart for PPE was noted sitting at the entrance to Resident #41's room. During an interview on 12/15/24 at 12:14 PM, CNA A stated she and CNA B performed a clothing change and transfer for Resident #41 before taking her to the dining room for lunch. She stated she did not put on PPE prior to performing direct care for Resident #41 because she did not think she needed to. CNA A stated she did not recall when she had been trained on Enhanced Barrier Precautions. She stated the purpose of EBP was to show those entering the room that the resident had something like a catheter or feeding tube and remind nursing to use PPE when they do care on the resident. CNA A read aloud the EBP signage on the door to Resident #41's room and stated she had not properly followed EBP, according to the sign, because it says if you're doing a transfer, you should wear PPE. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455946	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sweetwater Healthcare Center	1600 Josephine St Sweetwater, TX 79556

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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 12/15/24 at 04:12 PM, CNA B stated she and CNA A performed a gown change and transfer to the Geri-chair for Resident #41, before taking her to the dining room for lunch. She stated she did not put on PPE prior to performing direct care for Resident #41. She stated EBP was a precaution for residents with a catheter, wounds, a breathing tube, or a feeding tube. She stated she was trained on EBP approximately quarterly by the DON and ADON through in-services and she was aware EBP required PPE while doing care on a resident. CNA B stated, we should have had our PPE on while we were doing care for the resident. We just forgot because state was here. She stated failure to observe EBP properly could cause the resident to get an infection.

During an interview on 12/17/24 at 11:29 AM, the ADM stated he was not aware, prior to survey, that staff were not observing EBP while performing direct care. He stated the DON was responsible for training staff on proper precautions needed for EBP. He stated the system for assuring that staff were following EBP properly was done by rounds conducted by the DON. He stated his expectation of staff regarding EBP was that staff followed policy at all times. He stated a potential negative outcome for failure to follow Enhanced Barrier Precautions would be the spread of infection.

During an interview on 12/17/24 at 11:34 AM, the DON stated she was not aware, prior to survey, that staff were not observing EBP while performing direct care. She stated she was responsible for training staff on observing proper EBP. The DON stated the system for monitoring to assure staff followed EBP was done through rounds in the facility made by herself and the weekend supervisor. She stated her expectation of staff was to follow policy and procedure for EBP at all times. She stated a potential negative outcome for failure to follow Enhanced Barrier Precautions would be spreading infection.

Record review of the facility-provided policy titled, Enhanced Barrier Precautions, revised 4-1-24, revealed:

Policy Statement

It is the policy of this facility to implement enhanced barrier precautions for the prevention of transmission of multidrug-resistance organisms.

Definition:

Enhanced barrier precautions (EBP) refers to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and gloves use during high contact resident care activities.

Policy Interpretation and Implementation

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2. Initiation of Enhanced Barrier Precautions:

b. An order for enhanced barrier precautions will be obtained for residents with any of the following:

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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	i. Wounds (e.g., chronic wounds such as pressure ulcers, diabetic foot ulcers, unhealed surgical wounds, and chronic venous stasis ulcers) and/or indwelling medical devices (e.g., central lines, urinary catheters, feeding tubes, tracheostomy/ventilator tubes) even if the resident is not known to be infected or colonized with a MDRO. Record review of the facility's, undated, sign posted outside Resident #41's door, titled Enhanced Barrier Precautions, revealed: EVERYONE MUST: Clean their hands, including before entering and when leaving room. PROVIDERS AND STAFF MUST ALSO: Wear gloves and a gown for the following High-Contact Resident Care Activities Dressing Bathing/Showering Transferring Changing Linens Providing Hygiene Changing briefs or assisting with toileting Device care or use: central line, urinary catheter, feeding tube, tracheostomy Wound Care; any skin opening requiring a dressing