STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455961	A. Building B. Wing	04/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Palo Pinto Nursing Center	200 Southwest 25th Ave Mineral Wells, TX 76067

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 0728 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that nurse aides who have worked more than 4 months, are trained and competent; and nurse aides who have worked less than 4 months are enrolled in appropriate training. 41944 Based on interview and record review, the facility failed to not use any individual working in the facility as a nurse aide for more than four months on a full-time basis unless that individual completed a training and competency evaluation program for 2 (SNA A and SNA B) of 2 Student Nurse Aides reviewed for nursing services. The facility failed to ensure SNA A and SNA B was certified within the required time. This failure could place residents at risk for receiving inappropriate care from an individual whose skill level was not known. Findings include: Review of the facility's employee files revealed: -SNA A had a hire date of 12/08/2021 and worked full time. An annual EMR/NAR check on 11/08/2024 indicated SNA A did not have a CNA certification number. -SNA B had a hire date of 05/20/2024 and worked full time. An annual EMR/NAR check on 05/30/2024 indicated SNA B did not have a CNA certification number. During an interview on 04/09/2025 at 5:30 PM, SNA A stated he had been working continuously at the facility since 05/30/2024. He stated he performed the duties of a nurse aid on the evening shift and assisted certified nurse's aides with transfers and other patient care tasks. He stated that he had gone to take his certification test, did not have the proper ID, and was turned away. He stated he was not aware of the identification that he needed in order to take the test. He stated he was in the process of getting the proper ID to take the test. He stated the adverse outcome that could result from failure to be certified would be the resident might not get the care that they should receive, and that might affect their health and overall wellbeing. He stated he had not registered to take the test again because of his lack of an ID. SNA B was not interviewed during the investigation (unable to reach by phone. (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 0728 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 04/10/2025 at 2:47 pm, the DON stated that her expectation would be for the facility to have certified nurse assistants. She stated that she recently took on the responsibility of monitoring and ensuring the CNAs tested and became certified. She stated she didn't know there was a limit on how long SNA A and B could work before becoming certified. She stated no negative effect had occurred to residents due to care received from a non-certified SNA, but an adverse outcome could be that a resident could not receive appropriate care. She stated it was the responsibility of the prior ADON to monitor training and certifications, but going forward it was her responsibility. Record review of a document titled How To Become a Certified Nurse Aide (CNA) in Texas (from website www.hhs.texas.gov)website not dated stated in part: - Complete NATCEP Training (Nurse's aide Certification and Evaluation Training program) - Submit an application through TULIP (Texas Unified Licensure Portal) - NATCEP approval - based on successful completion of training; Successful background check Student not listed on the EMR - Schedule and pass the exam : Student schedules and passes both the written and skills exams Record review of the document provided by the DON titled Job Description For a SNA dated 2010, and signed on 04/18/23 by SNA A stated the following [in part] : Must provide written proof of a completion of 16-hour ADL training by authorized school instructor. Only perform patient care areas that they have been trained for, accountable for personal care (grooming, dressing, personal care, catheter care, peri care, and dressing), basic computer knowledge, identifies and reports any condition requiring management attention, ambulate and transfer residents utilizing appropriate assistive devices and body mechanics . Applicant declaration: I have read the qualifications and requirements of the position of student nurses aide; I understand this position is not permanent but limited to 120 days in which I am required to test and obtain certification. I understand and certify that the foregoing is a non-exhaustive criterion that is consistent with the needs of this facility and is a legitimate measure of the qualifications for a Certified Nursing assistant and relates to the functions essential to a certified nursing assistant.

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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** 41944 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 1 (Resident # 1) of 5 residents reviewed for infection control, in that: The facility failed to implement Enhanced Barrier Precautions for Resident #1 who had an Enhanced Barrier Precautions sign posted on her room door. This failure could affect residents and place them at risk for cross contamination and infections. The findings included: Record review of Resident 1's electronic Face Sheet dated 04/09/2025 revealed a [AGE] year-old female admitted to the facility on [DATE]. Her diagnoses included: sepsis (a serious condition resulting from the presence of harmful microorganisms in the blood or other tissues), MRSA (methicillin resistant staph aureus, a drug resistant bacteria) , clostridium difficile (inflammation of the colon caused by the bacteria clostridium difficile) diagnoses. An observation and interview on 04/10/25 at 9:21 AM revealed CNA C and CNA D entered Resident #1's room to perform incontinent care. There was an Enhanced Barrier Precaution sign on the door, and personal protective equipment outside of the room. CNAs C and D entered the room to provide incontinent care. They did not wear a gown. The DON was standing outside the door because the call light remained on. The CNAs washed their hands, applied gloves, and informed Resident #1 that they were going to do incontinent care. Resident #1 requested the surveyor leave the room for privacy. There were no gowns in the room. In an interview on 4/10/25 at 9:30 AM with CNA C and CNA D, both stated they realized after they got in the room they should have donned a gown to provide any direct patient care. Both stated they were not sure why they didn't put on a gown. CNA C stated she knew the resident had a bowel movement be and was laying crooked in the bed before she entered the room. She stated she did not usually work that hallway, so she wasn't familiar with the residents. She stated she went to get CNA D who was assigned to the hall. She stated they proceeded to the room and provided privacy by shutting the door and pulling the curtain and completed incontinent care. CNA C stated she knew after they had started to perform the incontinent care they had messed up because they didn't put on gowns. She stated she did not know why they did not get gowns when they realized their mistake. She stated she felt like she forgot the gown because they were trying to hurry because the resident was laying crooked in the bed and was upset that she had a bowel movement in the bed. She stated she just thought it was more important to get her cleaned up quickly. Both CNA C and CNA D stated that a negative outcome for the resident that could result from their failure to wear a gown would be the spread of infection. They both stated they did not remember when they last had an in-service on enhanced barrier precautions at the facility. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 04/10/2025 at 3:30 PM, the DON stated it was her expectation that the CNAs should have worn a gown when performing direct care on a resident on Enhanced Barrier Precautions. She stated they had been in-serviced on enhanced barrier precautions. She stated failure to implement enhanced barrier precautions could result in the spread of multi drug resistant organisms. Record review of the facility's policy titled Infection Prevention and Control Program dated 10/24/2022 stated in part: Enhanced barrier precautions are used in conjunction with standard precautions and expand the use of PPE to donning of gown and gloves during high contact resident care activities that provide opportunities for transfer of Multi Drug Resistant organisms to staff hands and clothing. Enhanced barrier precautions are indicated for residents with any of the following: infection or colonization with a multi drug resistant organism when contact precautions do not otherwise apply, wounds and or indwelling medical devices regardless of multi drug resistant organism colonization status