

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455989	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/22/2024
NAME OF PROVIDER OR SUPPLIER Borger Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1316 S Florida Borger, TX 79007	

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 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47854</p> <p>Based on observation, interview, and record review the facility failed to ensure residents the right to be free from abuse and/or neglect for 1 (Resident #1) of 8 residents reviewed for abuse and/or neglect.</p> <p>Observation revealed Resident #1's bed was saturated with urine.</p> <p>This failure could affect residents resulting in physical or emotional harm resulting in in deterioration in their health condition, need for medical treatment, physical impairment, exacerbation of their condition, serious bodily harm, emotional distress, and feelings of isolation.</p> <p>Findings include:</p> <p>Record review of Resident #1's face sheet, printed 06/22/2024, revealed a [AGE] year-old female, who was admitted to the facility on [DATE] with the following diagnoses: Unspecified dementia, severe, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety, Muscle weakness (generalized), Personal history of urinary (tract) infections, other reduced mobility, other lack of coordination, need for assistance with personal care, altered mental status, unspecified, cognitive communication deficit.</p> <p>Record review of Resident #1's clinical record revealed her last MDS, completed on 05/20/2024, revealed Resident #1 did not have a BIMS score listed on her MDS. Resident #1's functionality revealed that she is totally dependent upon staff for activities of daily living.</p> <p>Record review of Resident #1's care plan, last revision was 05/07/2024, revealed the following:</p> <p>Problem Start Date: 12/04/2018</p> <p>Category: Pressure Ulcer/Injury</p> <p>Resident is at risk for pressure ulcers R/T</p> <p>Incontinence.</p> <p>Edited: 05/07/2024</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
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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Edited By: [Named RN], RN</p> <p>Long Term Goal Target Date: 08/07/2024</p> <p>Resident's skin will remain intact.</p> <p>Edited: 05/07/2024</p> <p>Edited By: [Named RN], RN</p> <p>Approach Start Date: 12/04/2018</p> <p>Conduct a systematic skin inspection Weekly.</p> <p>Pay particular attention to the bony prominences.</p> <p>Created: 12/04/2018</p> <p>Created By: [Unidentified staff]</p> <p>Nurse Aides, Nursing</p> <p>Approach Start Date: 12/04/2018</p> <p>Keep clean and dry as possible. Minimize skin exposure to moisture.</p> <p>Created: 12/04/2018</p> <p>Created By: [Unidentified Staff]</p> <p>Nurse Aides, Nursing</p> <p>Approach Start Date: 12/04/2018</p> <p>Report any signs of skin breakdown (sore, tender, red, or broken areas).</p> <p>Created: 12/04/2018</p> <p>Created By: [Unidentified Staff]</p> <p>Problem Start Date: 05/30/2018</p> <p>(continued on next page)</p>

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Category: Urinary Incontinence</p> <p>Resident experiences bladder incontinence</p> <p>Edited: 05/07/2024</p> <p>Edited By: [Named RN], RN</p> <p>Long Term Goal Target Date: 08/07/2024</p> <p>Resident will maintain current level of bladder continence.</p> <p>Edited: 05/07/2024</p> <p>Edited By: [Named RN], RN</p> <p>Approach Start Date: 05/30/2018</p> <p>Resident will wear briefs and pad r/t briefs are saturated and does not hold all her urine</p> <p>Every 6 Hours; 12:00 AM, 06:00 AM, 12:00 PM, 06:00 PM</p> <p>Edited: 08/29/2019</p> <p>Edited By: [name], LVN ADON</p> <p>During an observation on 06/22/2024 at 3:14am Resident #1 was in her bed sleeping. Bed saturated to the touch.</p> <p>During an observation on 06/22/2024 at 3:55am of Resident #1's bed still saturated and had not been changed as of yet.</p> <p>Interview/Observation on 06/22/2024 at 3:56am with CNA A on when the last time Resident #1 was changed. CNA A stated at 2am and that it was close to time to change her again. CNA A stated that residents were checked every 2 hours. Incontinent care was requested for Resident #1 at this time. Incontinent care was performed, and a total bed change took place during this resident care.</p> <p>Observation on 06/22/2024 at 4:05am revealed CNA B came into assist CNA A with the remaining incontinent care of Resident #1.</p> <p>(continued on next page)</p>

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 06/22/2024 at 5:11am, CNA A was able to answer all abuse and neglect questions appropriately to include that leaving Resident #1 saturated would be considered neglect. CNA A stated that she had not been trained on abuse or neglect training since she started work in the facility three days ago.</p> <p>During an interview on 06/22/2024 at 5:20 am, CNA B was able to answer all abuse and neglect questions appropriately to include that leaving Resident #1 saturated in urine would be considered neglect. CNA B could not confirm or deny any abuse, neglect, or exploitation training upon hire or in the past 6months of being employed in the facility.</p> <p>During [NAME] nterview on 06/22/2024 at 5:33am, Regional RN was able to answer all abuse and neglect questions appropriately to include that leaving Resident #1 saturated in urine would be considered neglect.</p> <p>Record Review revealed that CNA B did receive abuse, neglect, and exploitation training at date of hire.</p> <p>During an interview on 06/22/2024 at 6:28am ADM was able to answer all abuse and neglect questions appropriately. ADM would not confirm that leaving a resident saturated in urine was neglect. ADM stated, It could be, depends on the last time the resident received prompt toileting and incontinence care and if there is a medication change, if the resident would need to be changed to a Q1 hour. We would have to look at all of those factors.</p> <p>Record review of employee training for CNA A, dated 06/11/2024, revealed that CNA A was trained on abuse and neglect policy and procedure.</p> <p>Record review of employee training for CNA B, dated 12/26/2023, revealed that CNA B was trained on abuse and neglect policy and procedure.</p> <p>Record review of facility provided policy, Abuse, Neglect, and Exploitation, revised 10/2023, revealed the following:</p> <p>.III. Identification of Abuse, Neglect, and Exploitation .</p> <p>.B .Possible indicators of abuse, include, but are not limited to: .</p> <p>.*. Failure to provide care needs such as comfort, safety, feeding, bathing, dressing, turning, and positioning;</p> <p>.</p> <p>Record review of facility provided policy, Residents Rights, revised February 2021, revealed the following:</p> <p>Policy Statement</p> <p>Employees shall treat all residents with kindness, respect, and dignity.</p> <p>Policy Interpretation and Implementation</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>1. Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to:</p> <ul style="list-style-type: none"> a. a dignified existence; b. be treated with respect, kindness, and dignity; c. be free from abuse, neglect, misappropriation of property, and exploitation; .

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47854</p> <p>Based on observation and record review, the facility failed to provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, administering, and documentation of all drugs and biologicals) to meet the needs of 1 out of 8 residents (Residents #2) whose medical records were reviewed for medication administration, in that:</p> <p>LVN C administered medication to Resident #2 via nebulizer and left Resident #2 unattended.</p> <p>These deficient practices can affect residents that receive medications resulting in adverse reactions to medication, deterioration in their health, exacerbation of their disease process, and/or hospitalization .</p> <p>Findings include:</p> <p>Record review of Resident #2's face sheet revealed a [AGE] year-old male, who was admitted to the facility on [DATE], with the following diagnoses: Unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety, Shortness of breath, Pneumonia, unspecified organism, Acute upper respiratory infection, unspecified, Cough, unspecified, Need for assistance with personal care.</p> <p>Record review of Resident #2's MDS, dated [DATE], revealed a BIMS of 14, which indicates that Resident #2 is cognitively intact, and had a functionality of supervision.</p> <p>Record review of Resident #2's care plan, revision on 06/13/2024, revealed that Resident #2 does not self-administer any of his medications.</p> <p>Record Review of Resident #2's active physicians orders, printed 06/22/2024, revealed the following:</p> <p>Albuterol sulfate solution for nebulization; 2.5 mg /3 mL (0.083 %); amt: 1; inhalation Every 6 Hours - PRN 1, PRN 2, PRN 3, PRN 4</p> <p>1 of 5 Linked Orders Start date: 04/24/2024; End date: Open ended.</p> <p>Pre-Nebulizer Evaluation Special Instructions: Schedule Frequency to match Aerosolized Medication Time. Every 6 Hours - PRN 1, PRN 2, PRN 3, PRN 4</p> <p>2 of 5 Linked Orders Start date: 05/15/2024; End date: Open Ended.</p> <p>Post-Nebulizer Evaluation Special Instructions: (Set Frequency to Match Aerosolized Medication Time) Every 6 Hours - PRNPRN 1, PRN 2, PRN 3, PRN 4</p> <p>3 of 5 Linked Orders Start date 05/15/2024; End Date: Open Ended.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Change Nebulizer Mask and tubing weekly Every 6 Hours - PRN 1, PRN 2, PRN 3, PRN 4</p> <p>4 of 5 Linked Orders Start date 05/15/2024; End Date: Open Ended.</p> <p>ipratropium bromide solution; 0.02 %; amt: 0.5mg; inhalation Every 6 Hours - PRN 1, PRN 2, PRN 3, PRN 4</p> <p>5 of 5 Linked Orders Start date: 04/24/2024; End date: Open ended.</p> <p>Observation on 06/22/2024 at 3:43am of Resident #2 was in the activities room with a nebulizer treatment with no observation by nursing staff. LVN C was at nurses' station and not in the same room with Resident #2.</p> <p>During an interview on 06/22/2024 at 3:44am, LVN C was asked why Resident #2 was in the activities room with a nebulizer treatment going. LVN C stated that he didn't want to wake up his roommate.</p> <p>Observation on 06/22/2024 at 3:45am of LVN C leaving nurses station and walking down Hall 400 away from nurses station and away from the activities room where Resident #2 was receiving his nebulizer treatment.</p> <p>During an interview on 06/22/2024 at 4:48am, LVN C was asked why Resident #2 was left unattended during his nebulizer treatment. LVN C stated I didn't know that was an issue. LVN C was asked what a negative outcome would be for not remaining with the resident during a treatment, LVN C stated, The resident would not take all of the medication.</p> <p>During an interview on 06/22/2024 at 5:33am, Regional RN stated a negative outcome of staff not remaining with a resident during a medication administration was it could lead to an adverse reaction to the medication, not all of the medication not being taken in their entirety.</p> <p>During an interview on 06/22/2024 at 6:28am, ADM stated that a negative outcome of not staying with a resident during a medication administration was it could be adverse effects with the treatment, if something was to happen during the administration of the medication.</p> <p>Record review of in-service, dated 06/22/2024, performed by Regional RN. Inservice topic was administering medication through a small volume (handheld) Nebulizer. Inservice revealed that LVN C was re-educated on this topic.</p> <p>Record review of facility provided policy titled, Administering Medications through a Small Volume (Handheld) Nebulizer, revised October 2010, revealed the following:</p> <p>.Steps in the procedure</p> <p>.17. Remain with the resident for the treatment.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>47854</p> <p>Based on observation, interview, and record review, the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment to help prevent the development and transmission of communication diseases and infections for 2 of 8 (Resident #1 and Resident #3) Residents reviewed for infection control, in that:</p> <ul style="list-style-type: none"> -CNA A and CNA B failed to use proper hand hygiene during incontinent care of Resident #1. -CNA B failed to use proper hand hygiene during toileting of Resident #3. <p>These failures had the potential to affect residents in the facility by placing them at risk of contracting, spreading, and/or exposing them to bacterial or viral infections that could lead to the spread of communicable diseases.</p> <p>Findings included:</p> <p>Observation on 06/22/2024 at 3:34am of Resident #3 being toileted by CNA B. No HH was performed before peri-care was provided to Resident #3. Dirty brief was removed from Resident #3, then a clean brief was placed on Resident #3 with no glove change or hand hygiene performed by CNA B. Resident #3 was assisted with the cleaning of the peri area and then clean clothes were obtained from Resident #3's dresser drawer, no glove removal or HH performed by CNA B before finding clean clothes. Resident #3 was then transferred back into her w/c and then transferred to her bed. No HH was performed after the completion of toileting.</p> <p>Observation/Interview on 06/22/2024 at 3:56am of CNA A performing incontinent care for Resident #1. Before incontinent care was performed, HH was not performed before donning gloves to begin incontinent care for Resident #1. Resident was saturated with urine and required a total clothing and bed change during this incontinent care.</p> <p>CNA A started to perform incontinent care for Resident #1, and at 4:05am CNA B came to assist with this resident care. CNA B did not perform HH before donning gloves to assist CNA A. Both CNA A and CNA B touch dirty linens and then touched clean linens of Resident #1. Resident #1's peri-care was performed by CNA A and once Resident #1's genitals were cleaned and her dirty brief was removed, a clean brief was touched with soiled gloves, due to no glove change or HH being performed in between the dirty and clean portion of this incontinent care. Resident #1 also had a clean night gown put on with soiled gloves and due to the bed being saturated with urine, dirty sheets were changed, and clean sheets were placed on Resident #1's bed with no glove change or HH performed.</p> <p>Interview on 06/22/2024 at 5:11am CNA A was asked why HH was not performed during incontinent care, CNA A responded with No ma'am, state was here, and I just got nervous, to be real honest with ya. CNA A stated that the negative outcome for not performing HH or glove changes could lead to cross contamination.</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 - Few</p>	<p>Interview on 06/22/2024 at 5:20am CNA B was asked if there was a reason why HH was not performed during incontinent care, CNA B stated, I sanitized my hands and then put my gloves on. CNA B could not give a reason as to why HH and gloves were not changed during incontinent care of Resident #1 and Resident #3.</p> <p>Interview on 06/22/2024 at 5:33am Regional RN stated that a negative outcome for not performing HH and glove changes during incontinent care could lead to the spread of infection.</p> <p>Interview on 06/22/2024 6:28am ADM stated that a negative outcome for not performing HH and glove changes during incontinent care could lead to Increased infections.</p> <p>Record review of in-service performed by Regional RN, dated 06/22/2024, revealed that CNA A, CNA B, and LVN were all re-educated on Handwashing/Hand Hygiene.</p> <p>Record review of facility provided policy, titled Handwashing/Hand Hygiene, revised 01/0/2023, revealed the following:</p> <p>Policy Statement</p> <p>This facility considers hand hygiene the primary means to prevent the spread of infections.</p> <p>Policy Interpretation and Implementation</p> <p>1. All personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, resident, and visitors.</p> <p>.5. Hand hygiene must be performed prior to donning and after doffing gloves.</p> <p>6. hand Hygiene is the final step after removing and disposing of personal protective equipment.</p> <p>Record review of facility provided policy, titled Perineal Care, revised 01/20/2023, revealed the following:</p> <p>Steps in the procedure .</p> <p>.3. Perform hand hygiene and done gloves.</p> <p>.12. Remove gloves and discard into designated container.</p> <p>13. perform hand hygiene.</p>