STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 45E761	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/30/2024
NAME OF PROVIDER OR SUPPLIER McCamey Convalescent Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2500 Hwy 305 S McCamey, TX 79752	

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 - Some	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51011 Based on observations, interviews, and record review, the facility failed to ensure residents had the right to personal privacy and confidentiality of his or her personal and medical records for 3 of 13 residents (#4, #5, #6) reviewed for privacy. 1. CMA F failed to protect Resident #4's record by not locking the screen of her laptop, while CMA F was in a resident's room administering medication. 2. CMA G failed to protect Resident #5's record by not locking the screen of her laptop when going to the restroom. 3. CMA G failed to protect Resident #6's record by not locking the screen of her laptop while in a room checking vital signs. These deficient practices could place residents at-risk of loss of dignity due to lack of privacy. The findings included: 1. An observation 12/29/24 at 9:20 a.m. revealed an open laptop on the facility's medication cart, outside of room [ROOM NUMBER]. The screen was not locked and displayed Resident #4's information. CMA F was in a resident's room administering medication. During an interview with CMA F on 12/29/2024 at 12:26 p.m., she verbally confirmed her laptop's screen should have been locked when she was not using it to protect the privacy of information of the residents. 2. An observation 12/30/24 at 9:30 a.m. revealed an open laptop on the facility's medication cart. The screen was not locked and displayed resident #5's information. CMA G had stepped away to the restroom. 3. An observation 12/30/24 at 9:35 a.m. revealed after vital signs were taken, this state surveyor walked out of the room and noticed CMA G's laptop screen was not locked and was showing Resident #6's medication information. (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 - Some	During an interview with CMA G on 12/30/2024 at 9:50 a.m., she verbally confirmed her laptop's screen should have been locked when she was not using it to protect the privacy of information of the residents. During an interview with the DON on 12/30/24 at 4:31 p.m., the DON stated privacy must be provided during care. She confirmed laptop screens should always be locked when not in use to protect residents' information. She stated the staff had received training when hired and annually on HIPPA, keeping medical records private, not giving out paper copies of resident's records, and to keep screens locked. The training was provided by the DON. The DON states she did spot checks for unlocked screens during walk throughs. Record review of the facility's policy titled Access Control with Scope: HIPAA, EPHI, Security, dated 11/2021, revealed the following in part: .Workforce members are responsible for complying with this policy, including protecting ePHI by logging off system/application or workstation/electronic device before leaving a workstation unattended.

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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 - Some	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** 26221 Based on observations, interviews, and record review, the facility failed to ensure a resident who was incontinent of bladder received appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible for 4 of 5 (Residents # 116, 122, 126, and 127) reviewed for indwelling catheters. The facility failed to ensure Resident # 116, 122, 126, and 127's indwelling catheter were secured to prevent pulling or tugging. The failure could place residents at risk for discomfort, urethral trauma, and urinary tract infections. Findings included: Review of Resident #116's Admission Record, dated 12/29/24 revealed he was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses that included benign prostatic hyperplasia with lower urinary tract symptoms (blocked urinary tract due to swollen prostate). Review of Resident #116's Significant Change MDS, dated [DATE], revealed: He had a mental status score of 9 of 15 with signs of delirium including inattention and altered level of consciousness that fluctuated. (Indicating interview status was difficult to determine due to delirium.) He had an indwelling catheter. Review of Resident #116's Care Plan, revised on 11/17/24, revealed: Focus: The resident has indwelling catheter: Terminal Condition. Goal: The resident will be/remain free from catheter-related trauma through review date. Interventions: Check tubing for kinks with peri care each shift. Monitor for signs/symptoms of discomfort due to catheter. Review of Resident #116's Order Summary, dated 12/29/24, revealed orders dated 12/18/24 Change Foley Cather 16 French (size of catheter) every 18th starting on the 18th every month related to Urinary Tract Infection. Observation and interview on 12/28/24 at 11:08 a.m. with LVN B revealed Resident #116 in bed with his catheter not secured. In an interview at that time LVN B said it was not secured. (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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #122's Admission Record, dated 12/29/24, revealed he was an [AGE] year-old male admitted to the facility on [DATE] with diagnoses that included pressure-induced deep tissue damage of the right and left buttocks. Review of Resident #122's Admission MDS assessment dated [DATE] revealed: He had a mental status score of 15 of 15 with no signs of delirium (indicating he was cognitively intact). He used an indwelling catheter. Review of Resident #122's Care Plan initiated 11/28/24 revealed: Focus: The resident has Indwelling Catheter: Pressure Ulcer, Skin Breakdown Goal: The resident will be/remain free from catheter-related trauma through review date. Interventions: Check tubing for kinks every two hours and as needed each shift. Monitor / document for pain/discomfort due to catheter. Review of Resident #122's Order Summary Report, dated 12/29/24, revealed orders dated 11/28/24 may place Coude (A Coude catheter is a type of catheter with a curved tip. The bent tip allows the catheter to bypass obstructions and navigate spaces that a straight catheter, which has a completely straight tip, may have trouble with.) 16 f, change every month and as needed for wound healing. Observation and interview on 12/28/24 at 11:08 a.m. with LVN B revealed Resident #122 was in bed but his catheter was not secured. In an interview at that time LVN B said it was not secured. Review of Resident #126's Admission Record, dated 12/29/24 revealed she was an [AGE] year-old female admitted to the facility on [DATE] with diagnoses which included neuromuscular dysfunction of the bladder. Review of Resident #126's Quarterly MDS Assessment, dated 10/3/24, revealed: She had a mental status score of 3 of 15 (indicating she was severely cognitively impaired). She had an indwelling catheter. Review of Resident #126's Care Plan, revised 8/17/23, revealed: Focus: The resident has an indwelling catheter. Goal: The resident will be/ remail free from catheter-related trauma through review date. Interventions: Check tubing for kinks each shift. (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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #126's Order Summary, dated 12/29/24 revealed orders dated 3/6/24 for Change Foley Catheter (a type of catheter) with 16 French Foley as needed if removed. Observation and interview on 12/28/24 at 11:08 a.m. with LVN B revealed Resident #126 in her room in bed with the catheter not secured. In an interview at that time LVN B said it was not secured. Review of Resident #127's Admission record, dated 12/29/24, revealed she was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses that included fracture of the left femur. Resident #127 was on hospice services. Review of Resident #127's Quarterly MDS assessment dated [DATE] revealed: She had long and short-term memory loss and severely impaired decision-making abilities with signs of delirium that included inattention. (Indicating she was not interviewable.) She was incontinent of bowel and bladder. (The catheter was not inserted yet.) Review of Resident #127's Care Plan, initiated 12/16/24 and revised 12/29/24, revealed: Focus: The resident has indwelling catheter related to immobility. Goal: The resident will be/remail free from catheter-related trauma through review date. Interventions: Check tubing for kinks on rounds every shift. Monitor/document for pain/discomfort due to catheter. Review of Resident #127's Order Summary, dated 12/29/24, revealed orders dated 12/19/24 for 16 French Foley Change every day shift starting on the 18th and ending on the 16th of every month. Observation on 12/28/24 at 10:56 a.m. revealed Resident #127 in bed asleep with the bed in the lowest position to the floor. Her catheter was under her low bed and the catheter was not secured. Interview on 12/28/24 at 11:08 a.m. LVN B stated Resident #127's catheter was not secured to her leg and the catheter was probably not effective when it was under the bed. In an interview at 12/28/24 at 11:08 a.m. LVN B stated the potential outcome to having unsecured catheters were injuries to the urethra causing damage to the inside of the resident. LVN B said the damage would cause bleeding and swelling, urinary tract infections, or impede urine flow. LVN B said she received in-servicing on keeping the catheter secured but she did not remember when the last time was, it had been a while. LVN B said the Infection Control Coordinator was responsible for monitoring that the catheters were secured. LVN B said she could not think of anything else the state surveyor needed to know about the catheter. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 12/28/24 at 4:12 p.m. the DON stated her expectation for catheter care was they be cleaned at least once a shift and drained at the end of the shift and as needed. The DON said the nurses were responsible for changing the catheters per physician orders and monitoring for kinks. The DON said a catheter on the floor, under a bed would not be an effective catheter. The DON said the facility used a device to secure catheters. The DON explained the devices were a leg sticker that went over the catheter on the resident's leg to keep the catheter from moving. The DON said nurses and CNAs were responsible for monitoring that the devices were present. The DON replied the CNAs were supposed to let the nurses know if there was not a device on the resident's leg so the nurses could put one on. The DON said she would have to look when the last time she in-serviced the staff on catheter care. The DON stated the outcome to an unsecured catheter would be trauma, pain, or bleeding. Review of the facility's undated RN/LVN Initial/Annual Skills Competency Checklist revealed: Foley Catheter care and management per policy/Urinary drainage systems management: Securing the catheter: secure the catheter to the patient's thigh or abdomen to prevent movement and urethral traction. Maintain Unobstructed Flow: Ensure that the tubing is not kinked, or twisted and that urine flows freely into the drainage bag. Review of the facility's undated Initial/Annual Certified Nurse Aide Competency Checklist revealed: Foley Catheter Care/Urinary Drainage System Management: Foley Catheter Care: Securing the Catheter: Secure the catheter to the patient's thigh or abdomen to prevent movement and urethral traction. Maintain Unobstructed Flow: Ensure that the tubing is not kinked, or twisted and that urine flows freely into the drainage bag. Review of the facility's in-service for Catheter Care, dated 12/28/24, revealed: The catheter should be attached to the patient's leg or abdomen, and it should be secured so that there is no traction or tension on the catheter. The CNA needs to remember that traction or tension on an indwelling urinary catheter can be painful, and it can cause trauma and/or an infection. Securing the catheter will also prevent it from being accidently pulled out. The catheter can be secured using commercially available devices or improvised methods, and it should be secured to either the upper thigh or the abdomen. Review of the facility's undated policy and procedure on Catheterization - Foley revealed: Objective: To maintain constant urinary drainage. Procedure: secure catheter to thigh and attach to drainage bag. Review of the facility's undated Stat Lock Stabilization Device Directions revealed: (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Purpose: To stabilize indwelling urinary catheters, reducing Foley catheter movement, and minimizing accident dislodgement. Using Device maximized patient comfort by eliminating circumferential compression and alleviating 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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30057 Based on observation, interviews, and record review, the facility failed to ensure that a resident who needed respiratory care was provided such care consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences for two (Residents #12 and #127) of three residents reviewed for Respiratory Care. The facility failed to ensure Resident #12's and #127's nasal cannula was properly stored when not in use. This failure could place residents at risk for respiratory infection and not having their respiratory needs met. Findings included: Resident #12 Review of Resident #12's Admission Record, dated 12/30/24, revealed he was an [AGE] year-old male admitted to the facility on [DATE] with diagnoses which included pleural effusion (lungs clogged with mucous). Review of Resident #12's Quarterly MDS Assessment, dated 10/26/24, revealed: He had a mental status score of 8 of 15 (indicating severe cognitive impairment). He had shortness of breath upon exertion. Breathing Treatments were not coded on the MDS. Review of the facility's Care Plan, updated 9/7/24, revealed no care plan or interventions regarding the breathing treatment. Review of the Order Summary Report, dated 12/30/24, revealed orders dated 10/16/24 for Ipratropium-Albuterol Inhalation Solution 0.5-2.5 mg/3mL 1 inhalation inhale orally every 6 hours as needed for shortness of breath. During an observation on 12/28/24 at 11:20 a.m. revealed Resident #12's SVN mask was unbagged and open to air on the nightstand table. RESIDENT #127 Review of Resident #127's Admission record, dated 12/29/24, revealed she was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses that included fracture of the left femur. Resident #127 was on hospice services. Review of Resident #127's Quarterly MDS assessment dated [DATE] revealed: (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	She had long and short-term memory loss and severely impaired decision-making abilities with signs of delirium that included inattention. (Indicating she was not interviewable.) She had pneumonia. MDS did not include breathing treatments. Review of Resident #127's Care Plan, initiated 11/8/22 and revised on 10/9/23, revealed: Focus: The resident has shortness of breath related to disease process and was on oxygen. Goal: The resident will have no complications related to shortness of breath through review date. Interventions did not address the keeping of respiratory equipment. Review of Resident #127's Order Summary, dated 12/29/24, revealed orders dated 12/9/24 Ipratropium-Albuterol Inhalation Solution 0.5-2.5 mg/3mL 1 inhalation inhale orally every 4 hours as needed for shortness of breath related to pneumonia while awake during the night. During an observation on 12/28/24 at 10:56 a.m. revealed Resident #127 in bed asleep with the bed in the lowest position to the floor. She had a breathing treatment mask on the bedside table unbagged and open to air. During an interview on 12/30/24 at 9:42 a.m. the DON stated her expectation for breathing treatment masks was for them to be stored in a bag to keep them from being contaminated from germs. She stated she personally made sure they got rinsed out and put back in a bag. She was informed of the 12/28/24 observation. She stated someone did not put them where they needed to go. The DON said the Infection Control Nurse typically monitored for the breathing treatment masks to be placed in bags, but her hours were Monday through Friday and 12/28/24 was a Saturday. The DON stated she sometimes came into the facility early on Sundays to catch the night shift or mid-day to catch the day shift. Record Review of the facility's undated policy and procedure on Small Volume Aerosol Treatment (Breathing treatment masks) revealed: Purpose: To standardize the delivery of inhalation aerosol drug therapy via small volume nebulizer. Facility will provide equipment and therapy for the aerosolization of pharmacological agents per MD orders to maintain airway patency and provide clearance of retained secretions. Procedure: Place equipment in a patient plastic equipment bag or Wiki pouch labeled with the date the equipment was opened.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30057 Based on observations, interviews, 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 communicable diseases and infections for 2 (#116 and #122) of 10 residents reviewed for infection control. The facility failed to ensure CNAs A, C, D and E use PPE during urinary catheter care performed for Residents #116 and #122 as the residents were on EBP precautions. This failure could place residents at risk for cross contamination and the spread of infection. Findings included: NO EBP PRECAUTIONS Review of Resident #116's Admission Record, dated 12/29/24 revealed he was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses that included Benign Prostatic Hyperplasia with Lower Urinary Tract Symptoms (blocked urinary tract due to swollen prostate). Review of Resident #116's Significant Change MDS, dated [DATE], revealed: He had a mental status score of 9 of 15 with signs of delirium including inattention and altered level of consciousness that fluctuated. (Indicating interview status was difficult to determine due to delirium). He had an indwelling catheter. Review of Resident #116's Care Plan, revised on 11/17/24, revealed: Focus: The resident has indwelling catheter: Terminal Condition. Goal: The resident will be/remain free from catheter-related trauma through review date Interventions: Check tubing for kinks with peri care each shift Monitor for signs/symptoms of discomfort due to catheter. Review of Resident #116's Order Summary, dated 12/29/24, revealed orders dated 12/18/24 Change Foley Cather 16 French (size of catheter) every 18th starting on the 18th every month related to Urinary Tract Infection. During an observation on 12/30/24 at 11:14 a.m. CNA A and CNA C performed urinary catheter care for Resident #116. CNA A and CNA C entered the resident's room, washed their hands, and put gloves on. CNA A performed the urinary catheter care by cleansing the catheter tubing with some wet washcloths. CNA C assisted by helping with resident placement in bed. Neither of the CNA's put on any type of PPE except gloves during the entire process. There was also no EBP posting outside Resident #116's room. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 12/30/24 at 11:24 p.m. CNA A said as far as she knew the EBP precautions had not applied to Resident #116 because he did not have an infection in his urine. CNA A said there were other resident's in the facility that had EBP precaution but that was because they had some form of active infection. CNA A said she had not been told by the DON that they had to use EBP for Resident #116. RESIDENT #122 Review of Resident #122's Admission Record, dated 12/29/24, revealed he was an [AGE] year-old male admitted to the facility on [DATE] with diagnoses that included pressure-induced deep tissue damage of the right and left buttocks and urinary incontinence. Review of Resident #122's Admission MDS assessment dated [DATE] revealed: He had a mental status score of 15 of 15 with no signs of delirium (indicating he was cognitively intact) He used an indwelling catheter. Review of Resident #122's Care Plan initiated 11/28/24 revealed: Focus: The resident has Indwelling Catheter: Pressure Ulcer, Skin Breakdown Goal: The resident will be/remain free from catheter-related trauma through review date. Interventions: Check tubing for kinks every two hours and as needed each shift. Monitor / document for pain/discomfort due to catheter Review of Resident #122 Order Summary Report, dated 12/29/24, revealed orders dated 11/28/24 may place Coude (A Coude catheter is a type of catheter with a curved tip. The bent tip allows the catheter to bypass obstructions and navigate spaces that a straight catheter, which has a completely straight tip, may have trouble with.) 16 f change every month and as needed for wound healing. During an observation on 12/30/24 at 01:18 p.m. CNA E and CNA D performed urinary catheter care for Resident #122. CNA E and CNA D entered the resident's room, washed their hands, and put gloves on. CNA D performed the urinary catheter care by cleansing the catheter tubing with some wet washcloths. CNA E assisted by helping with resident placement in bed. Neither of the CNA's put on any type of PPE except gloves during the entire process. During an interview on 12/30/24 at 01:25 p.m. CNA D said as far as she knew the EBP precautions had not applied to Resident #122 because he did not have an active infection. CNA D said there were other resident's in the facility that had urinary catheters, but they did require EBP because they had an infection in their urine. CNA D said she had not been told by the DON that they had to use EBP for Resident #122. (continued on next page)

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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 - Some	During an interview on 12/30/24 02:32 p.m. the Infection Preventionist (IP) said EBP was to be used for any resident with any MDRO (Multi-Drug Resistant Organisms) or residents with chronic indwelling devices such as urinary catheters. The IP said if the staff were going to expose themselves to potentially the resident's bodily fluids then they should use the PPE. The IP said staff was not expected to wear PPE because the Resident's #116 and #122 did not have a current infection in their urine. After re-reading the facility's policy the IP acknowledged that the staff should have used the PPE during catheter care for Residents #116 and #122 because the resident did not have to necessarily have an active infection to qualify for EBP precautions. The IP said if the staff did not wear the correct PPE such as the gown and gloves that could lead to possible cross contamination for residents #116 and #122. During an interview on 12/30/24 at 03:27 p.m. the DON said Resident's #116 and #122 were not expected to be on EBP due to no current infection in their urine. After discussing the facility's EBP policy the DON acknowledged that both residents should have been on EBP precautions due to them having an indwelling catheter. The DON said that due to staff not wearing EBP such as gown and gloves it was possible for the staff to cause cross contamination. During an interview on 12/30/24 at 04:30 p.m. the Administrator acknowledged the issue with the EBP and possibility of cross contamination. Record Review of the facility's policy and procedure titled Enhanced Barrier Precautions (EBP) dated 03/25/2024 indicated in part: EBP shall be used in conjunction with standard precautions and expand the use of personal protective equipment (PPE) to donning of gown and gloves during high-contact resident care activities that may result in transfer of MDRO's to staff hands and clothing. EBP are indicated for residents with any of the following: Wounds and/or indwelling medical devices even if the resident is not known to be infected or colonized with an MDRO. For residents for whom EBP are indicated. EBP shall also be used when performing the following high-contact resident care activities: Devices care or use, e.g., central line, urinary catheter, feeding tube, tracheostomy/ventilator. Record Review of the facility's undated policy and procedure titled Infection Prevention Plan indicated in part: The purpose of the infection prevention (IP) program is to identify infections, reduce the risk of disease transmission and facilitate safe, cost-effective healthcare for our patients, clients, employees, visitors, and others in the healthcare environment with emphasis on populations at high risk for infections. The program is designed to prevent and reduce healthcare-associated infections (HAIs) and to provide education and support to all staff regarding the principles and practices of IP to support the development of a safe environment for all who enter the facilities.