STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	45E761	A. Building B. Wing	12/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
McCamey Convalescent Center	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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to ensure residents had the right to be free from any physical or chemical restraints imposed for the purpose of discipline or convenience for 1 (Resident #27) of 2 residents reviewed for chemical restraints.The facility failed to ensure Resident #27's Seroquel 200mg at bedtime (atypical antipsychotic medication used to treat several mental health conditions by balancing the levels of dopamine and serotonin in the brain) was only used to treat as indicated for use. The facility failed to ensure that documentation in Resident #27's was done in the clinical record. The facility failed to ensure Resident #27's had documentation on a rationale for the continued provision of the medication. The facility failed to ensure residents who receive psychotropic drugs receive gradual dose reductions and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This failure could place residents at risk for adverse reactions and negative side effects from the administration of medication and dependence on unnecessary medications. Findings included: Review of Resident #27's Face Sheet on 10/15/2025 reflected he was a [AGE] year-old male, who admitted to the facility on [DATE], with diagnoses including unspecified dementia without behavioral disturbance, psychotic disturbance, mood disturbance and anxiety (a cognitive decline is evident, but does not exhibit symptoms like agitation, hallucinations, depression, or anxiety), and syncope and collapse Review of Resident #27's quarterly MDS Assessment, dated 09/12/25, revealed he was taking prescribed antipsychotic medication which had an indication for use and no gradual dose reduction has been attempted. No behaviors noted on this MDS. Review of Resident #27's Care Plan, dated 04/30/25, revealed he was taking prescribed psychotropic medication (Seroquel) related to behavior management, disease process, and unspecified dementia. Goals included for Resident #27 to be free from discomfort or drug related complications through the next review date. Interventions included monitoring side effects and effectiveness each shift, discussing with MD and family ongoing need for use of medication, review behaviors and effectiveness as per facility policy. There was no care plan for specific behavior. Review of Resident #27's Physician's Orders, dated 10/15/25, revealed he was prescribed Seroquel 200mg at bedtime (quetiapine fumarate). The orders specified for staff to give 1 tablet by mouth at bedtime related to unspecified dementia without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety. The start date was 04/28/25. There was no specified end date. No behavior or side effect monitoring is noted. She stated she was responsible for monitoring behaviors and adverse effects. Review of Resident #27's History and Physical dated 4/28/2025 revealed no psychological diagnosis warranting the use of psychotropic medication. Review of Resident #27's Medication Administration Record, from August 2025 to October 15, 2025, reflected Resident #27 received his prescription daily as ordered. Review of pharmacy records for Resident #27 revealed a request for a gradual dose reduction on 8/27/2025 was signed by the nurse practitioner, but the response was not acknowledged or a clinical contraindication to dose reduction acknowledged. Review of a progress note for Resident #27 dated 8/27/2025 written by Nurse Practitioner indicated is the resident pleasantly confused most of the time and was asleep at the time of assessment. Observation on 10/14/2025 at 10:00AM, Resident #27 was in bed with eyes closed.Observation on 10/15/2025 at 1:30PM Resident #27 was in bed with eyes closed. Observation on 10/16/2025 at 9:30AM, Resident #27 was in bed with eyes closed. During an interview on 10/16/2025 at 10:36AM with the ADON, she stated she was the one who scanned the GDR request into the chart not realizing it was not acknowledged by the physician. She stated she has been trained on the gradual dose reduction requirements. She stated the resident did not have many behaviors, just wandered sometimes. She stated this could lead to overuse of medication. During an interview with the DON on 10/16/25 at 11:00AM, she stated the expectation for psychotropic medications was that there to be a proper diagnosis warranting the use and gradual dose reductions attempted if necessary. She stated she was not sure why Resident #27's psychotropic prescription medication of Seroquel had not been reduced or physician documentation showing that reduction was clinically contraindicated. She stated this could lead to residents being improperly dosed and possibly over medicated. She stated that psychotropic drug use was monitored in care plan meetings with the interdisciplinary team. The risk of not following up on gradual dose reductions could lead to overuse of medications. A policy titled Psychotropic Medication Use Policy with no date revealed the following: Psychotropic drugs- any drug that affects brain activities associated with mental processes and behavior. These drugs include but are not limited to drugs in the following categories: anti-psychotics, anti-anxiety

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to develop and implement comprehensive person-centered care plan that includes measurable objectives and time frames to meet a resident medical and nursing needs to be furnished to attain or maintain the residents highest practicable physical, mental, and psychosocial well-being for 5 of 13 residents (Resident #3, Resident #6, Resident #7, Resident #11, and Resident #15) reviewed for accurate care plans.Resident #3, #6, #7, and #15's care plan did not address their current code status. Resident #6 and #11's Care Plan did not address ADL Status Resident #11's Care Plan did not address wander guard use. Resident #11's Care Plan did not address her choice of Authorized Electronic Monitoring. These failures could place the residents at increased risk of not having their individual needs met, injury, not receiving necessary services, and a decreased quality of life. Findings include: RESIDENT #3 Record review of Resident #3's admission record, dated 10/14/2025, indicated He was admitted to the facility on [DATE] with diagnoses of dementia and heart failure. He was [AGE] years of age. Record review of Resident #21's quarterly MDS assessment dated [DATE] indicated in part: BIMS of 15 indicating the resident was cognitively intact. Record review of Resident #3's order summary report dated 10/14/2025 revealed a code status of Full code order status active with a start date of 08/23/2023. Record review of the current care plan for Resident #3, last reviewed/revised: 10/10/2025, revealed there was no specific care plan regarding the residents current code status. Resident #6 Record review of Resident #6's admission Record, dated 10/14/25 revealed he was an [AGE] year-old male admitted to the facility on [DATE] with diagnoses including need for assistance with personal care. Record review of Resident #6's quarterly MDS Assessment, dated 9/4/25, revealed: *Resident #6 had a BIMS score of 5 of 15 (indicating severe cognitive impairment) *Resident #6 needed moderate assistance with standing, transfers, toileting, and showering. Record review of Resident #6's Order Summary Report, dated 10/14/25, revealed no code status. Record review of Resident #6's care plan, last updated 9/23/25, revealed no care plan for ADL status and no care plan for his Full-Code status. Interview on 10/15/2025 at 1:59 PM, the ADON stated the DON did the care plans.Interview on 10/15/2025 at 2:51 PM the DON stated there was no care plan for ADL care. The DON said care plans were updated with the MDS Assessments unless there was a significant change. The DON said Resident #6's care plan was not updated and she just missed it. Resident #7 Record review of Resident #7's admission Record, dated 10/15/25 revealed she was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses including dementia, heart problems with a cardiac pacemaker, and urinary tract infections. Record review of Resident #7's Quarterly MDS Assessments, dated 9-1-25, revealed: She had a BIMS score of 2 of 15 (indicating she was severely cognitively impaired) and had signs of delirium including inattention. Resident #7 did not have a chronic condition that resulted in a life expectancy of less than six months. Record review of Resident #7's Order Summary, dated 10/15/25, revealed she was a DNR. Record review of Resident #7's Care Plan, last updated 2/10/25, revealed no care plan for Resident #7 DNR status. Resident #11 Record review of Resident #11's admission Record, dated 10/16/25 revealed she was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses including Dementia, and adult failure to thrive. Record review of Resident #11's Quarterly MDS Assessment, dated 9/27/25 revealed Resident #11 had long- and short-term memory impairment (BIMS of 0) with moderately impaired decision-making skills. Resident #11 showed signs of delirium including inattention, disorganized thinking, and altered level of consciousness. Resident #11 had no behaviors identified. Resident #11 needed substantial to maximum assistance with hygiene, bathing, dressing, bed mobility, and transfers. Resident #11 used a wander/elopement guard. Record review of Resident #11's Order Summary Report revealed orders dated 8/25/25 revealed a wander guard to be used due to poor safety awareness every shift. Record review of Resident #11's Care Plan, last updated 10/9/25, revealed no care plan for ADL ability, Wander guard, or AEM. Observation on 10/14/25 at 10:41 a.m. revealed Resident #11 had a sign outside her door documenting electronic monitoring occurred. Record review of Resident #11's consent section of the electronic record showed a consent for the Electronic Monitoring dated 8/29/25. Interview on 10/16/2025 at 1:46 PM the Administrator stated Resident #11 did not have a wander-guard for a long time and then the facility decided to put one on her. He was informed that the wander guard order was before the care plan cycle. The Administrator said the resident's code status should have been care-planned. Observation and interview on 10/16/2025 at 9:55 AM the DON showed Resident #11 wore her wander guard on her left ankle

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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to provide the necessary treatment and services based on the comprehensive assessment and consistent with professional standards of practice to promote healing and prevent worsening of pressure injuries for 1 (Resident #3) of 2 residents reviewed for pressure ulcers. The facility failed to ensure Resident # 6 received care and services to meet professional standards of practice to heal his pressure ulcer. Resident #6 did not receive wound care to prevent the spread of infection. The findings included: Review of Resident #6's admission Record, dated [DATE] revealed he was an [AGE] year-old male admitted to the facility on [DATE] with diagnoses including unstageable pressure ulcer (unable to assess the wound due to hidden tissue) of the sacral area (base of the spine above the buttocks); stage IV pressure ulcer (a wound that has exposed bone, tendon, or muscle often including tunneling or undermining of the surrounding skin) of the right buttock, and stage II pressure ulcer (partial skin loss with a red or pink open without dead tissue), incontinence, and need for assistance with personal care. Review of Resident #6's admission MDS Assessment, dated [DATE] revealed: *Resident #6 had a BIMS of 5 of 15 (indicating he was severely cognitively impaired). *Resident #6 weighed 107 pounds. *Resident #6 had two Stage IV pressure sores on admission, and he received pressure sore care. Review of Resident #6 Care Plan, updated [DATE], revealed: *Focus: The resident multiple stage 4 pressure ulcers to sacrum (end of spine), right trochanter (hip) related to history of pressure ulcer, lack of assistance, frequently removes dressing. *Goal: The resident's pressure ulcer will show signs of healing and remain free from infection through review date ([DATE]). *Interventions: Administer treatments as ordered and monitor for effectiveness. Educate the resident/ family/ caregivers as to causes of skin breakdown; including transfer/positioning requirements, importance of taking care during ambulating/mobility, good nutrition, and frequent repositioning. Enhanced Barrier Precautions: every shift per CDC guidelines; EBP related to wound care EBP during wound care. Follow facility policies/ protocols for the prevention/ treatment of skin breakdown. Review of Resident #6's Order Summary, dated [DATE], revealed orders:*[DATE] Cleanse Stage 4 to right trochanter with Normal Saline or wound care, pat dry with 4cm x 4 cm gauze, pack wound with Acticoat (Silver-Coated Antimicrobial Barrier Dressings) Flex dressing and cover with sacrum dressing as needed *[DATE] Cleanse Stage 4 to sacrum and Stage 4 to right hip with Normal Saline or wound car, pat dry with 4cm x 4 cm with Acticoat Flex 3 dressing an cover with sacrum dressing. *[DATE] Enhanced Barrier Protection while wound care dressing in place every shift for wound per CDC guidelines. Observation and interview on [DATE] at 11:08 AM revealed Resident #6 was in his room. Resident #6 pulled down his pants to show the surveyor his coccyx wound. It was hand sized with a loss of full skin depth, a pink wound bed and no tunneling observed. There was no wound dressing observed covering the wound. All wound care supplies were observed in the bathroom, including a saturated pad in the trash with brown drainage on it. Resident #6 stated his back/ buttocks area hurt. Resident #6 stated the wound was slowly getting better and did not cause him pain. Observation on [DATE] at 4:00 PM of Resident #6's wound care by the ADON. There was no dressing on the wounds when the ADON pulled Resident #6's pants down. The ADON gathered supplies, cleansed the wounds, and applied the dressing. The ADON did not change gloves between wounds, nor did she sanitize her hands between wounds. The ADON did not put on PPE and PPE was not available at the door. Observation and interview on [DATE] at 1:59 PM the ADON said she did not feel she did a very good job during the wound care. The ADON said she messed up and did not change gloves. The ADON said this put Resident #6 more at risk for infection. The ADON said she did not remember if she did hand hygiene. The ADON said she did not put on PPE during the wound care and wound expect her staff to do so. The ADON stated this also placed Resident #6 at a higher risk for infection. The ADON said Resident #6 did not have a PPE hanger on the back of the door. The ADON explained the DON was the Infection Control Preventionist, and they (the DON and ADON) were sharing the responsibilities and there was no process to keep them on the same page. The ADON stated Resident #6's uncovered wound placed him at higher risk for infection. The ADON added she found it uncovered and did the dressing change. The ADON stated the dressings needed to be checked every day to make sure the dressings were on. The ADON stated if the aides found it uncovered, the aides were supposed to report. The ADON stated the dressing in the trash looked horrible. The ADON stated the facility monitored for effectiveness by taking weekly wound pictures and weekly skin assessments. The ADON stated the nurse checked for infection. The ADON

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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. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure that a resident who needs respiratory care is provided such care, consistent with professional standards of practice for 1 (Resident #3) of 4 residents observed for oxygen management. 1esident #15's oxygen nasal cannula and tube were not covered in a bag when it was not being used. The facility failed to ensure there was oxygen in use sign posted outside Resident #15's room. This failure could affect residents who required respiratory care and place them at risk of not having their needs met.The findings included: Record review of Resident #15's admission record, dated 10/15/2025, revealed she was admitted to the facility on [DATE] with diagnoses of dementia and dependence of supplemental oxygen. She was [AGE] years of age. Record review of Resident #15's order summary report dated 10/14/2025 revealed May use O2 at 2-4 liters per minute via N/C as needed for as needed for low O2 Sat to maintain O2 Sat above 90%. with a start date of 06/12/2025. Record review of the current care plan for Resident #15, last reviewed/revised: 06/16/2025, revealed The resident has oxygen therapy r/t CHF, dependence on supplemental oxygen. The resident will have no s/sx of poor oxygen absorption. Give medications as ordered by physician. Monitor/document side effects and effectiveness. Oxygen settings O2 via nasal cannula @ 3-4 L continuously humidified. Record review of Resident #15's significant change MDS assessment dated [DATE] revealed in part: BIMS of 03 indicating the resident was cognitively intact. Section O - Special Treatments, Procedures, and Programs = Oxygen therapy. During an observation on 10/14/2025 at 11:16 AM there was a nasal cannula and tube observed wrapped around the oxygen tank of Resident #15's wheelchair which was located in her room. There was no storage bag observed to place the nasal cannula in. There was also an oxygen concentrator in the resident's room. There was no sign on the door or anywhere in the room posted that indicated there was oxygen use in the room. During an observation and interview on 10/15/2025 at 2:46 PM CNA E was observed pushing Resident #15 in her wheelchair into her room, the resident was seen wearing her nasal cannula which was connected to her oxygen tank that was located behind her wheelchair. Surveyor entered the resident's room and observed the nasal cannula wrapped around the oxygen tank and not stored in a bag or container. CNA E said she had placed the nasal cannula on the tank and that as far as she knew there were no bags to place the nasal cannula into. Resident #15 was then seen sitting up in her recliner awake and alert wearing her nasal cannula which was connected to the oxygen concentrator machine in her room. Resident #15 said she had transferred herself to her recliner with some slight assistance from the CNA. The resident said the CNAs would help her remove the nasal cannula when she got off the wheelchair and they would place it on the back of the wheelchair. Resident #15 was she did not place the nasal cannula on the back of the wheelchair because she was unable to do that. Resident #15 said the CNAs would then help her put on the nasal cannula that was connected to the oxygen concentrator that was in her room. CNA E returned to the resident's room with a bag that she was going to place on the back of the wheelchair to store the nasal cannula. CNA E said if the nasal cannula was just wrapped around the oxygen tank or left lying on the wheelchair that could possibly lead to cross contamination. During an interview on 10/16/2025 at 1:46 PM the DON said it was expected for the oxygen tubing and nasal cannula to be stored in the Wiki-pouch (a replacement technology for plastic bags used for storing reusable nasal cannula.) when it was not in use. The DON said this was done to prevent the growth of bacteria if not stored in the pouch and wrapped around the oxygen tank. The DON said if the nasal cannula was used on the resident then that could lead to respiratory infections. The DON said resident rooms that had oxygen in use needed to have oxygen in use signs posted outside of the door. The DON said this was done to alert people that there was oxygen in the room which could be flammable, no smoking allowed and no use of Vaseline on the resident. During an interview on 10/16/2025 at 2:25 PM the Administrator said it was expected for the oxygen tubing and nasal cannula to be stored in the Wiki-pouch. The Administrator said this was supposed to be done to prevent the spread of infections. The Administrator said resident rooms that had oxygen in use were supposed to have oxygen in use signs posted outside the rooms. The Administrator said he was not sure why the room had no sign posted. The Administrator said the sign was supposed to be posted so that people would know that oxygen was being used in that room and take the proper precautions. Record review of the facility policy's titled Oxygen administration per nasal cannula, and dated 2014 revealed Purpose to supply low flow supplemental oxygen at low to moderate Fi02 to the hypoxic (a condition where there is an inadequate

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on interview and record review, the facility failed to provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident for 1 out of 1 med rooms reviewed for medication storage and 1 of 1 medication carts reviewed. The facility failed to ensure the medication cart and refrigerator in the medication room did not contain expired medications and unlabeled medications. These failures could place residents at risk of adverse medication reactions.Findings included: Observation on 10/15/25 at 11:30 AM revealed the medication cart had the following expired medications: 1. Coreg 6.25mg expired 7/30/2025 (Medication to treat high blood pressure).2. Celexa 40mg expired on 4/26/2024 (Medication to treat depression).This same observation also revealed a medication bottle with no label. Written in black ink on the bottle, it said Celexa 40mg cut in half. Observation on 10/15/2025 at 11:45 AM revealed the refrigerator in the Medication room had the following opened medications that were expired: 1. Covid Vaccine MRNA Spike Vax had an expiration date of 9/8/2025. Interview on 10/15/25 at 11:51 AM with CMA F, she said it was the responsibility of all nurses and medication aides to check carts for labelling and dating every shift, and expiration dates, but she did not check the whole cart that morning. She stated that the risk of having expired medications was that the medication could possibly not be effective. She stated she has received training on medications and when they expire during her continuing education classes that she does annually to renew her certificate. Interview on 10/16/25 at 12:02 PM the Administrator said the expectations were for nursing staff to discard any medications with an expired date. He stated the DON is responsible for ensuring this is complete, and she is responsible for training nurses and medication aides to complete.Interview on 10/16/25 at 12:36 PM the DON said expired medications should be discarded appropriately when they expire. She stated it was the responsibility of nursing management to check and audit the carts after the nurses periodically.

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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. (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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 and to help prevent the development and transmission of communicable disease and infection for 2 of 4 residents (Resident #6 and Resident #9) reviewed for infection control in that:CNA A failed to wash or sanitize her hands after removing her soiled gloves and then putting on a new pair of gloves when she provided peri-care for Resident #9. CNA C and CNA D failed to wash or sanitize their hands after removing their soiled gloves and then putting on a new pair of gloves when they provided peri-care for Resident #9. The facility ADON failed to use PPE while performing wound care on Resident #6 These failures could place residents at risk for cross contamination and the spread of infection. Findings include: Resident #9. Record review of Resident #9's admission record dated 10/15/2025 revealed she was admitted to the facility on [DATE] with diagnoses of Alzheimer's disease and dementia. She was [AGE] years of age. Record review of the current care plan for Resident #9, last reviewed/revised: 06/22/2025, revealed The resident has bowel and bladder incontinence r/t disease process. Resident will remain free of skin breakdown through the next review date. Check resident every two hours and assist with toileting as needed. Record review of Resident #9's MDS dated [DATE] revealed: Cognitive Skills for Daily Decision Making = Severely impaired - never/rarely made decisions. Urinary continence = Always incontinent. Bowel continence = Frequently incontinent. During an observation on 10/14/2025 at 1:26 PM CNA A and CNA B performed incontinent care for Resident #9. Both CNAs sanitized their hands, put on a pair of gloves, and proceeded to perform incontinent care. Both CNAs undid the brief and then CNA A took some wet wipes and wiped the residents vaginal area then Resident #9 was turned on her side and CNA A wiped the resident's buttocks and rectal area the resident had-had a bowel movement. After CNA A performed the wiping she removed her gloves and put on a new pair of gloves without sanitizing or washing her hands and preceded to apply the new brief. Both CNAs then removed their gloves, sanitized their hands, covered Resident #9 with her blankets and exited the room. During an interview on 10/14/2025 at 3:32 PM CNA A said she should have sanitized or washed her hands after changing her gloves. CNA A said by not doing that it could possibly lead to cross contamination. CNA A said they had been trained to do that but had forgotten to. During an observation on 10/15/2025 at 1:26 PM CNA C and CNA D performed incontinent care for Resident #9. Both CNAs sanitized their hands, put on a pair of gloves, and proceeded to perform incontinent care. Both CNAs undid the resident's brief and then CNA C took some wet wipes and wiped the residents vaginal area. Resident #9 was then turned on her side and CNA D wiped the resident's buttocks and rectal area, the resident had some bowel movement. After CNA D wiped the resident's rectal area, she removed her gloves and put on a new pair of gloves but did not sanitize or wash her hands prior to putting on the new gloves. CNA C had to wipe Resident #9's vaginal area again due to the resident urinating when she was placed on her side. After CNA C wiped the vaginal area she removed her gloves and put on a new pair of gloves without first sanitizing or washing her hands. Both CNAs then fastened a new brief on the resident and placed a clean underpad under the resident. Both CNAs then went to the resident's restroom and washed their hands. During an interview on 10/15/2025 at 1:30 PM CNA C and CNA D were asked what were they expected to do whenever they had to change their gloves after they became possibly contaminated. Both CNAs said they should have washed or sanitized their hands before they changed their gloves. The CNAs said if they did not sanitize or wash their hands that could lead to possible cross contamination. CNA C said she knew she was supposed to close the faucet with a paper towel after she washed her hands but she had forgotten and that could lead to recontamination of her hands. During an interview on 10/15/24 at 1:50 PM, the DON was made aware of the incontinent care observation performed on Resident #9 by CNAs A, B, C and D. The DON said it was expected for the CNA's to wash to sanitize their hands in between glove changes as that could lead to cross contamination. The DON said the CNAs knew about sanitizing their hands but they had probably gotten nervous and forgotten their steps. The DON said CNAs not following the correct steps could lead to cross contamination. During an interview on 10/15/24 at 2:20 PM, the Administrator was made aware of the incontinent care observation performed on Resident #9 by CNAs A, B, C and D. The Administrator said due to the CNAs not washing or sanitizing their hands in between glove changes could lead to cross contamination. The Administrator said the failure probably occurred because the staff got nervous. Record review of the facility undated policy titled Hand hygiene

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	45E761	A. Building B. Wing	12/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
McCamey Convalescent Center	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 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Keep all essential equipment working safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to maintain essential mechanical and electrical equipment in safe operating condition for 1 kitchen of 1 reviewed for essential equipment. The facility failed to ensure the dishwasher worked. This failure could place residents at risk of malfunctioning equipment being used for their service/care.The findings included: Interview on 10/14/25 at 9:52 AM the FSS stated the dishwasher went out two months ago. The FSS stated that the facility was getting new quotes. The FSS stated maintenance fixed the dishwasher by replacing the booster heater. The FSS stated then the booster heater went out and had water spraying continuously and the dishwasher went out - it smoked and sparked and sounded like gunshots. The FSS stated that the kitchen was not functioning without it. The FSS said currently the staff washed everything through the 3-compartment sink. The FSS stated they (the kitchen) were waiting for maintenance to get quotes. The FSS stated the residents complained about the Styrofoam dishes. The FSS explained the cups fell over because they were flimsy, and the staff would put lids on the cups and give the residents a straw. The FSS said the plates broke at least once a week. The FSS said the plastic silverware was flimsy and would not cut. The FSS stated the kitchen staff did not think about cutting meat into bite-sized pieces before going out to residents to work around the flimsy silverware. The surveyor requested the maintenance reports. Interview on 10/14/25 at 10:05 AM the Administrator stated the dishwasher was not working for three weeks. The Administrator stated they were trying to get quotes. The Administrator stated that the CEO wanted more than two quotes for the dishwasher. The Administrator explained the water leaked out on the electrical box and it blew out. The Administrator said the dishwasher was [AGE] years old. The Administrator stated there were no complaints that he was aware of. The Administrator said residents had no problems eating that he was aware of. Interview on 10/14/25 at 10:07 AM RN I explained the water in the town was very hard and ate everything. Observation and interview on 10/16/25 at 11:06 AM [NAME] J stated the kitchen used the three-compartment sink to wash everything right now. [NAME] J walked off to the dirty dish area, sprayed off food particles, and returned to put in dirty compartment of the sink. Interview and record review on 12/16/25 at 1:22 PM the FSS stated maintenance came in and said there was no way to fix the dishwasher. The surveyor requested the maintenance report. The FSS explained staff completed a maintenance request in a computer program. The FSS said the staff did not get an acknowledgement email and did not get a receipt of being fixed email. The FSS stated maintenance just came in and tried to fix it. The FSS brought up the computer program, and there was no way to verify when the request(s) were sent and no way to verify when maintenance was going to get the request attempted. The FSS stated she knew the tag was coming. Interview on 10/16/2025 at 1:46 PM the Administrator stated he did not know when the dishwasher was going to be fixed. He explained it all depended on the (attached) hospital board, and it met monthly. Interview on 10/16/25 at 2:41 PM the DON said there was no policy on essential equipment.