

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  675075	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/08/2025
NAME OF PROVIDER OR SUPPLIER  Diversicare of Luling		STREET ADDRESS, CITY, STATE, ZIP CODE  208 Maple St Luling, TX 78648	

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 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interviews and record reviews, the facility failed to ensure that the comprehensive care plan was reviewed and revised by the interdisciplinary team after each assessment for 1 (Resident #14) of 6 residents reviewed for care plans.</p> <p>The facility failed to update Resident #14's care plan to reflect current needs for oxygen as needed.</p> <p>This failure placed residents at risk of not receiving the appropriate care and services to maintain the highest practical well-being.</p> <p>Findings include:</p> <p>Review of Resident #14's face sheet, dated, 05/07/2025, reflected a [AGE] year-old female who was admitted on [DATE] and readmitted on [DATE]. Resident #14 had diagnoses which included chronic obstructive pulmonary disease, unspecified ( an ongoing lung condition caused by damage to the lungs), essential hypertension ( a chronic characterized by persistently elevated blood pressure with no identifiable underlying cause), and anemia (leads to a reduced ability to carry oxygen to the body's tissue and organs. Symptoms can include fatigue, weakness, and shortness of breath).</p> <p>Review of Resident #14's Quarterly MDS, dated [DATE], reflected Resident #14 had a BIMS score of 9 which indicated her cognition was moderately impaired. Resident #14 had a diagnoses of chronic obstructive pulmonary disease, anemia, essential hypertension, and pneumonia (a lung infection that causes the air sacs to be filled with fluid). Resident #24 had shortness of breath.</p> <p>Review of Resident 14's Physician's Order dated 04/27/2025 (last order reviewed) reflected Resident #14 had an order for oxygen at 2LPM via N/C as needed for shortness of breath or to keep sats &gt;92 percent.</p> <p>Review of Resident #14's Comprehensive Care Plan, revised on 04/16/2025, reflected Resident #14 had alteration in respiratory status due to chronic obstructive pulmonary disease initiated on 02/20/2025. Interventions: did not include oxygen as needed. Resident #14 had shortness of breath related to chronic obstructive pulmonary disease initiated on 02/25/2025. Intervention: did not include oxygen as needed.</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 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Observation and interview on 05/06/2025 at 10:50 AM revealed Resident #14 was in her room lying in bed. She stated she did not feel very well. Resident #14 stated sometimes she could not breathe very well but I am breathing fine right now. Resident #14 stated I am very tired. An oxygen concentrator or any type of oxygen tanks was not located in Resident #14's room.</p> <p>Interview on 05/07/2025 at 3:30 PM LVN B stated Resident #14 was on oxygen as needed. She stated if any resident had a physician's order for oxygen as needed, it was required to be on the care plan. She stated it was the responsibility of the nurse supervisor to monitor any type of equipment any resident needed in their room. She stated the care plan assisted the nursing staff for what type of care a resident needed. LVN B stated if a resident needed oxygen as needed and it was not documented on the resident's care plan, it would be difficult for the nursing staff especially CNAs to know a resident may need oxygen if they reviewed the plan of care in the electronic system the CNAs followed from the care plan.</p> <p>Interview on 05/07/2025 at 4:00 PM CNA E stated she did give care to Resident #14. She stated she was not aware Resident #14 required oxygen as needed. CNA E stated all residents' care was in the electronic medical record for the CNAs. She stated CNAs did not have access to residents' physician's orders or any other medical records except what was documented in the electronic medical record. CNA E stated the information in the CNAs electronic records was from the residents care plan. She stated oxygen was not documented in the CNAs electronic medical record. CNA E stated she did view Resident #14's electronic records for the CNAs and oxygen were not on their records of what type of care a resident needed.</p> <p>Interview and record review on 01/28/2025 at 8:30 AM the MDS Coordinator stated it was her responsibility to ensure the comprehensive care plan was revised as needed. She reviewed the care plans and MDS for Resident #14 in the electronic medical records and stated Resident #14's care plan had not been revised to reflect Resident #14 needed oxygen as needed. She stated Resident #14 did have a physician's order for oxygen as needed when Resident #14's care plan was revised. The MDS Coordinator stated if there were changes in Resident #14's care during the MDS assessment or after the MDS assessment that was to be included in a comprehensive care plan with the other information for staff to follow to give medical, cognitive, and social needs. She stated it would be difficult for the nursing staff to know what type of care to give a resident if there was any change and if the care plan was not updated. The MDS Coordinator stated if Resident #14 began having symptoms of problems with breathing, heart racing or feeling tired throughout the day. She stated if the oxygen was not documented on the care plan in the CNAs' records there was a possibility a CNA may not realize Resident #14 needed oxygen and may not report issues to the nurse.</p> <p>Interview on 05/08/2025 at 11:45 PM the Director of Nurses stated any time there was a change in a resident's treatment the care plan was expected to be updated. She stated Resident #14 was on oxygen as needed per physician's orders. The Director of Nurses stated the physician's order for oxygen was not revised on Resident #14's care plan. She stated CNAs information was transferred from the care plan to the [NAME] (the CNAs information for the care each resident was expected to be provided). The Director of Nurses stated if the CNAs did not know Resident #14 required oxygen as needed there was a possibility Resident #14 may develop symptoms and the CNAs would not realize she needed oxygen to report to the nurse. (Director of nurses did not elaborate on what type of symptoms Resident #14 may develop). She stated it was her responsibility and the MDS Coordinator's responsibility to ensure the care plans are monitored and revised as needed.</p> <p>(continued on next page)</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the facility's Policy on Care Conference Guidelines, dated November 2017, reflected To involve residents, patients and their representatives with goals and preferences of care, and to integrate with those of the interdisciplinary team (IDT). This should be completed at the time of admission, regular intervals, and where there is a change in health status. It should be based on functional/nutritional goals and psycho-social needs.</p>

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observations, interviews, and record reviews, the facility failed to ensure that a resident who needed respiratory care was provided such care, consistent with professional standards of practice, for 1 of 2 residents (Resident # 93) reviewed for the use of oxygen concentrator.</p> <p>The facility failed to ensure Resident #93 had continuous oxygen therapy.</p> <p>This failure could place residents that receive oxygen therapy at risk for inadequate care and respiratory distress.</p> <p>Findings include:</p> <p>Review of Resident #93's face sheet, dated 05/08/2025, reflected an [AGE] year-old female who was admitted on [DATE]. Resident #93 had diagnoses which included acute respiratory failure with hypercapnia (the lungs cannot release enough oxygen into the blood, which prevents organs from functioning properly. Hypercapnia- shortness of breath, headaches, persistent tiredness during the day, and altered mental status), orthostatic hypotension (low blood pressure), and unspecified dementia without behavioral disturbance ( affects the memory, thinking and social abilities without any behaviors).</p> <p>Review of Resident #93's admission MDS, dated [DATE], reflected Resident #93 had a BIMS score of 6, which indicated her cognition was severely impaired. Resident #93 was dependent on staff for toileting, shower, dressing, transfers, and personal hygiene. She had a diagnosis of acute respiratory failure with hypercapnia. Resident #93 had shortness breath or trouble breathing with exertion (walking, bathing, or transferring), and shortness of breath or trouble breathing when lying flat). Resident #93 had a condition or chronic disease may result in a life expectancy of less than six months. She had respiratory treatments and was on oxygen therapy.</p> <p>Review of Resident #93's Comprehensive Care Plan, with completion date of 05/05/2025 reflected Resident #93 was on hospice services related to acute respiratory failure with hypoxia (lack of oxygen) . Interventions: Evaluate effectiveness of medications/interventions to address comfort. Keep family informed of change in condition. Notify hospice of any change in condition or medication changes. Resident #93 had oxygen therapy related to respiratory failure with hypercapnia. Interventions: Oxygen settings: O2 via nasal prongs at 2-4L/min. Monitor for signs and symptoms of respiratory distress and report to Medical Doctor as needed: respirations, pulse, increased heart rate, restlessness, diaphoresis (excessive sweating), headaches, confusion, cough, pain, and skin color. Promote lung expansion and improve air exchange by positioning with proper body alignment.</p> <p>Review of Resident #93's Physician's Order, last order date, 04/27/2025, reflected Resident #93 had a physician's order for oxygen via NC for SOB 2-4 L/min.</p> <p>Review of Resident #93's O2 sats, on 05/08/2025, reflected the last entry for O2 sats was on 05/05/2025 at 10:34 AM and she had 96 percent .</p> <p>(continued on next page)</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Observation and interview on 05/06/2025 at 1:15 PM, revealed an oxygen concentrator was plugged into the outlet in the common area near the nurse's desk (one of one nurse's desk). There was not a resident near the concentrator. After approximately 5-8 minutes it was discovered the oxygen concentrator was Resident #93's. RN A and LVN B went to Resident #93's room and pushed the oxygen concentrator. Resident #93 was lying in bed without oxygen. Resident #93 would not respond to questions. She was not interviewable. Resident #93 had a sad expression on her face such as: furrowed brow, lips turned down, and pouting her lips.</p> <p>Review of Resident #93's nurses notes, dated 05/06/2025 at 2:08 PM , reflected Resident #93 was observed for brief time with no oxygen. RN A applied oxygen via NC @ 4 liter, no signs or symptoms of distress observed, respiratory even and unlabored, no shortness of breath, oxygen saturation 96 % 4 LMP NC. The Nurse Practitioner was informed of the situation with Resident #93. Resident #93 was assessed (unknown who assessed her). Resident #93 did not receive any new orders. Resident #93 denied any pain. Resident #93 vital signs was blood pressure 132/71, and 97.9% O2 setting at 4 LPM NC.</p> <p>Interview on 05/06/2025 at 1:35 PM, CNA D stated she was pushing the mechanical lift past the nurses' desk and she stopped and asked LVN B to assist her with Resident #93's oxygen concentrator. She stated LVN B stated ok. CNA D stated she entered Resident's #93's room with the mechanical lift and CNA E was in Resident #93's room to assist with transferring Resident #93 with the mechanical lift. CNA D stated Resident #93's oxygen concentrator was not in the room until Resident #93 was lying in bed. She stated she did not ask CNA D to move Resident #93's oxygen concentrator from the common area to the Resident #93's room. She stated Resident #93 was in her room without the oxygen concentrator when she was on another hall to locate the mechanical lift. CNA D stated Resident #93 was to always have oxygen. She stated it was approximately 20 minutes from assisting Resident #93 to her room and assisting her to bed prior to Resident #93 received her oxygen.</p> <p>Interview on 05/06/2025 at 1:50 PM, LVN B stated CNA D asked if I was available to assist with transferring Resident #93's oxygen concentrator from the common area to Resident #93's room. She stated CNA D was pushing the mechanical lift to Resident #93's room to transfer her from the wheelchair to the bed. LVN D stated, I was busy with the pharmacist and did not ask anyone else to assist [CNA D] with the oxygen concentrator. LVN B stated RN A was sitting at the nurses' desk. LVN B stated she did not ask RN A or any other staff to assist CNA D with Resident 93's oxygen concentrator. LVN B stated Resident #93 had a potential of having shortness of breath or hypoxia (low levels of oxygen in your body tissues. Symptoms such as: confusion, restlessness, difficulty with breathing, rapid heart rate, and bluish skin). LVN B stated Resident #93 had a physician's order for continuous oxygen. She stated oxygen was expected to be used on Resident #93 continuously throughout the day and night. LVN B stated she did not recall the last in-service the staff had on oxygen care.</p> <p>Interview on 05/06/2025 at 2:05 PM, RN A stated LVN B did not ask her to assist with Resident #93's oxygen concentrator. She stated she was not aware CNA D needed assistance with transferring Resident #93's oxygen concentrator from the common area to Resident # 93's room. She stated Resident #93 had a physician's order for continuous oxygen. RN A stated if a resident was not receiving continuous oxygen there was a possibility a resident may become hypoxia. She stated she did not recall the last time she had in-service on oxygen care and protocol.</p> <p>(continued on next page)</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 05/06/2025 at 2:10 PM, CNA E stated CNA D asked her to assist transferring Resident #93 from the wheelchair to the bed with a mechanical lift. CNA E stated she was in Resident #93's room waiting for CNA D to locate a mechanical lift to use on Resident #93. She stated it was approximately 5-8 minutes prior to CNA D return to Resident #93's room with the mechanical lift. CNA E stated Resident #93 was not using oxygen. She stated she did not give care to Resident #93 and was not aware Resident #93 required oxygen. CNA E stated no one asked her to assist to move Resident #93's oxygen concentrator from the common area to Resident #93's room. She stated after she assisted with transferring Resident #93 from the wheelchair to her bed, she exited Resident #93's room.</p> <p>Interview via phone on 05/07/2025 at 9:05 AM, Resident #93's family member did not answer phone or return phone call after leaving a message.</p> <p>Interview via phone on 05/07/2025 at 9:40 AM , Resident #93's Physician did not answer phone or return phone call.</p> <p>Interview on 05/08/2025 at 11:45 AM the Director of Nurses stated only nurses could check the oxygen concentrator and place the tubing into a resident's nose. She stated anyone was capable of transferring oxygen concentrator from one area to another area. The Director of Nurses stated any resident not receiving continuous oxygen for several minutes the nurse was to do an assessment on resident to check the residents O2 sats and vital signs. She stated if a staff needed assistance in transferring oxygen concentrator the staff could ask a nurse, a CNA, or come to the nurse administration and asked for assistance. She stated if a resident was not receiving oxygen there was a potential a resident may become hypoxia or had shortness of breath.</p> <p>Record review of the Facility's Oxygen Guideline Policy, updated on 08/01/2024, Medical oxygen is classified by the Food and Drug Administration as a drug and therefore it is provided accordance with a health care provider's order and in accordance with acceptable standards of practice.</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>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>Based on observations, interviews, 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 of 1 medication room reviewed for pharmacy services.</p> <p>The facility failed to ensure an expired medication was removed from the medication storage room.</p> <p>This failure could place residents at risk of receiving an expired medication, not reaching the intended therapeutic dose and possible exacerbation of health conditions.</p> <p>Findings included:</p> <p>Observation on 5/06/2025 at 1:40 PM in the medication storage room revealed a bottle of Aspirin 325 mg with an expiration date of 4/2025.</p> <p>In an interview on 05/06/2025 at 1:50 PM RN A stated she had worked at the facility for almost ten years. She stated if an expired medication was given to a resident, it might not have the required potency. She further stated she thought the weekend medication aide might be responsible for checking the storage room for expired medications, but she was unsure.</p> <p>In an interview on 05/08/2025 at 9:31 AM the DON stated she typically checked for expired medications in the medication storage room on Monday mornings. She stated the weekend night MA was also responsible for checking for expired medications in the carts and storage room. She further stated the potential risk of a resident receiving an expired medication was that it would not be as effective.</p> <p>In an interview on 05/08/2025 at 11:48 AM the ADM stated there should not be any expired medications in the storage room. She stated she would assume that an expired medication would not have the proper potency. She further stated nursing leadership would be responsible.</p> <p>Record review of a facility policy and procedure titled Storage of Medications dated 09/2018 and revised on 08/2020 and 08/2024 reflected Policy Medications and biologicals are stored safely, securely, and properly, following manufacturers recommendations or those of the supplier. Procedures: General guidance: 8. Outdated, contaminated, or deteriorated medications and those in containers that are cracked, soiled or without secure closures are removed from inventory, disposed of according to procedures for medication disposal, and recorded from the pharmacy if a current order exists.</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>Based on observation, interview, and record review, the facility failed to store, prepare, distribute food in accordance with professional standards for food service safety for one of one kitchen reviewed for kitchen sanitation.</p> <p>The facility failed to ensure Dietary [NAME] G, and Dietary Aide H used proper hand hygiene during food preparation.</p> <p>These failures could place residents who ate food from the kitchen at risk for foodborne illness.</p> <p>Findings include:</p> <p>Observation on 05/07/2025 at 6:50 AM, revealed Dietary [NAME] G was not wearing gloves. He touched a disinfectant dish cloth and wiped a food prep table. Dietary [NAME] G placed the dish cloth in a container with other disinfectant dish cloths. He proceeded to puree food. Dietary [NAME] G exited from the puree food prep area to the steam table. Dietary [NAME] G placed his middle finger, fore finger, ring finger and small finger from the knuckles to the tip of his fingers inside the silver container sitting on the steam table and carried it the puree food prep table. Dietary [NAME] G did not sanitize or wash his hands after touching the disinfectant dish cloth. He placed puree hashbrowns inside the silver container he obtained from the steam table.</p> <p>Observation on 05/07/2025 at 7:15 AM, revealed Dietary Aide H's right palm and fingers on her right hand touched her top and her pants while she was obtaining a meal tray. Dietary Aide H was not wearing gloves. She gathered cups for the breakfast meal from a shelf. When she picked up the cups she placed her middle, ring, and forefingers from the knuckle to the tip of her fingers on her right hand inside of 5 small plastic cups to be used for breakfast. Dietary Aide H placed the cups on a small food prep area located beside the coffee maker. She also placed her fingers on her right hand inside the breakfast meal trays located on the meal cart. Dietary Aide H did not wash or sanitize her hands.</p> <p>Interview on 05/07/2025 at 1:40 PM Dietary Aide H stated she did touch her shirt and her pants prior to carrying cups to the food prep area by the coffee maker. She stated she did touch inside the cups and was expected to wash her hands after she touched anything that was dirty. She stated germs from her pants and shirt possibly transferred to her hands. She stated the germs on her hands may transfer to the inside of the cups and meal trays. Dietary Aide H stated if germs were inside the cups or on meal trays and transferred to drink or food, there was a potential a resident may become physically ill with stomach virus. She stated she had been in-service on hand hygiene. Dietary Aide H stated she did not recall the date of the in-service.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Interview on 05/08/2025 at 10:45 AM Dietary [NAME] G stated on 05/07/2025 he did touch the disinfectant kitchen towel and wiped area on the food prep table. He stated he did not wash his hands and was not wearing any gloves. Dietary [NAME] G stated he did place his fingers inside the silver container when he picked up the silver container from the steam table and placed it by the food puree prep table. He stated he did place puree potatoes inside the silver container. Dietary [NAME] G stated there was a possibility germs transferred on the puree potatoes when they were transferred from the puree blender into the silver container. He stated there was a potential if germs were on the puree potatoes a resident may become ill with food borne illness such as nausea or vomiting. He stated he had been in-service on hand hygiene. He did not recall the date of the last hand hygiene in-service prior to 05/06/2025.</p> <p>Interview on 05/08/2025 at 11:25 AM the District Director of Operations for the kitchen stated the staff was expected to wash their hands between tasks. He stated if the staff were not washing their hands after touching contaminated items there was a potential of cross contamination. He stated the staff was in-serviced on hand hygiene. The District Director of Operations stated he would need to observe the staff not washing their hands prior to responding to any questions.</p> <p>Interview on 05/08/2025 at 12:40 PM the Dietary Manager stated all staff were required to wash their hands between tasks and whenever they touched their clothes or a disinfectant kitchen towel. She stated clothes and disinfectant kitchen towels were considered contaminated. The Dietary Manager stated food may become cross contaminated if there was bacteria on the staffs hands and the staff touched plates, food, plate covers and/or napkins. She stated it was a possibility a resident may become ill with stomach issues such as vomiting if they ingested bacteria transferred from staff's contaminated hands onto their food, silver container, cups, or meal trays.</p> <p>Review of the Facility's Policy on Proper Hand Hygiene, dated 2020, reflected While alcohol-based hand sanitizers containing 60 percent or more alcohol are the preferred method for cleaning your hands in most clinical situations, handwashing is the standard set by the 2017 Food Code, Section 2-301 for kitchen settings. Handwashing with soap and water is required in a dining service setting in the following situations:</p> <ol style="list-style-type: none"> <li>1.  When you take one step away from your workstation.</li> <li>2.  After touching your hair, face, or clothes.</li> </ol> <p>Between tasks:  Example- switching between cutting chicken and cutting onion.</p>		

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<p>F 0814</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Dispose of garbage and refuse properly.</p> <p>Based on observation, interview, and record review the facility failed to dispose of garbage and refuse properly for one of one kitchen.</p> <p>The facility failed to keep overflowing garbage in a container without a lid on the kitchen utility cart away from clean dishes and the food prep area where dietary staff was preparing food for lunch.</p> <p>The failure could place residents at risk for exposure of germs and diseases carried by vermin and rodents.</p> <p>Findings include:</p> <p>Observation on 05/06/2025 at 9:18 AM revealed a kitchen utility cart with a garbage can attached to the utility cart. The garbage was not covered and was overflowing with food and containers. The utility cart was touching the area where staff prepped for drinks and there were clean cups on the small prep area beside the coffee maker. The utility cart was approximately 2-3 feet from the food prep table where food was lying on the food prep table beside the stove. Dietary [NAME] G was not standing near the food prep area. He was on the other side of the kitchen near the dishwasher (approximately 8 feet) from the food prep area and garbage. Observed the garbage container attached to the utility cart approximately 10 minutes. The dietary staff did not throw any food or anything in the garbage container. The dietary staff was not prepping food for lunch during the observation.</p> <p>In an interview on 05/07/2025 at 1:40 PM the Dietary Aide H stated any type of garbage container was expected to have a lid on the container. She stated the garbage was expected to be stored out of the kitchen area. She stated sometimes the cook would bring the garbage container into the kitchen when he needed to throw things away when someone was cooking a meal. She stated she had been in-service not to leave any type of garbage in the kitchen area and to always keep the lid on it. Dietary Aide H stated there was a possibility garbage in the kitchen area may cause bugs to come into the kitchen where food is prepped. She stated she had been in-serviced on garbage disposal. Dietary Aide H stated she did not remember the date of the in-service.</p> <p>Interview on 05/08/2025 at 10:45 AM Dietary [NAME] G stated the garbage is in the kitchen when the staff is preparing or cooking a meal. He stated it was easier and more convenient to have the garbage container in the kitchen area. He also stated if the garbage container was not being used, it should be located out of the kitchen. He stated he was not using the garbage container on 05/06/2025 in AM after breakfast and before lunch. He stated he heard staff answering questions about the garbage container and he stated at that time he was not using the garbage container and he would be the only one who needed the garbage container when he was preparing food and cooking. He stated they had an in-service on disposal of garbage, however, he did not recall the date and time.</p> <p>Interview on 05/08/2025 at 11:25 AM the District Director of Operations for the kitchen stated garbage containers did not require to have a lid on the container. He stated garbage containers were allowed to be in the kitchen. The District Director of Operations stated there was not anything wrong with the garbage being in the kitchen on 05/06/2025. He stated if dietary staff was prepping food, opened garbage containers was allowed in the kitchen.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER  Diversicare of Luling		STREET ADDRESS, CITY, STATE, ZIP CODE  208 Maple St Luling, TX 78648	
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<p>F 0814</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>( QA Reviewer he would not respond when asked during the observation of garbage in the kitchen was anyone prepping food. He would not respond if there was any negative outcome for having overflowing garbage in the kitchen He would not answer the question if garbage was sanitary He would not answer if the staff had been inserviced on garbage and who was responsible to monitor garbage)</p> <p>Interview on 05/08/2025 at 8:40 AM, the Interim Administrator (Regional [NAME] President of the facility) stated all garbage should not be near any food prep area or the stove. She stated the garbage was expected to be located away from the kitchen area around food. The Interim Administrator stated the kitchen did not have any pest issues, however, if there was overflowing garbage located near food prep area and near food there was a possibility the garbage may attract flies.</p> <p>Interview on 05/08/2025 at 12:40 PM the Dietary Manager stated garbage was allowed to remain in the kitchen. She stated the garbage container did not require to have a lid to cover the garbage. She stated any dietary staff could use a plastic bag to cover the top of the garbage. The Dietary Manager stated there was nothing covering the garbage container in the AM on 05/06/2025. She stated no one was prepping for lunch and there was food on the food prep table. She stated the utility cart was near the coffee maker and there were cups on small food prep area next to the coffee machine. The Dietary Manager stated garbage was not considered sanitary.</p> <p>( this is for the QA reviewer. Dietary Manager was asked what negative outcome could be if there was flies landing on food or if there was rodents or flies in the kitchen. She did not respond. Asked if she considered having garbage next to food and clean dishes sanitary and she did not respond. She would not respond to any other questions and did not feel it was an issue to have uncovered over flowing garbage in the kitchen She would not respond if staff had been inservice on garbage storage or if the staff had been in-service on garbage disposal )</p> <p>Record review of the facility's Environment policy, revised on 09/20217, reflected All food preparation areas, food service areas, and dining areas will be maintained in a clean and sanitary condition. All trash will be contained in leak-proof containers that prevent cross contamination; trash container must be covered during meal service.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview, and record review, the facility failed to establish and 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 diseases and infections for 4 of 10 residents (Resident #27, Resident #22, Resident #32 and Resident #31) reviewed for infection control.</p> <p>1.</p> <p>The facility failed to ensure MA C cleaned the blood pressure cuff before using it on Residents #27, #22 and #32 during the AM medication pass on 5/07/2025.</p> <p>2.</p> <p>The facility failed to ensure the ADON, ICP identified a resident who met the criteria for EHP during wound care. The facility failed to ensure RN A and LVN B performed Enhanced Barrier Precaution steps while providing wound care to Resident #31.</p> <p>These deficient practices could place residents in the facility at risk for acquiring MDRO infections that could lead to delayed wound healing, sepsis , and hospitalizations.</p> <p>Findings included:</p> <p>1.</p> <p>Review of the undated Face Sheet for Resident #27 reflected she was an [AGE] year-old female admitted to the facility on [DATE] and readmitted on [DATE] with a diagnosis of Essential (primary) Hypertension (high blood pressure).</p> <p>Review of the Physician's Order dated 02/20/2025 for Resident #27 for a daily diuretic (medication that causes decreased fluid retention leading to lower blood pressure) reflected hold if SBP (systolic blood pressure - top number in a reading) is less than 110.</p> <p>Observation and interview on 05/07/2025 at 7:18 AM revealed MA did not clean the blood pressure cuff before or after taking Resident #27's blood pressure reading. MA C stated her blood pressure was 127/89.</p> <p>Review of the undated Face Sheet for Resident #22 reflected she was a [AGE] year-old female who was admitted to the facility on [DATE] with a diagnosis of Essential (primary) Hypertension (high blood pressure).</p> <p>Review of a Medication Administration Record for Resident #22 reflected her blood pressure reading was recorded on 05/07/2025 by MA C prior to her receiving a morning blood pressure medication.</p> <p>Observation and interview on 05/07/2025 at 7:26 AM revealed MA C did not clean the blood pressure cuff before or after taking Resident #22's blood pressure reading. MA C stated her blood pressure was 134/68.</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 - Some</p>	<p>Review of the undated Face Sheet for Resident #32 reflected she was an [AGE] year-old female admitted to the facility on [DATE] with a diagnosis of Essential (primary) Hypertension (high blood pressure).</p> <p>Review of a Medication Administration Record for Resident #32 reflected her blood pressure reading was recorded on 05/07/2025 by MA C prior to her receiving a morning blood pressure medication.</p> <p>Observation and interview on 05/07/2025 at 7:41 AM revealed MA C did not clean the blood pressure cuff before or after taking Resident #32's blood pressure reading. MA C stated her blood pressure was 142/67.</p> <p>In an interview on 05/07/2025 at 7:58 AM MA C stated he had been an MA since 2012 and had been working at the facility since December 2024. He stated he had received an in-service on infection control and was aware he should have been cleaning the blood pressure cuff between residents. He further stated the blood pressure cuff should be cleaned with the purple top disinfecting cloths so that germs would not go from one person to another. He stated by not cleaning the blood pressure cuffs in between residents it was an issue with cross-contamination. He stated, It just slipped my mind.</p> <p>Observation on 05/07/2025 at 9:40 AM of a facility purple top container of germicidal (germ killing) disposable wipes revealed the wipes disinfected surfaces in two minutes.</p> <p>In an interview on 05/08/2025 at 08:54 AM the ADON, ICP stated equipment that was used for multiple residents, including blood pressure cuffs, should be cleaned in between residents. She stated if the equipment was not cleaned it could potentially spread infections.</p> <p>In an interview on 05/08/2025 at 9:31 AM the DON stated blood pressure cuffs should be sanitized with the purple top wipes before and between each resident use. She stated if the cuff was not cleaned it could spread germs to other residents.</p> <p>In an interview on 05/08/2025 at 11:48 AM the ADM stated her expectation was for a blood pressure cuff to be sanitized before use on a resident and in between residents. She stated there was a potential for cross contamination if the blood pressure cuff was not cleaned.</p> <p>Record review of a facility Policy and Procedure dated 05/2020 and titled Equipment and Departmental Cleaning/Maintenance Policy. Policy: Equipment is to be cleaned and maintained according to manufacturer's instructions. Policy Interpretation and Implementation: Each piece of equipment used for patient/resident care is to be cleaned with a center approved surface disinfectant before and after each patient care. This includes but not limited to: wheelchairs, blood pressure cuffs, glucometers, temperature probes, lifts, all therapy equipment, shower chairs, bedside tables and scales. Each piece of equipment should be cleaned with disinfectant wipe on [facility] formulary or product that is purchased for an approved list of EPA registered disinfectants. The manufacturer's instructions should be reviewed carefully for dry time after cleaning and before next use. Typical dry time is 3 minutes. Equipment should not be used between patients without being appropriately disinfected.</p> <p>2 .</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 - Some</p>	<p>Observation on 05/07/2025 at 9:54 AM of wound care for Resident #31's right heel and right lateral (outer) ankle by LVN B and RN A, revealed they were not wearing gowns during the wound care. RN A's uniform top was touching the resident's bedding during the wound care as she was holding his leg up. There was no signage on the door to indicate Resident #31 should have been on EBP.</p> <p>In an interview on 05/07/2025 at 10:42 AM RN A stated Resident #31 had a chronic wound on his right lateral ankle. RN A stated her uniform had been touching the bed while she was holding Resident #31's leg up for LVN B to perform wound care.</p> <p>In an interview on 05/07/2025 at 11:14 AM LVN B stated residents should have been on EBP if they had an open area on their body, or had devices such as G-tubes , or urinary catheters. She stated they should have been wearing gowns while providing wound care for Resident #31. She stated if they had been wearing gowns, they would have been protecting Resident #31 from any bacteria on them and vice versa. She further stated by not wearing gowns it could have led to cross contamination. (when harmful bacteria or other pathogens transfer from one source to another during wound care procedures)</p> <p>In an interview on 05/07/25 at 11:20 AM RN A stated by not wearing a gown while providing wound care for Resident #31 the nurses, including herself, could have picked up bacteria and spread it to other residents leading to a cross contamination infection.</p> <p>Observation on 05/07/2025 at 3:26 PM revealed EBP signage was still not on Resident #31's door.</p> <p>In an interview on 05/08/2025 at 08:54 AM the ADON, ICP stated Resident #31 probably had a chronic wound, but she was not 100% sure. She stated the concept of EBP was kind of new to her. She stated on 05/08/2025 she had placed an EBP sign on Resident #31's door. She stated the two nurses (RN A and LVN B) who performed his wound care on 05/07/2025 should have been gowned and gloved. She stated by the nurses not wearing gowns during Resident #31's wound care there was an increased risk of pathogens being transferred to him or to other residents. She stated that would be considered cross contamination. She stated it was her responsibility to ensure EBP was put into place for appropriate residents.</p> <p>In an interview on 05/08/2025 at 9:31 AM the DON stated EBP should be used for residents who had catheters, tracheostomies , g-tubes, and chronic wounds. She stated those residents were at a higher risk of infection. She stated EBP should be used for any high contact activity such as wound care, perineal care, and bathing. She stated a gown, and gloves should be worn and if there was a high risk of body fluid splashes, then a face shield and mask should be worn. She stated Resident #31 should have been on EBP due to having a chronic wound. She stated she and the ADON ICP were responsible for ensuring EBPs were set up for the appropriate residents. She stated the potential risk if the EBP procedures were not followed was the transmission of MDRO (bacteria that have become resistant to certain antibiotics) infections to other residents.</p> <p>In an interview on 05/08/2025 at 11:48 AM the ADM stated her expectation was for staff to utilize EBP for residents that meet the criteria. She stated by not utilizing EBP, residents could be exposed to infections.</p> <p>Record review of a CDC document provided by the ADM, dated July 12, 2002, and titled Implementation of Personal Protective Equipment (PPE) use in Nursing Homes to Prevent Spread of Multidrug-resistant Organisms (MDROs) reflected,</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 - Some</p>	<p>Key Points:</p> <ol style="list-style-type: none"> <li>1. Multidrug-resistant organism (MDRO) transmission is common in skilled nursing facilities, contributing to substantial resident morbidity and mortality and increased healthcare costs.</li> <li>2. Enhanced Barrier Precautions (EBP) are an infection control intervention designed to reduce transmission of resistant organisms that employs targeted gown and glove use during high contact resident care activities.</li> <li>3. EBP may be indicated (when Contact Precautions do not otherwise apply) for residents with any of the following: <ul style="list-style-type: none"> <li>o Wounds or indwelling medical devices, regardless of MDRO colonization status</li> <li>o Infection or colonization with an MDRO.</li> </ul> </li> <li>4. Effective implementation of EBP requires staff training on the proper use of personal protective equipment (PPE) and the availability of PPE and hand hygiene supplies at the point of care.</li> <li>5. Standard Precautions, which are a group of infection prevention practices, continue to apply to the care of all residents, regardless of suspected or confirmed infection or colonization status.</li> </ol> <p>Background Residents in nursing homes are at increased risk of becoming colonized and developing infection with</p> <p>MDROs more than 50% of nursing home residents may be colonized with an MDRO, nursing homes have been the setting for MDRO outbreaks, and when these MDROs result in resident infections, limited treatment options are available [1-9]. Implementation of Contact Precautions is perceived to create challenges for nursing homes trying to balance the use of PPE and room restriction to prevent MDRO transmission with residents' quality of life. Thus, many nursing homes only implement Contact Precautions when residents are infected with an MDRO and on treatment. Focusing only on residents with active infection fails to address the continued risk of transmission from residents with MDRO colonization, who, by definition, have no symptoms of illness. MDRO colonization may persist for long periods of time (e.g., months) which contributes to the silent spread of MDROs. With the need for an effective response to the detection of serious antibiotic resistance threats, there is growing evidence that the traditional implementation of Contact Precautions in nursing homes is not implementable for most residents for prevention of MDRO transmission.</p> <p>Enhanced Barrier Precautions expand the use of PPE and refer to the use of gown and gloves during high-contact resident care activities that provide opportunities for transfer of MDROs to staff hands and clothing [11-15]. MDROs may be indirectly transferred from resident-to-resident during these high-contact care activities. Nursing home residents with wounds and indwelling medical devices are at especially high risk of both acquisition of and colonization with MDROs. The use of gown and gloves for high-contact resident care activities is indicated, when Contact Precautions do not otherwise apply, for nursing home residents with wounds and/or indwelling medical devices regardless of MDRO colonization as well as for residents with MDRO infection or colonization.</p> <p>Examples of high-contact resident care activities requiring gown and glove use for Enhanced Barrier Precautions include:</p> <ul style="list-style-type: none"> <li>o Dressing</li> </ul> <p>(continued on next page)</p>		

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F 0880  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Some	<ul style="list-style-type: none"> <li>o Bathing/showering</li> <li>o Transferring</li> <li>o Providing hygiene</li> <li>o Changing linens</li> <li>o Changing briefs or assisting with toileting</li> <li>o Device care or use: central line, urinary catheter, feeding tube, tracheostomy/ventilator</li> <li>o Wound care: any skin opening requiring a dressing</li> </ul> <p>In general, gown and gloves would not be required for resident care activities other than those listed above, unless otherwise necessary for adherence to Standard Precautions. Residents are not restricted to their rooms or limited from participation in group activities. Because Enhanced Barrier Precautions do not impose the same activity and room placement restrictions as Contact Precautions, they are intended to be in place for the duration of a resident's stay in the facility or until resolution of the wound or discontinuation of the indwelling medical device that placed them at higher risk.</p>