STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675151	A. Building B. Wing	06/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Meadowbrook Care Center	632 Windsor Way Van Alstyne, TX 75495

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 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide or obtain dental services for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37028 Based on observation, interview, and record review, the facility failed to ensure they assisted residents in obtaining routine dental care for 1 of 8 residents (Resident #3) reviewed for dental services. The facility failed to refer Resident #3 for dental services. This failure could put residents needing dental services at risk of oral complications or weight loss, resulting in a decreased quality of life. Findings included: Record review of Resident 3's Annual MDS assessment , dated 03/07/24, reflected she was a [AGE] year-old female who admitted to the facility on [DATE]. Her cognitive status was moderately impaired. Her diagnoses included stroke, non-Alzheimer's dementia, multiple sclerosis (a long-lasting disease of the central nervous system), malnutrition, and contractures. The record showed she was dependent on staff for oral care. Record review of Resident 3's Care Plan, revised on 03/07/24, reflected the resident had oral/dental problems. The plan was to obtain a dental consult. An observation and interview on 06/04/24 at 12:11 PM with Resident #3 revealed she was lying in bed with her headphones on. Her teeth were thick with some kind of yellow-brown build-up on them. She did not appear to be missing teeth, but it was difficult to tell because the teeth were so misshapen and caked with the yellow-brown build-up. The resident said she was able to eat and staff fed her. An interview on 06/05/24 at 2:45 PM with the ADON revealed she did not know when Resident #3 last saw the dentist. The ADON said she did not know the resident had a care plan to obtain a dental consult. The ADON said poor dental health could affect the resident's health and cause them to not be able to drink and eat well. An interview on 06/06/24 at 11:01 AM with the MDS nurse revealed she reviewed the care plan for Resident #3. She said she knew about the dental consult but thought the SW would see the care plan and get the referral. The MDS nurse said the SW was responsible for obtaining referrals. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview on 06/06/24 at 11:24 AM with the SW revealed she worked part-time at the facility for the last 2 months and did the facility referrals if she knew about them. She said she did not know about the referral for Resident #3. She said Resident #3 did not have a referral to see the dentist and she did not know when the resident last saw the dentist. She said if residents did not get the referrals they needed, then their needs would not be met.]An interview on 06/06/24 at 12:11 PM with the Administrator revealed she did not know why Resident #3 did not have a referral to see the dentist. She said if a resident did not get the referrals they needed, then they would not receive the care they needed. Review of the facility policy, Subject: Coordination of Ancillary Services, revised 2023, reflected: Policy: The Facility has a process to coordinate the care of patients and residents among the professional services involved. The Social Services department or designee coordinates ancillary medical services such as psychological services, dentistry, podiatry, optometry, audiologist and hospice as signed.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47743 Based 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 diseases and infections for one (Resident #17) of eight residents observed for infection control. The facility failed to ensure that CNA A and CNA B did not place the used bed padding on top of Resident #17's open, clean, and new brief. This failure could place the residents at risk of cross-contamination and development of infection. Findings included: Review of Resident #17's Face Sheet, dated 06/05/2024, reflected resident was a [AGE] year-old female admitted on [DATE]. Relevant diagnoses included diarrhea and urinary incontinence. Review of Resident #17's Comprehensive MDS Assessment, dated 05/09/2024, reflected Resident #17 had a severe impairment in cognition with a BIMS score of 03. The Comprehensive MDS Assessment also indicated Resident #17 was always incontinent for bowel and bladder. Review of Resident #17's Care Plan, dated 05/16/2024, reflected resident required assistance with ADLs and one of the interventions was assist with all ADLs as needed. Observation on 06/05/2024 starting at 8:05 AM revealed Resident was on her bed awake. It was observed that the resident had a cloth padding placed beneath her torso. CNA A and CNA B were about to prepare the resident for her doctor's appointment. Both CNAs washed their hands and put on gloves. CNA A prepared the things needed and told Resident #17 that they would be cleaning her. CNA A positioned herself on Resident #17's left side and CNA B on the right side. CNA A unfastened the tape on both sides of the brief, rolled the front half of the brief and then pushed it between the resident's thighs. CNA A cleaned the front part of the resident using the front to back technique. CNA A then instructed and assisted the resident to turn towards CNA B. When the resident was on the side lying position, it was observed that the resident just had a bowel movement. CNA A and CNA B begun cleaning the resident's bottom. Both CNAs placed the wipes used to clean the resident's bottom on the soiled brief. Some of the soiled wipes touched the cloth padding. After cleaning the resident's bottom, CNA A took off her gloves, washed her hands, and put on new gloves. While CNA A was washing her hands, CNA B transferred to the other side, pulled the rest of the soiled brief, and threw it. CNA B rolled the padding halfway. CNA B took off her gloves, sanitized her hands, and put on new gloves. CNA A then took the new brief, opened it, placed it beside the resident's bottom, and tucked it under the used and soiled padding. The used padding was on top of the open, new brief. CNA A then instructed the resident to roll to the other side. CNA A pulled the padding and asked the resident to roll back. CNA B then fixed the new brief. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview with CNA A on 06/05/2024 at 8: 30 AM, CNA A stated she washed her hands before and after doing incontinent care. She said she also changed her gloves after touching the soiled items. CNA A then acknowledged that she tucked the brief under the padding. She said that during incontinent care, the soiled wipes could had touched the padding making dirty. She said she should had pulled the soiled padding first before tucking the new brief under the resident's bottom. She said the germs from the padding could transfer to the new brief and the resident could had urinary tract infection. In an interview with CNA B on 06/05/2024 at 8: 37 AM, CNA B stated she also washed her hands before and after doing incontinent care and sanitized her hands when she changed her gloves. CNA B then acknowledged that the padding touched the new brief when it was tucked under the resident. She said the padding, whether clean or not, should not the touch the clean brief to prevent cross contamination. She said the resident might catch an infection if dirty items touched the clean items. In an interview with RN C on 06/05/2024 at 8:45 AM, RN C stated the right procedure was to wash to do hand hygiene before and after any care. She said it was also important to change and sanitize the hands during the duration of any care if soiled items were touched. RN C added that any soiled items should not touch the clean items to prevent cross contamination and possible infection. She said, for the same reason, the used and soiled padding should not be placed on top of an open and clean brief because female residents were prone to urinary tract infections. She said everything soiled should had been taken away before placement of the clean item. In an interview with the Interim DON on 06/06/2024 at 7:22 AM, the Interim DON stated she was made aware about the infection control issue during incontinent care. The Interim DON said the soiled items should be removed first before placing the clean brief to prevent possible infections. She said there should be not contact between the clean items and the dirty items. The Interim DON said the DON and the ADON were responsible in making sure the staff were adhering to the infection control practices. The interim DON said the expectation was for the staff to carry out care without the possibility of cross contamination and introduction of infection. The interim DON said she would do an infection control in-service pertaining to incontinent care for all the staff. She also said she did a check off with CNA A and B about peri-care and would do spot checks for all the staff pertaining to peri-care. She concluded that she would continually remind the staff to be attentive to the procedures for infection control. In an interview with the ADON on 06/06/2024 at 7:48 AM, the ADON stated placing the soiled padding on top of the new brief could result to cross contamination because if the soiled wipes and brief touched the padding, the padding was considered not clean. The same reason applied when the used and soiled padding touched the clean brief. She continued that cross contamination could lead to infection such as urinary tract infection. The ADON said the expectation was for the staff not to put the soiled or the used padding on top of a clean brief. The ADON said they would do an in-service to correct the issue and would monitor their adherence to the procedure of separation of clean and dirty items. In an interview with the Administrator on 06/06/2024 at 8:23 AM, the Administrator stated clean and dirty items should not be touching each other to prevent infection. She said the expectation was for the staff to be mindful and do the right and proper way of care to protect the residents. The Administrator said she would collaborate with the clinicals to address the issue. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of CNA A and B's competency check-off for Peri-Care Competency, dated 06/06/2024, revealed Performance Criteria . 24. Apply clean undergarment. Record review of facility's procedure, Perineal Care revealed Perineal care, which includes care of the external genitalia and anal area . promotes cleanliness and prevents infection . Completing the procedure . dispose of soiled articles.