| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675153 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 02/20/2025 |
|---|---|---|---|

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Heritage House at Keller Rehab & Nursing | 1150 Whitley Road<br>Keller, TX 76248 |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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| F 0694<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide for the safe, appropriate administration of IV fluids for a resident when needed.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48520<br><br>Based on observation, interview, and record review, the facility failed to ensure parenteral fluids were administered consistent with professional standards of practice and in accordance with physician orders for one of one (Resident #1) reviewed for intravenous fluids.<br><br>The facility failed to change Resident #1's PICC (this is a soft, flexible catheter inserted into a central vein used for prolonged antibiotic therapy) line dressing before 02/20/25.<br><br>This failure could affect residents by placing them at risk for infection and IV complications.<br><br>Findings included:<br><br>Review of Resident #1's admission record dated 02/20/25 revealed an [AGE] year-old female who was admitted to the facility on [DATE]. Her diagnoses were acquired absence of left leg above the knee, orthopedic after care following surgical amputation, pressure ulcers (bed sore), and infection following a procedure.<br><br>Review of Resident #1's physician's orders for February 2025 reflected:<br><br>-Change transparent dressing to the Midline (a type of IV line) site one time a day every 7 day(s) for PICC IV ACCESS. Measure upper arm circumference and exterior catheter length with each dressing change.<br><br>- Observe IV access site for erythema (redness), drainage, and edema (swelling) every shift for IV access Record any abnormal findings in the progress notes and notify the physician.<br><br>(continued on next page) |

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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| F 0694<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of Resident #1's care plan initiated 02/12/25 revealed Resident#1 had multiple pressure ulcers to sacrum & thigh and was at increased risk for infection, pain, and a decline in functional abilities. The goal was Resident #1's pressure ulcer would show signs of healing through next review date. Resident#1's pressure ulcer would be free from infection and the risk for infection would be minimized through the next review date. The intervention was to provide pain management prior to dressing changes and repositioning as needed, provide wound care per physician's order, Keep dressing clean, dry, and intact, replace the dressing as needed for soiling. Monitor dressing to ensure it is intact and adhering. Report loose or soiled dressings to treatment or charge nurse. Routinely evaluate and document the wound dimensions, drainage, and condition of surrounding tissue. Notify the physician as needed for changes. Monitor and document for signs and symptoms of infection such as foul-smelling drainage, redness, swelling, tenderness, fever, and red lines or streaking originating at the wound. Notify the physician when detected. Weekly skin checks to monitor for redness, circulatory problems, pressure sores, open areas, and other changes in skin integrity. Report new conditions to the physician. Low air loss mattress. Provide incontinent care as needed. The care plan did not reflect Resident #1 a PICC line.<br><br>Review of Resident #1's MAR/TAR for February 2025 reflected Change transparent dressing to the Midline site one time a day every 7 day(s) for PICC IV ACCESS Measure upper arm circumference and exterior catheter length with each dressing change. Start Date- 02/14/2025 0900, the MAR/TAR was marked that the dressing change was completed by LVN D on 02/14/25 at 09:00 AM.<br><br>During wound care observation and interview with LVN A on 02/20/25 at 1:30 PM, it was revealed that Resident #1 had an IV on her right upper arm with a single lumen (access port of the IV line) . LVN A stated it was a PICC line. The PICC line dressing was dated 02/10/25.<br><br>In an interview with LVN A on 02/20/25 at 1:48 PM, LVN A stated the PICC dressing was supposed to be changed every 7 days. He stated Resident #1's PICC dressing should have been changed 3 days ago [02/17/25]. He stated the nurse taking care of Resident #1 was responsible for changing the IV dressing unless the floor nurse had asked him to do so, he would have changed it. He stated if he had noticed the IV dressing beforehand, he would have informed the nurse (LVN C) taking care of Resident #1. He stated he was training on PICC line dressings. He stated he would inform the floor nurse, LVN C, right away. LVN A stated IV dressing changes was important to prevent infection.<br><br>In an interview with LVN C on 02/20/25 at 1:54 PM, she stated she did not check the date on Resident #1's IV dressing. She stated, To be honest I only focused on the assessment of the IV site for redness and swelling. She stated she had used the PICC line to infuse an antibiotic this morning. She stated the PICC line dressing was changed every 7 days or as needed. She stated the risk to the resident was infection. She stated she would change the dressing immediately.<br><br>In an interview with the DON on 02/20/25 at 4:47 PM, she stated they had a batch order for a PICC line, and the task had popped up on the EMR 3 days ago and one of the nurses might have marked the task as done . She stated nurses were responsible for completing the tasks and not just marking it as completed. She stated LVN C was responsible for accessing the PICC before and after use and she should have noticed the date. She stated the expectation was that PICC dressing change was completed every 7 days on the night shift. She stated all nursing was responsible for accessing the IV's. She stated the dressing change was necessary for infection control.<br><br>LVN D was not available for interview on 02/20/25 by 5:15 PM.<br><br>(continued on next page) |

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| F 0694<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | In an interview with the Administrator on 02/20/25 at 5:15 PM revealed that nurses were responsible for assessing the PICC line dressings and completing dressing changes as ordered, weekly. She said all dressing changes should be documented by the nurses. She stated if the IV dressing was not changed as ordered, then there was a potential for infection.<br><br>Review of the facility's PICC line Transparent Dressing Change policy, revised 07/06/2018, revealed, Policy to prevent external infection of the peripheral or central venous catheter .Upon initial insertion of PICC Line monitor the dressing in the first 24 hours for accumulation of blood fluid or moisture beneath the dressing . Transparent membrane dressings (no gauze over site) are changed every 7 days and PRN . Document the procedure in the Nurses Notes or initial Treatment Administration Record. Chart for any signs, symptoms of complications related to the vascular access device, arm circumference measurement and external exposed PICC line catheter measurement . |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide and implement an infection prevention and control program.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48520<br><br>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 infections for 1 of 7 residents (Resident #1) reviewed for infection control.<br><br>CNA B failed to wear a gown for Enhanced Barrier Precautions while assisting LVN A with wound care for Resident #1.<br><br>These failures could place residents at risk of infectious disease.<br><br>The finding included:<br><br>Review of Resident #1's admission record dated 02/20/25 revealed an [AGE] year-old female who was admitted to the facility on [DATE]. Her diagnoses were acquired absence of left leg above the knee, orthopedic after care following surgical amputation, pressure ulcers (bed sore), and infection following a procedure.<br><br>Review of Resident #1's admission MDS dated [DATE] was not completed and did not reflect a Brief Inventory of Mental Status (a standardized assessment to measure long and short-term memory), indwelling medical devices, wounds, wound vac (this is a medical device that helps to heal the wound from the inside using a suction motion) or infection.<br><br>Review of Resident #1's physician orders for February reflected:<br><br>-Cleanse pressure wound with cleanser, pat dry, apply collagen particles and calcium alginate to wound bed and cover with silicone foam dressing everyday shift for Right Posterior Thigh Wound.<br><br>-Cleanse pressure wound with cleanser, pat dry, apply collagen particles and calcium alginate to wound bed and cover with silicone foam dressing everyday shift for Sacrum (tail bone) Wound.<br><br>Review of Resident #1's care plan initiated 02/12/25 revealed Resident#1 had multiple pressure ulcers to sacrum & thigh and was at increased risk for infection, pain, and a decline in functional abilities. The goal was Resident #1's pressure ulcer would show signs of healing through next review date. Resident#1's pressure ulcer would be free from infection and the risk for infection would be minimized through the next review date. The intervention was to provide pain management prior to dressing changes and repositioning as needed, provide wound care per physician's order, Keep dressing clean, dry, and intact, replace the dressing as needed for soiling. Monitor dressing to ensure it is intact and adhering. Report loose or soiled dressings to treatment or charge nurse. Routinely evaluate and document the wound dimensions, drainage, and condition of surrounding tissue. Notify the physician as needed for changes. Monitor and document for signs and symptoms of infection such as foul-smelling drainage, redness, swelling, tenderness, fever, and red lines or streaking originating at the wound. Notify the physician when detected. Weekly skin checks to monitor for redness, circulatory problems, pressure sores, open areas, and other changes in skin integrity. Report new conditions to the physician. Low air loss mattress. Provide incontinent care as needed.<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | The care plan did not reflect EBP for Resident #1with wounds or wound vac.<br><br>Observation and interview on 02/20/25 at 1:30 PM, revealed a door signage that read STOP Enhanced Barrier Precautions. Everyone must clean their hands before entering the room and when leaving the room. Providers and staff must wear gloves and gown for the following: dressing, bathing/showering, transferring, changing linens, providing hygiene, changing briefs or assisting with toileting, device care or use such as central lines, urinary catheter, feeding tube, tracheostomy. Wound care: any skin opening requiring dressing. LVN A put on his gown and gloves to perform wound care for Resident #1. CNA B stated she was there to assist LVN A. CNA wore gloves. She did not wear a gown. Resident #1 was in the bed with family at bedside. Family stated Resident #1 moved from another facility due to worsening infection. Family stated resident had a wound vac on her amputated leg and that she admitted with wounds. CNA B helped to hold Resident #1 onto the left side by the amputated leg without a gown on.<br><br>In an interview with LVN A on 02/20/25 at 1:48 PM, he stated he did not remind CNA B to put on a gown because he thought only the person completing the actual wound care needed to wear a gown. LVN A stated following EBP was important to prevent infection.<br><br>In an interview with CNA B on 02/20/25 at 1:51 PM, she stated she forgot to put on her gown for EBP. She stated she had been in serviced for EBP which was used to prevent infection. She stated she was not thinking and forgot to wear a gown.<br><br>In an interview with DON on 02/20/25 at 4:47 PM, DON stated CNA B should have worn a gown for PPE during wound care assistance. She stated the expectation was to follow precautions of EBP when touching bed, resident, or any high contact activities. She said EBP was put in place for infection control, and everyone should wear PPE, as necessary.<br><br>In an interview the administrator on 02/20/25 at 5:15 PM revealed that all staff were expected to wear their PPE for EBP. She stated this was part of the infection control and all staff were responsible for following the infection control policy.<br><br>Review of the facility's in-service dated 12/10/24, titled skin assessment during shower: Head to toe, Weekly skin assessment, abnormal findings must be reported, wound care revealed, LVN A, LVN C and CNA B had completed training.<br><br>Review of policy Infection Prevention and Control Program, revised 11/06/24, revealed, .Enhanced Barrier Precautions<br><br>EBP are used in conjunction with standard precautions and expand the use of PPE to donning of<br><br>gown and gloves during high-contact resident care activities that provide opportunities for<br><br>transfer of MDROs to staff hands and clothing.<br><br>EBP are indicated for residents with any of the following:<br><br>a. Infection or colonization with an MDRO when Contact Precautions do not otherwise apply.<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | b. Wounds and/or indwelling medical devices (e.g., central lines, urinary catheter, feeding tube, tracheostomy/ventilator) regardless of MDRO colonization status<br>During high-contact resident care activities:<br>o Dressing<br>o Bathing/showering<br>o Transferring<br>o Providing hygiene<br>o Changing linens<br>o Changing briefs or assisting with toileting<br>o Device care or use: central line, urinary catheter, feeding tube, tracheostomy/ventilator<br>o Wound care: any skin opening requiring a dressing<br>Gloves and gowns prior to the high-contact care activity<br>(Change PPE before caring for another resident)<br>(Face protection may also be needed if performing activity with risk of splash or spray) . |