| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 675171 | A. Building<br>B. Wing | 01/30/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Meridian Care | 7181 Crestway Dr<br>San Antonio, TX 78239 |

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) |
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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** 38511<br><br>Based on observations, interviews, and record reviews, the facility failed to establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development of communicable diseases and infections for 1 resident (Residents #1) of 4 residents reviewed for infection control.<br><br>1. The facility failed to ensure LVN A and CNA B wore a gown while providing wound care and peri care to Resident #1 who was on EBP (enhanced barrier precautions) on 1/25/2025.<br><br>2. The facility failed to ensure LVN A who was the weekend wound care nurse used appropriate infection control principles including wound care cleansing technique, hand hygiene/glove changes during care on 1/25/2025.<br><br>These deficient practices affect residents who require assistance and wound care treatments and could place residents at risk for cross contamination and infections.<br><br>The findings included:<br><br>Record review of Resident #1's face sheet dated 1/28/2025 revealed an admitted [DATE] with diagnoses which included: anoxic brain damage (damage to the brain due to lack of oxygen), type 2 diabetes mellitus without complications and dependance on respirator (ventilator) status.<br><br>Record review of Resident #1's MDS records revealed a complete MDS had not been completed due to new admission status.<br><br>Record review of Resident #1's Baseline Care Plan initiated on 1/23/2025 revealed the resident was cognitively impaired and in a coma with multiple indwelling devices including an indwelling catheter, tracheostomy (a whole that surgeons make through the front of the neck and into the windpipe), feeding tube and had a current skin integrity issue.<br><br>Record review of Resident #1's physician's order summary dated 1/30/2025 revealed an order to maintain enhanced barrier precautions during high-contact resident care activities which included .transferring, providing hygiene, linen changes, peri care/changing briefs/toileting, chronic wound care and all in-dwelling device care with an order date of 1/23/2025.<br><br>(continued on next page) |



| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Record review of Resident #1's physician order summary dated 1/30/2025 revealed an order for wound care: cleanse pressure ulcer to sacrum with wound cleanser, apply Medi-honey gel to wound bed, cover with alginate and secure with bordered foam dressing with an order date of 1/24/2025.<br><br>During an observation of a video time stamped 1/25/2025 at 7:43 p.m.-7:48 p.m. revealed Resident #1 could be seen lying in bed connected to a ventilator via tracheostomy with oxygen, feeding pump (for feeding tube) and a Foley catheter. LVN A was observed entering Resident #1's bedside with wound care supplies on a bedside table wearing gloves and did not have on a gown. CNA B was observed at Resident #1's bedside performing peri-care, repositioning and assisting with positioning for the wound care. CNA B was observed wearing gloves but did not have on a gown. Both LVN A and CNA B were observed leaning on the bed which enabled their uniforms to touch the sides of the bed and the resident's linens without a gown to protect their uniforms. Further observation revealed, during wound care, LVN A touched the bed and bed linen, and then repositioned Resident #1 on her left side with the same gloved hands as when she entered the bed space on the camera view. LVN A then removed the old dressing from the wound and left it on the open brief in the bed. Without changing her gloves, she touched the clean wound care supplies. LVN A then used the wound care bottle to spray wound cleanser on the wound, LVN A sprayed the wound three times and wiped the wound 3 times using the same piece of gauze without using a clean piece of gauze with each wipe. LVN A continued with applying the new dressing to the wound without changing her gloves. She then removed the soiled dressing and placed it on Resident #1's sheets before moving it back to the used brief which was then discarded. LVN A continued to touch Resident #1 on her side, hip, legs, right arm, left hand and arm assisting CNA B with putting a new brief on the resident still with the same gloves that she had on when she entered the resident's bed space. LVN A then touched the trach, ventilator tubing and oxygen tubing, handled the Foley catheter tubing and catheter bag before again repositing Resident #1 while still wearing the same used gloves. LVN A had not changed her gloves and then touched the bed remote and ventilator machine before finally removing her gloves and exiting the resident's bedside taking the bedside table with her. LVN A did not change her gloves or perform any hand hygiene during the care.<br><br>During an observation on 1/28/2025 at 4:30 p.m. revealed Resident #1's room was observed. There was a pod of PPE including gowns hanging on the exterior of the door with wording indicating the resident was on Enhanced Barrier Precautions.<br><br>During a telephone interview on 1/29/2025 at 3:52 p.m. LVN A stated she was a change nurse on weekends and worked as the weekend wound care nurse. LVN A declined to come to the facility to review the video of Resident #1 dated 1/25/2025. LVN A stated she had been a nurse for over [AGE] years and could not specifically state how and when she was trained for wound care. She stated she was trained to get a bedside table, clean it, wash her hands, prepare items on a clean table. She stated she was trained to change her gloves after touching the resident, use hand sanitizer and then put on clean gloves. She stated she was trained not to take the entire wound care bottle into the room. She stated she was trained to use hand sanitizer after she touched the patient, after she touched something considered dirty. She stated she would change her gloves after removing an old/dirty dressing and then after cleaning the wound. She stated she was taught to toss the gauze after each cleaning and use a new piece of gauze with each cleaning. She stated she would change her gloves again after cleaning the wound. LVN A stated she was taught that she did not have to use hand hygiene between glove changes. She stated she could change her gloves 3 times without using hand sanitizer but after the 3rd time she would need to wash her hands. LVN A stated she could not remember Resident #1 or what happened on 1/25/2025.<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 | During an interview on 1/29/2025 at 5:03 p.m., the DON observed the video dated 1/25/2025. She stated she had not previously observed the video. After viewing the video in its entirety, the DON stated the wound care was all wrong. She stated there were infection control issues in the video including hand hygiene, changing gloves and EBP. The DON stated staff should have worn gowns for the wound care because Resident #1 was on EBP.<br><br>During a telephone interview on 1/30/2025 at 11:19 a.m. LVN A again declined to view the video. She stated she did not remember the encounter with Resident #1 on 1/25/2025 exactly. She stated she may have deviated from the way she was trained to perform wound care because she was in a hurry. LVN A stated she should have used a new piece of gauze with each wipe of the wound. She stated she was not trained to use the same piece of gauze to wipe the wound multiple times. LVN A stated she should have tossed her gloves after cleaning the wound. She stated there was no excuse for her not changing her gloves. LVN A stated she was trained to utilize EBP including wearing a gown when she was doing anything related to trach care, wound care, or peri-care. She stated she did not know why she did not put on a gown. She stated she knew she was supposed to put on a gown when caring for Resident #1 because she was on EBP and stated there was no excuse for why she did not.<br><br>During a telephone interview on 1/30/2025 at 11:39 a.m., CNA B declined to view the video of Resident #1 dated 1/25/2025. CNA B stated she was not aware Resident #1 was on EBP. She stated all the residents had gowns positioned on their doors. She stated she believed the gowns and other PPE were there as an option and were not a requirement because it was optional. CNA B stated she could not remember being trained on EBP. CNA B stated she was reliant on the nursing staff to inform her when she needed to use PPE. She stated LVN A was the wound care nurse and was usually adamant about using precautions, but LVN A did not say anything, so she did not know she needed to wear a gown. CNA B stated she knew she was supposed to wear gloves but not the gown.<br><br>During an interview on 1/30/2025 at 11:35 a.m., the Administrator stated the DON was not at the facility. The Administrator stated the DON was the facility Infection Preventionist.<br><br>During attempted contact on 1/30/2025 at 11:42 a.m. via telephone with the DON, a voicemail was left requesting a return call. No return call was received prior to exit.<br><br>During an interview on 1/30/2025 at 11:48 a.m., LVN C stated she was currently working on obtaining her Infection Prevention certification and had completed approximately half of the required training. She stated provided supervision of staff to ensure they are following infection prevention principles including EBP, hand washing, and isolation procedures. She stated she also provided training to staff. LVN C stated EBP were for residents with invasive devices including pegs , traches, chronic wounds, Foley catheters, and other indwelling items on the body. LVN C stated Resident #1 met the criteria for EBP because she had all of those things. She stated Resident #1's door hand a teal hanger with gowns and a sign indicating EBP. She stated staff should wear a gown when providing care for any indwelling item. LVN C stated she did not know if a gown should be worn during peri-care. LVN C stated staff should change gloves and use hand hygiene after removing a dirty dressing and after cleansing the wound and after wound care if they continued to touch the resident. She stated any time gloves were changed hand hygiene either using hand sanitizer or washing the hands was expected. She stated she had never heard of changing gloves 3 times before utilizing hand hygiene. LVN C stated using appropriate infection control principles was important because they did not want to spread infection. She stated the residents at the facility were super susceptible because a lot of them had extra openings and they want to prevent the spread of infection.<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 | Record review of a facility policy titled Enhanced Barrier Precautions dated August 2022 revealed: Enhanced barrier precautions (EBPs) are utilized to prevent the spread of multi-drug resistant organisms (MDROs) to residents. 2. EBPs employ targeted gown and glove use during high contact resident care activities when contact precautions do not otherwise apply. A. Gloves and gown are applied prior to performing the high contact resident care activity (as opposed to before entering the room) 3. Examples of high-contact resident care activities requiring the use of gown and gloves for EBPs included: a. dressing e. changing linens f. changing briefs or assisting with toileting g. Device care or use (central line , urinary catheter, feeding tube, tracheostomy/ventilator, etc.) and h. wound care (any skin opening requiring a dressing). 5. EBPs are indicated for residents with wounds and/or indwelling medical devices regardless of MDRO colonization.<br><br>Record review of a facility policy titled Handwashing/Hand Hygiene last revised August 2015 revealed: This facility considers hand hygiene the primary means to prevent the spread of infections. 7. Use an alcohol-based hand rub containing at least 62% alcohol; or alternatively, soap (antimicrobial or non-antimicrobial) and water for the following situations: b. before and after direct contact with residents d. before performing any non-surgical invasive procedures e. before and after handling invasive devices (e.g. urinary catheters, IV access sites), g. before handling clean or soiled dressings, gauze pads, etc. h. before moving from a contaminated body site to a clean body site during resident care i. after contact with a residents intact skin j. after contact with blood or bodily fluids k. after handling used dressings, contaminated equipment, etc. l. after contact with objects (e.g. medical equipment) in the immediate vicinity of the resident m. after removing gloves n. before and after entering isolation precaution settings 9. The use of gloves does not replace hand washing/hand hygiene. Integration of glove use along with routine hand hygiene is recognized as the best practice for preventing healthcare-associated infections.<br><br>Record review of a facility policy, titled Wound Care last revised 2010 revealed: 2. Wash and dry and dry your hands thoroughly 3. Position resident 4. Put on exam glove. Loosen tape and remove dressing 5. Pull glove over dressing and discard into appropriate receptacle. Wash and dry your hands thoroughly. 6. Put on gloves. 8. Pour liquid solutions directly on gauze sponges on their papers 13. Dress wound .16. Discard disposable items into the designated container .remove disposable gloves and discard into designated container. Wash and dry your hands thoroughly. |