

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675230	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/24/2024
NAME OF PROVIDER OR SUPPLIER Pine Grove Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 246 Haley Dr Center, TX 75935	

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 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46436</p> <p>Based on observations, interviews, and record review, the facility failed to provide the necessary services to maintain personal hygiene for 3 of 12 residents (Resident #12, #48, and #35) reviewed for ADLs.</p> <p>The facility failed to provide incontinent care to Residents #12 and #48 in a timely manner on 7/22/2024.</p> <p>The facility failed to provide denture care for Resident #35 on 7/23/2024.</p> <p>These failures could place residents who required assistance from staff for ADLs at risk of not receiving care and services to meet their needs which could result in feelings of poor self-esteem, lack of dignity, and poor health.</p> <p>Findings:</p> <p>1. Record review of a facility face sheet dated 7/22/2024 indicated Resident #12 was an [AGE] year-old male that admitted to the facility on [DATE] with diagnosis of mild cognitive impairment.</p> <p>Record review of comprehensive care plan dated 4/14/2024 indicated Resident #12 was at risk for problems with elimination and an intervention was to provide peri-care after each incontinent episode.</p> <p>Record review of a quarterly MDS assessment dated [DATE] indicated Resident #12 had a BIMS of 8 indicating moderate cognitive impairment, was frequently incontinent of bowel and bladder and required maximal assistance with toileting hygiene.</p> <p>Record review of ADL flow sheet dated 7/22/2024 at 3:33 am indicated Resident #12 received care for bowel incontinence episode on 7/22/24 at 1:56 pm. Further review revealed there were no other entries dated prior to 7/22/24.</p> <p>During an interview on 7/22/2024 at 9:30 am, Resident # 12 said he needed to be changed and had a diaper full. He said the staff changed him this morning before breakfast and the staff get to him when they get to him, and it was irritating.</p> <p>During observations of on 7/22/2024 revealed Resident #12 was soiled with urine and feces at the following times:</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 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>*10:05 am,</p> <p>*10:30 am,</p> <p>*10:55 am, and</p> <p>*11:10 am.</p> <p>2. Record review of a facility face sheet dated 7/22/2024 indicated Resident #48 was a [AGE] year-old male that admitted to the facility on [DATE] with diagnosis of hemiplegia and hemiparesis following cerebral infarction (paralysis to one side following a stroke).</p> <p>Record review of a comprehensive care plan dated 3/14/2024 indicated Resident #48 was at risk for problems with elimination and an intervention was to check resident every two hours and assist with toileting as needed.</p> <p>Record review of a quarterly MDS assessment dated [DATE] indicated Resident #48 had a BIMS of 9 indicating moderately impaired cognition, always incontinent of bowel and bladder and dependent on toileting hygiene.</p> <p>During an interview on 7/22/2024 at 9:25 am Resident # 48 said he was wet and had not been changed since before breakfast. He said he was unsure of exact time but said breakfast was around 8:00 am and the lady came in but did not change his brief.</p> <p>During observations and interviews on 7/22/2024 at 10:05 am, 10:30 am, 10:55 am and 11:10 am Resident # 48 remained soiled with urine and had an odor. He said no one had been by to change him.</p> <p>During an interview on 7/22/2024 at 11:15 am, CNA A said she had been a CNA for [AGE] years and had been trained on ADL care and care should be given every 2 hours. She said she checked Resident #12 and #48 at 8:15 am and they were wet but did not change them at that time. She said she had not gotten back around to providing care to them. She said ADL care should be provided every 2 hours and by not doing so could cause skin breakdown.</p> <p>During an interview on 07/24/24 at 9:17 am, LVN B said she had been a nurse for 3 years and was the charge nurse for Resident #12 and #48. She said she had not noticed that Residents #12 and #48 were soiled when she rounded. She said incontinent care should be done every 2 hours to prevent skin breakdown and infections.</p> <p>3. Record review of a facility face sheet dated 7/22/2024 indicated Resident #35 was an [AGE] year-old female that admitted to the facility on [DATE] with diagnosis of unspecified dementia (a group of symptoms that affects memory, thinking and interferes with daily life) and cognitive communication deficit (which can affect social language skills, attention, memory, reasoning, judgment, and executive functions).</p> <p>Record review of comprehensive care plan dated 6/6/24 indicated Resident #35 had self-care deficits and to assist with ADL's and had altered nutritional status had required dentures.</p> <p>(continued on next page)</p>

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Record review of a quarterly MDS assessment dated [DATE] indicated Resident #35 had a BIMS of 6 indicating severe cognitive impairment, section L indicated no natural teeth.</p> <p>Record review on 7/23/2024 of Resident #35's CNA ADL flow sheet dated 7/23/2024 revealed no interventions for denture care were included.</p> <p>Record review on 7/24/2024 of Resident #35's CNA ADL flow sheet dated 7/24/2024 indicated corrections had been made to include interventions for denture care.</p> <p>During an interview on 7/23/2024 at 2:40 pm, CNA D said was assigned to work to Resident #35 care most evening shifts. CNA D said she helped Resident #35 with oral hygiene every day and Resident #35 does not have dentures.</p> <p>During an observation and interview on 7/23/2024 at 3:20 pm, Resident #35 removed both upper and lower dentures to demonstrate how she cleans them. The dentures had a brown discoloration and a white crusty build up on the outside. Resident #35 wiped the dentures with sanitary wipes and large white and brown food particles were removed and fell on her dress. CNA D said she thought Resident #35 had her real teeth and had only been assisting with brushing them.</p> <p>During an interview on 7/23/2024 at 3:25 pm with ADON she said she was not aware CNA D was not providing denture care.</p> <p>During an interview on 7/23/2024 at 3:42 pm with ADON she said Resident #35 had been identified as having full top and bottom dentures at admission, but interventions were not included in CNA ADL flow sheet.</p> <p>During an interview on 7/24/2024 at 11:56 am, the DON said she and the ADON and charge nurses were responsible for oversight of ADL's. She said ADL care documentation was reviewed almost daily by herself or the ADON. She said the CNA's should have been documenting each occurrence of incontinence and each resident that required denture care that task should have been on their ADL task for the CNA. She said she expected incontinent care to be provided timely to prevent skin breakdown and expected residents to receive denture care to prevent oral infections.</p> <p>During an interview on 7/24/2024 at 12:01 pm, the Administrator said the DON and ADON were responsible for oversight of all ADL's. He said nurse management should be reviewing ADL care documentation daily and expected all residents to receive all ADL care that they required per their care plan and policy. He said if ADL care was not completed it could affect the resident's health.</p> <p>Record review of a facility policy titled Perineal Care dated April 22, 2024 indicated, .staff will provide perineal care in accordance with the standard of practice to prevent skin breakdown and infection .</p> <p>Record review of policy revised 1/20/20 titled Denture Care policy Staff will provide denture care for residents in accordance with standard of practice guidelines.</p> <p>50818</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40124</p> <p>Based on observation, interview, and record review, the facility failed to ensure the residents' environment remains as free of accident hazards as possible for 1 of 1 facility reviewed for accident hazards.</p> <p>The facility failed to develop and implement a policy and procedure to properly handle care of Hoyer lift slings including interventions to inspect the Hoyer sling for signs of damage before each use and not removing damaged slings from service.</p> <p>This deficient practice could result in falls and injuries if damaged lift sling broke during mechanical lift transfers.</p> <p>The findings were:</p> <p>Record review of a facility face sheet dated 07/22/2024 indicated Resident #18 was a [AGE] year-old female that admitted to the facility on [DATE] with diagnosis of muscle weakness (generalized) and essential (primary) hypertension (high blood pressure).</p> <p>Record review of a comprehensive care plan revised 01/04/2024 indicated Resident #18 was at risk for problems with elimination and to check resident every two hours and assist with toileting as needed.</p> <p>Record review of a quarterly MDS assessment dated [DATE] indicated Resident #18 had a BIMS of 12 indicating moderately impaired cognition, impairment of both lower extremities and unable to stand.</p> <p>During an observation on 07/22/2024 at 10:11 AM, of a Hoyer lift sling in Resident #18's room, the colored connection tabs were faded light in color. The green edges are frayed with strings showing, the care label was illegible and shrunken, the sling has a handwritten date of 06/2018.</p> <p>During an observation on 7/23/2024 at 08:53 AM, Resident #18 was sitting in her chair with a Hoyer lift sling underneath her. The straps are faded light purple, light blue with the care tag illegible.</p> <p>During an observation and interview on 07/23/2024 at 08:58 AM, linen closet on A hallway accessed by CNA D, revealed there were 3 Hoyer lift slings inside that were faded in color, care tag labels are frayed and illegible. One of the three slings had a handwritten date 02/2019 on the label. CNA Daid she worked at the facility for months; she would take any Hoyer sling out of service that had tears or fraying and does not know how long they stay in service before they are removed. She said she had several residents that required a Hoyer lift for transfers. CNA D said that if a sling was not available on the hallway she would go to the linen closet and retrieve one for use. CNA D said the resident could suffer an injury or could be scared to get up with a lift if they were dropped.</p> <p>(continued on next page)</p>

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 07/23/2024 at 09:05 AM, the ADON said she worked for the facility for many years. She said provided education to the staff regarding use of the Hoyer lift slings and when to remove them out of service. The ADON said she was not aware the manufacturer recommended for them to be taken out of service if the sling had a change in color or the label was illegible that indicated it had been worn, bleached or was compromised. The ADON said the resident could suffer in injury of the straps broke.</p> <p>During an interview with the DON on 07/23/2024 at 09:15 AM, the DON said she worked for the facility for almost [AGE] years. She said she removed slings if they have holes, frays or strings but she was not aware the manufacturer recommended for them to be taken out of service if the sling had a change in color or the label was illegible that indicated it had been worn, bleached or was compromised. The DON said the resident could suffer in injury of the straps broke.</p> <p>During an interview on 07/23/2024 at 9:30 AM, the Administrator said he was aware the slings required special care, the facility needed to follow manufacturers suggested practices but did not know the color change could indicate the Hoyer lift slings should not be used. He said if the sling broke it could cause injury to the resident being transferred.</p> <p>A record review of Full Body Slings- Medline, Instructions for use www.medline.com accessed 07/23/2024 reflected .Always inspect slings prior to each use. Signs of rips, tears, or frays indicate sling wear which is unsafe and could result in injury. Signs of color fading, bleached areas, or permanent wrinkles on the straps indicate improper laundering which is unsafe and could result in injury. Any slings with signs of wear or improper laundering should be immediately removed from use</p> <p>Sling maintenance best practices</p> <p>Check condition before each use. If there is any fraying or visible wear and tear, do not use.</p> <p>Reusable slings should be replaced every six months.</p> <p>Follow care instructions on wash tag. If illegible, do not use.</p> <p>Keep at least two reusable slings per patient on hand-one available and one in the laundry.</p> <p>A record review of a facility policy for Mechanical Lifts dated 05/2023 indicated .Residents will be assisted with their Activities of Daily Living, utilizing lifts according to manufacturer's guidelines .</p> <p>e. Check to ensure the sling is in good working condition with no torn or ripped area, etc.</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>40124</p> <p>Based on observation, interview, and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety for 1 of 1 kitchen reviewed for dietary services.</p> <p>The facility failed to store food in accordance with professional standards in that:</p> <ol style="list-style-type: none"> 1. Dry storage items were improperly stored. 2. Frozen foods were unlabeled and open to air. <p>These failures could place residents at risk for food contamination and foodborne illness.</p> <p>Findings:</p> <p>During an observation of the facility kitchen on 7/22/24 at 9:10 am revealed the following:</p> <ul style="list-style-type: none"> *Flour was stored with a scoop inside the container. *Salt was stored with a scoop inside of an unoriginal container with no date or label. <p>During an observation of the freezer in the facility kitchen on 7/22/24 at 9:15 am revealed the following:</p> <ul style="list-style-type: none"> *a bag of Okra was stored in an opened box in an unsealed bag. *Squash was stored in a box without any label or date. *A left-over pecan pie dated 6/28 was stored in an uncovered pie tin. <p>During an interview on 07/22/24 at 9:30 AM with the Dietary manager she said her expectation was for the dietary staff to label and store all items according to policy and regulation. She said not storing food items could spread food borne illness.</p> <p>During an interview on 07/22/2024 at 2:00 PM the Administrator said he expected the dietary staff to label and store foods as required. He said there was a risk of food borne illness if storage regulations were in followed by the dietary staff.</p> <p>Record review of a Food Storage Policy: Sufficient storage facilities are provided to keep foods safe, wholesome, and appetizing. Food is stored . by methods designed to prevent contamination .</p> <p>Air-tight containers or bags are used for all opened packages of food. All containers are accurately labeled with the item and date opened .All foods are covered, labeled and dated .any item out of the</p> <p>(continued on next page)</p>		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	original case must be properly secured and labeled. 49017

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<p>F 0813</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Have a policy regarding use and storage of foods brought to residents by family and other visitors.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46273</p> <p>Based on observation, interview, and record review, the facility failed to maintain and ensure safe and sanitary storage of residents' food items, per facility policy, for 3 of 12 resident's (Resident #5, Resident #43, and Resident #51) personal refrigerators reviewed for food and nutrition services.</p> <p>The facility failed to ensure the refrigerator for Resident #43 did not contain an unlabeled, undated clear container of an unknown food item with a green, powdery substance covering it.</p> <p>The facility failed to ensure the refrigerator for Resident #5 and Resident #51 did not contain an unlabeled, undated clear container with fruit with a whit, grey fuzzy growth on the fruit and a zipper bag of food not labeled or dated.</p> <p>This failure could place residents at risk for food borne illnesses.</p> <p>Findings include:</p> <p>Resident #5</p> <p>Record reviews of a facility face sheet dated [DATE] for Resident #5 indicated that she was a [AGE] year old female admitted to the facility on [DATE] with diagnosis including Parkinsonism (a group of conditions that affect movement and mimic Parkinson's disease) , Chronic Obstructive Pulmonary Disease (causes obstructed airflow from the lungs) , hypertension (High blood pressure) , and diverticulosis (development of small sacs in the wall of colon) .</p> <p>Record review of an annual MDS dated [DATE] for Resident #5 indicated she had a BIMS score of 15, which indicated that she is cognitively intact. She required set up assist with eating.</p> <p>Record review of a comprehensive care plan dated [DATE] for Resident #5 indicated that she has a cognitive deficit in decision making.</p> <p>Resident #43</p> <p>Record review of a facility face sheet dated [DATE] for Resident #43 indicated that she was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses including: dementia (a group of symptoms affecting memory, thinking and social abilities), chronic atrial fibrillation (a type of heart arrhythmia that lasts longer than 12 months), and hypertension (high blood pressure).</p> <p>Record review of a quarterly MDS dated [DATE] for Resident #43 indicated that she had a BIMS score of 6, which indicated that she had severe cognitive impairment. She required set-up or clean up assist with eating.</p> <p>Record review of a comprehensive care plan dated [DATE] for Resident #43 indicated that she had severe cognitive impairment and poor decision making.</p> <p>(continued on next page)</p>		

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<p>F 0813</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Resident #51</p> <p>Record review of a facility face sheet dated [DATE] for Resident #51 indicated that she was an [AGE] year old female admitted to the facility on [DATE] with diagnosis including dementia (A group of symptoms that affects memory, thinking and interferes with daily life) , arthritis (A condition with swelling and tenderness of one or more joints) , anxiety (Fear characterized by behavioral disturbances.) , and cerebral infarction (- the pathologic process that results in an area of necrotic tissue in the brain) .</p> <p>Record review of a quarterly MDS dated [DATE] for Resident #51 indicated that she had a BIMS score of 5, which indicated that she had severe cognitive impairment. She required set up assistance with eating.</p> <p>Record review of a comprehensive care plan dated [DATE] for Resident #51 indicated that she had severe cognitive impairment and deficit in decision making.</p> <p>During an observation on [DATE] at 9:10 am a clear container was observed in Resident #43's refrigerator. The container was unlabeled and undated. A green, powdery substance was observed on an unknown food item that was inside container.</p> <p>During an observation on [DATE] at 12:00 pm Resident #43 was observed feeding self in dining room. She was unable to appropriately answer questions.</p> <p>During an observation on [DATE] at 9:40 AM Resident #5 and Resident #51's personal refrigerator had food that was not labeled or dated. The refrigerator contained a clear plastic container of cut fruit that had an appearance of white, grey fuzzy growth on part of the fruit. There was a zipper bag that contained fried meat that was not labeled or dated.</p> <p>During an interview on [DATE] at 9:37 am CNA A said the housekeeping supervisor was responsible for cleaning out resident refrigerators.</p> <p>During an interview on [DATE] at 11:40 am Housekeeping Supervisor said was responsible for cleaning out residents' personal refrigerators and she cleans them out about once per month. She said she does not have a set schedule and does not have documentation showing where she had done it. She said if residents consumed old or outdated foods it could make them sick.</p> <p>During an interview on [DATE] at 12:00 PM Resident #5 said her family brought her food from home and from the store and she stored it in the personal refrigerator. She said her roommate also stored things in the refrigerator at times. She said the fruit and the other food items belonged to her. She said she cleaned her refrigerator sometimes. She said that staff would clean the refrigerator out if she asked them to. Resident #5 said she would not eat spoiled food and that she would look at the items or smell them before consuming them.</p> <p>During an interview on [DATE] at 5:15 PM Administrator said he was aware that some rooms had items in the personal refrigerators that were not dated and appeared expired. He said the refrigerators were checked for unlabeled and expired items. He said resident families often brought in foods and that the family did not always label the food items and did not remove expired foods. He said housekeeping staff was responsible for cleaning the refrigerators monthly.</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>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46273</p> <p>Based on observations, interviews, and record reviews 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 3 of 12 residents (Resident #12, #30 and #259) reviewed for infection control.</p> <p>CNA A failed to perform hand hygiene during incontinent care for Resident #12 and failed to properly bag soiled linen before leaving Resident #12's room on 7/23/2024.</p> <p>CNA C failed to perform hand hygiene and follow EBP (enhanced barrier precautions) during incontinent care for Resident #30 on 7/23/2024.</p> <p>CNA E failed to perform hand hygiene during incontinent care for Resident #259 on 7/22/2024.</p> <p>These failures could place residents at risk for cross contamination and infection.</p> <p>Findings:</p> <p>1. Record review of a facility face sheet dated 7/22/2024 indicated Resident #12 was an [AGE] year-old male that admitted to the facility on [DATE] with diagnosis of mild cognitive impairment.</p> <p>Record review of comprehensive care plan dated 4/14/2024 indicated Resident #12 was at risk for problems with elimination and an intervention was to provide peri-care after each incontinent episode.</p> <p>Record review of a quarterly MDS assessment dated [DATE] indicated Resident #12 had a BIMS of 8 indicating mild cognitive impairment, was frequently incontinent of bowel and bladder and required maximal assistance with toileting hygiene.</p> <p>During an observation on 7/23/2024 at 9:55 am, CNA A provided incontinent care to Resident # 12. CNA A sanitized her hands and applied gloves. She opened Resident #12's brief, and he was soiled with feces. She cleaned the front area using disposable wipes. She then removed her gloves and applied new gloves without hand hygiene. Resident #12 was assisted to left side and back area was cleaned with disposable wipes. The soiled brief and bed pad was rolled under the resident and CNA A removed her soiled gloves and applied clean gloves without hand hygiene. She placed a clean linen pad and brief and assisted Resident #12 to his back. Soiled linen and brief were removed and placed at the foot of the bed. Clean brief applied and resident repositioned. CNA A then removed her glove from the right hand and carried soiled linen and brief openly with gloved left hand. CNA A exited the Resident #12's room with the soiled linen and soiled brief, walked down the hallway to the soiled linen closet and disposed of the linen and brief. She then removed her remaining glove and sanitized her hands.</p> <p>During an interview on 7/23/2024 10:05 am, CNA A said she had been a CNA for [AGE] years and had been trained on incontinent care and proper handling of soiled linen. She said she should have washed her hands in between glove changes, bagged the soiled linen, and removed her gloves and washed her hands before leaving the room. She said by not following infection control measures it could cause the spread of infection.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Pine Grove Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 246 Haley Dr Center, TX 75935	
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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>2. Record review of a facility face sheet dated 7/23/2024 for Resident # 30 indicated that she was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses including: Alzheimer's disease, osteoporosis, and myocardial infarction.</p> <p>Record review of a comprehensive MDS dated [DATE] for Resident #30 indicated that she had a BIMS score of 9 which indicated that she had moderate cognitive impairment. She was dependent with toileting and was always incontinent of bowel and bladder.</p> <p>Record review of a comprehensive care plan dated 7/18/2024 for Resident #30 indicated that she was on enhanced barrier precautions to prevent spread of multi-drug resistant organisms due to having a wound. Intervention read .Enhanced Barrier Precautions: gown and glove use during high-contact resident care activities such as dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs, assisting with toileting, wound care, and any skin opening requiring a dressing .</p> <p>Record review of resident's consolidated orders dated 7/23/2024 indicated that Resident #30 had the following order dated 7/18/24: .Enhanced Barrier Precautions (EBP) every shift Reason: stage 2 sacrum .</p> <p>During an observation and interview on 7/23/2024 at 9:58 am CNA C was asked what the blue dot beside Resident #30's name on door indicated. She said, I think it means they have an open wound She then was observed to provide incontinent care to Resident #30. She was observed to change gloves multiple times during care and did not wash or sanitize her hands between glove changes. She did not wear a gown while providing incontinent care. Upon exit from room, CNA C stated, I forgot to wash my hands when I changed my gloves. When asked if she was supposed to have worn a gown while providing resident care, she said Oh, yes, I think I was She then said they had been in-serviced multiple times and she knew she was supposed to be using enhanced barrier precautions due to residents wound, but she was nervous and forgot.</p> <p>Record review of an EBP Order Group Report provided by the facility indicated that Resident # 30 was on enhanced barrier precautions due to having a Stage 2 pressure ulcer to the sacrum.</p> <p>Record review of a facility in-service sign-in sheet dated 3/28/2024 and titled Enhanced Barrier Precautions (EBP) How to identify residents that require EBP, define and list high-contact care activities, PPE, and hand hygiene indicated that CNA C had signed indicating she had attended in-service and been trained on EBP.</p> <p>Record review of a facility in-service sign-in sheet dated 7/10/24 and titled EBP - Enhanced Barrier Precautions - Identifiers are blue bars by patient names on door indicated that CAN C had signed indicating she had attended in-service and been trained on how to identify residents with EBP.</p> <p>3. Record review of a face sheet dated 6/4/2024 for Resident #259 indicated she admitted to the facility on [DATE] and was [AGE] years old with diagnosis of hypertension (high blood pressure), end stage renal disease (kidneys no longer work as they should to meet the body's needs), and chronic obstructive pulmonary disease (causes obstructed airflow from the lungs).</p> <p>Record review of a care plan revised 7/19/2024 for Resident #259 indicated an ADL self-care deficit and was dependent on staff for toileting hygiene.</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>Record review of an Entry MDS assessment dated [DATE] for Resident #259. Resident #259 in facility for respite stay and discharged prior to admission MDS performed.</p> <p>During an observation on 7/22/2024 at 10:50 am, CNA E entered the room of Resident #259 to provide incontinent care. CNA E washed her hands and put on gloves. Supplies were in a plastic bag on the over bed table. CNA E opened the brief and pulled it down between Resident #259's thighs. CNA E removed a wipe from the plastic bag and wiped the resident's right inner thigh and folded it over and wiped the left inner thigh and placed the wipe in the trash. CNA E removed a wipe from the plastic bag and wiped down the middle of the vagina from front to back. CNA E rolled Resident #259 onto her left side. CNA E removed wipes from the plastic bag and wiped Resident #259's rectal area from front (vagina) to back (buttocks). CNA E removed a brief from the plastic bag and placed it underneath the resident's buttocks. Resident #259 was rolled onto her back and the brief was secured and the resident was repositioned in the bed. CNA E removed her gloves and washed her hands. CNA E failed to remove soiled gloves and wash hands after providing incontinent care and prior to placing clean brief on Resident #259.</p> <p>During an interview on 7/22/2024 at 12:25 am, CNA E said she had been employed at the facility for 4 years and worked on the 6 am-2 pm shift. She said the incontinent care provided to Resident #259 earlier, she should have washed her hands and changed her gloves between the soiled brief and clean brief. She said she had a check off on skills this year. She said residents could be at risk of infections if staff did not wash or sanitize their hands during incontinent care.</p> <p>During an interview on 7/24/2024 at 11:50 am, the DON said she and the ADON and Infection Preventionist were responsible for oversight of infection control in the facility. She said all staff had been trained on infection control measures when providing incontinent care and when a resident required EBP. She said training was completed on hire, annually and as needed throughout the year. She said if the infection control program was not followed by staff it could cause the spread of infections and expected all staff to follow the infection control program.</p> <p>During an interview on 7/24/2024 at 11:54 am, the Administrator said that the DON, ADON, and Infection Prevention nurse was responsible for the infection control program and oversight. He said he expected infection control measures to be followed daily and by not doing so could lead to the spread of infections.</p> <p>Record Review of a CNA competency evaluation dated 2/13/2024 indicated CNA A had been trained on incontinent care and infection control.</p> <p>Record review of a CNA Proficiency Skills Check dated 2/14/2024 conducted by the ADON for CNA C indicated she was satisfactory in perineal care, along with hand washing.</p> <p>Record Review of a CNA competency evaluation dated 2/13/2024 indicated CNA E had been trained on incontinent care and infection control.</p> <p>Record review of a facility policy titled Linen and Laundry Services dated January 2022 indicated, .6. soiled linen is bagged or put into carts where it is used (i.e., in the patient's/resident's room .</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>Record review of a facility policy titled Hand Hygiene for Staff and Residents dated January 2022 indicated, .</p> <p>1. H. Hand hygiene is done after removal of medical gloves .</p> <p>Record review of a facility policy titled Enhanced Barrier Precautions dated April 1, 2024 read .This facility utilizes Enhanced Barrier Precautions (EBP) as a strategy to decrease transmission of CDC-targeted and epidemiologically important MDROs when Contact Precautions do not apply . and .Indications: .Wounds and/or indwelling medical devices even if the resident is not known to be infected or colonized with an MDRO.</p> <p>b. Chronic wounds include, but are not limited to, pressure ulcers .3. High Contact Resident Care Activities: .</p> <p>f. Changing briefs or assisting with toileting . and .C. Communication: 1. Indicate the residents who are on EBP by subtle means, such as an alternate color of the resident's name badge on door, to maintain a home-like environment .</p> <p>46436</p>

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<p>F 0919</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Make sure that a working call system is available in each resident's bathroom and bathing area.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40124</p> <p>Based on observations, interviews, and record review, the facility failed to be equipped to allow residents to call for staff through a communication system which relayed the call directly to a centralized staff work area for 2 of 16 residents reviewed for call lights. (Resident #9 and Resident #19)</p> <p>The facility failed to ensure Resident #9's and Resident #19's emergency call light in the bathroom had a cord enabling it to be reachable from the floor.</p> <p>This failure could place residents at risk of injury, pain, hospitalization, and a diminished quality of life.</p> <p>Findings included:</p> <p>1. Record review of a facility face sheet dated 07/22/2024 indicated Resident # 9 was a [AGE] year-old female that admitted to the facility on [DATE] with diagnosis of muscle weakness (generalized).</p> <p>Record review of a comprehensive care plan revised 01/04/2024 indicated to assist with toileting as needed and Resident # 9 had a history of falls while toileting.</p> <p>Record review of a quarterly MDS assessment dated [DATE] indicated Resident # 9 had a BIMS of 06 indicating severe impaired cognition, impairment of both lower extremities and unable to stand.</p> <p>2. Record review of a facility face sheet dated 07/22/2024 indicated Resident #19 was a [AGE] year-old male that admitted to the facility on [DATE] with diagnosis of muscle weakness (generalized).</p> <p>Record review of a comprehensive care plan revised 06/06/2024 indicated Resident # 19 had intervention to take resident to the toilet at the same time every day.</p> <p>Record review of a quarterly MDS assessment dated [DATE] indicated Resident # 19 had a BIMS of 15 indicating intact cognition, no impairment of lower extremities, and received partial assistance with toileting including toilet transfers.</p> <p>During an observation and interview on 07/22/24 at 9:45 AM room [ROOM NUMBER], the bathroom call light had a metal string 4 inches long sticky out of the wall, no string attached. Resident #9 said she uses the restroom occasionally and the staff assist her to transfer to the toilet if she does use it.</p> <p>During an observation and interview on 07/23/24 at 10:00 AM room [ROOM NUMBER] Resident #19 says he uses the bathroom to wash up and uses the toilet. The call light string does not reach the floor by 2 feet.</p> <p>(continued on next page)</p>

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<p>F 0919</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an observation and interview on 07/23/24 2:15 PM, Housekeeper F was cleaning a resident bathroom in room [ROOM NUMBER]. Housekeeper F said she tried to pay attention to the call lights in the restrooms when cleaning residents' bathrooms. Housekeeper F said she did not see anything wrong with the restroom. Housekeeper F said she would report the missing string to the Maintenance Director for replacement. She said she has worked at the facility for about 5 months. She said she would go get the maintenance man to attach longer strings to rooms [ROOM NUMBERS]. Housekeeper F said there was risk of a resident lying on the floor after a fall if they could not reach the call light string.</p> <p>During an interview on 07/24/24 08:00 AM the Maintenance Director said the call light strings in the bathroom should be to the floor in case a resident falls they would be able to call for help. He said that the resident could lie on the floor until someone made rounds if the strings were missing. He said the housekeeper told he yesterday that room [ROOM NUMBER] and room [ROOM NUMBER] needed longer strings in the bathrooms and he corrected the problem. He said he made rounds in the rooms periodically to check functioning of the call light system, but there was no formal list for checking safety items in rooms.</p> <p>During an interview on 07/24/24 08:30 AM the Administrator said the bathroom call lights should have a string that fall near the floor. He said the resident could not be able to call for assistance if the string was missing or was not long enough for the resident to reach it.</p> <p>Record review of a facility policy dated 1/19/2023 Call lights Answering</p> <p>Policy: The staff will provide an environment that helps meet the resident's needs by answering call lights appropriately.</p>		