STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675279	A. Building B. Wing	12/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Villa Haven Health and Rehabilitation Center	300 S Jackson St Breckenridge, TX 76424

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48883 Based on interview, observation, and record review the facility failed to revise the resident's care plan for 1 of 14 residents (Resident #16) reviewed for comprehensive care plans. The IDT team failed to revise Resident #16's care plan to include the updated diet and advanced directive orders. These failures could affect residents by placing them at risk of not having their individual needs met. Findings included: Record review of Resident #16's electronic face sheet dated 12/18/2024 revealed she was an [AGE] year-old female admitted to the facility on [DATE] and most recently on 10/21/2024 with diagnoses to include dysphagia (difficulty swallowing). Record review of Resident #16's quarterly MDS dated [DATE] revealed: BIMS score of 11 which indicated moderate cognitive impairment. Further review of MDS revealed Resident #16 had symptoms of holding food in mouth/cheeks or had residual food in mouth after meals and she coughed or choked during meals or when swallowing medications. Record review of Resident #16's electronic physician orders revealed: Code Status: DNR with start date of 10/21/2024 and Diet/Consistency: Mechanical Soft-No added salt packet-Boost w/each meal-Super Pudding w/lunch & supper with start date 12/3/2024. Record review of Resident #16's comprehensive care plan dated 12/19/2024 revealed: Resident #16 was at risk for malnutrition with an approach of Diet as ordered by physician is pureed with thin liquids No Added Salt diet. Edited: 10/24/2024. Further review revealed Resident #16 was a Full Code with an approach of Resident #16 had completed the following advanced directives and DNR not selected Edited: 12/14/2024. During an observation on 12/17/2024 at 11:53 a.m., Resident #16 sitting in wheelchair at dining room table and was served lunch that was mechanical soft texture. Her lunch meal ticket stated a mechanical soft diet. (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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/19/2024 at 8:47 a.m., LVN B stated charge nurses did not revise the resident's care plans. She stated she had access to the care plans by looking into resident's paper charts kept behind the nurses' station. During an interview on 12/19/2024 at 10:54 a.m., the SSD stated she was responsible for updating residents' advanced directive choice on care plans. She stated if a resident had chosen to be a DNR and had a physician's order for DNR, then the care plan should not state Full Code. She stated she might have forgotten to update the care plan due to Resident #16's family having been indecisive during care plan meetings and would go back and forth on the advanced directive decision. She stated Resident #16's family had signed a DNR form and it had been placed in paper chart for staff to see during an emergency situation. She stated she did not feel any negative effect would occur from the care plan not reflecting physician orders because in Resident #16's paper chart had the advanced directive DNR kept in front of chart behind tab. The SSD stated there was also red sheet labeled DNR in paper chart and nurses knew to look there for advanced directive status. She stated she did not know who monitored her care plans to ensure they were correct. During an interview on 12/19/2024 at 10:58 a.m., the DM stated she was responsible for updating resident's diet choices on care plans. She stated if a resident had a mechanical soft diet, their care plan should reflect a mechanical soft diet. She stated Resident #16 had a pureed diet ordered after returning to facility from hospitalization . She stated Resident #16's diet had changed, and she must have forgotten to update care plan when the diet changed. She stated the care plan not being accurate could have a potential cause for weight loss if Resident #16 had been served the wrong diet. She stated all staff knew how to look at tray card for diet when passing out food and there are multiple staff who check the tray cards during meal service. She stated the dietician monitored resident care plans for accuracy of dietary service. During an interview on 12/19/2024 at 11:33 a.m., the ADON stated Resident 16's care plan should have the most accurate advanced directive and diet status in it. She stated she was not responsible for dietary or social services care need in care plans. She stated the Corporate MDS coordinator did come to the facility and performed chart audits at least yearly checking that care plans were accurate. She stated she had been present during care plan meetings for Resident #16 and stated Resident #16's family had been indecisive about care decisions which may have led to care plans being not updated. She stated nurses did not look in the care plan during an emergency to look for code status because it was faster to see in front of paper charts. She stated nursing staff reviewed meal tickets during mealtime to see if diet was correct for residents. She did not feel any negative outcome would occur from care plan not being updated. During an interview on 12/19/2024 at 11:33 a.m., the ADMN stated her expectation would be that care plans reflect current diet orders and advanced directive status. She stated the SSD was responsible for updating advanced directives in the care plan and the National Social Service Director was responsible for monitoring social service care needs in the care plan were accurate. She stated the DM was responsible for updating dietary needs in the care plan and those needs were monitored by the dietician. She stated staff knew to look in paper chart for advanced directive status and at meal tickets for diet orders. She stated that even so, care plans should have accurate information on them. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of facility policy titled Care Plan Process, Person-Centered Care revised on date May 5, 2023 revealed: Person-centered care means the facility focuses on the resident as the center of control and supports each resident in making his or her own choices .The services provided or arranged by the facility, as outlined by the comprehensive person - centered care plan, will meet professional standards of quality . Procedures: 3. Following RAI Guidelines develop and implement a comprehensive person-centered care plan that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment .6. The Interdisciplinary Team (IDT) will review for effectiveness and revise the person - centered care plan after each assessment. This includes both the comprehensive and quarterly assessments. For the comprehensive assessment the review will be completed with seven (7) days of V0200B2 and no more than 21 days after admission .Thru ongoing assessment, the facility will initiate person - centered care plans when the resident's clinical status or change of condition dictates the need such as but not limited to falls and pressure ulcer development.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44558 48883 Based on observations, interviews, and record reviews, the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment to help prevent the development and transmission of communicable diseases and infections for 3 of 5 staff (LVN-A, CNA-B, CNA-C) reviewed for infection control procedures. 1. The facility failed to ensure the CNA-B and CNA-C performed proper hand hygiene in between changing gloves during incontinent care. 2. The facility failed to ensure the LVN-A performed proper hand hygiene in between changing gloves during wound care and prior to reaching into medication cart. 3. The facility failed to ensure the CNA-B and CNA-C wore gown during foley catheter care. These failures could place residents at risk for the transmission of communicable diseases. Findings included: Record review of Resident #9's electronic face sheet dated 12/19/2024 revealed she was a [AGE] year-old female admitted into the facility on [DATE] and most recently on 12/11/2024 with diagnoses to include urinary tract infection and urinary incontinence. Record review of Resident #9's quarterly MDS dated [DATE] revealed: BIMS score of 14 which indicated cognitively intact. Further review of MDS indicated that Resident #9 was incontinent to urine and bowel and she was dependent on staff for bed mobility and to transfer from bed to chair. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During on observation on 12/18/2024 at 7:28 a.m., CNA B and CNA C entered Resident #9's room and performed hand hygiene and placed on gloves. Resident #9 was lying in her bed and CNA C assisted CNA B with incontinence care. CNA C stood on left side of bed to assist with bed mobility as CNA B removed tabs of the brief and cleansed Resident #9's front with wipes and disposed of wipes after every wipe starting on left side, then right side, then down middle of perineal area. Resident #9 assisted in turning to her left side by CNA C. CNA B wiped her rectal area with wipe and discarded wipe. Soiled brief was removed from Resident #9 then discarded into lined trash receptacle. CNA B removed her gloves and put on new gloves without performing hand hygiene. She placed a clean brief under resident and helped CNA C roll the resident to situate clean brief under resident along with Hoyer sling. After positioning, CNA B and CNA C took off the gloves and CNA B opened a drawer to get socks for Resident #9. CNA B put socks and shoes on Resident #9 while not wearing gloves and then placed gloves on her hands to move the mechanical sling lift over to Resident #9's bed. CNA C saw the soiled wipe on floor and put a glove on right hand to pick up the item and then disposed of both into the trash receptacle. CNA C put on gloves and assisted CNA B with mechanical sling transfer of resident into wheelchair. Both CNAs then assisted Resident #9 with removal of shirt and bra to change into clean clothes. CNA C then took trash and soiled linen out of room in plastic bag and put into covered bins in the hall. Both CNAs then performed hand hygiene for the first time since entering Resident #9's room. During an interview on 12/18/2024 at 7:33 a.m., CNA B stated she had been trained on infection control. She stated she should have sanitized her hands in between glove changes and after removal of gloves. She stated she just had a brain slip and forgot to sanitize hands. She stated no sanitizing hands could cause infection from spreading bacteria. Record review of Resident #228's electronic face sheet dated 12/19/2024 revealed she was an [AGE] year-old female admitted into the facility on [DATE] with diagnoses to include encephalopathy (swelling of the brain). Record review of Resident #228's admission MDS dated [DATE] revealed: BIMS score of 8 which indicated moderate cognitive impairment. Further review of MDS revealed Resident #228 had one or more unhealed pressure ulcers and was at risk of developing pressure ulcers. Record review of Resident #228's electronic physician orders dated 12/10/2024 revealed Resident #228 had wound to right upper thigh, left heel and right sacrum. During an observation on 12/18/2024 at 8:52 a.m., LVN A carried in wound care supplies into Resident #228's room and sat opened items onto wax paper on bedside table. She assisted Resident #228 into recliner and washed hands with soap and water prior to placing on her gloves. LVN A removed the heel dressing and cleaned the skin with wound cleanser and gauze. She removed her gloves and used ABHR to sanitize her hands prior to putting on new gloves to place dressing to heal wound. She disposed of the gloves and used ABHR prior to putting on clean gloves. LVN A removed dressing from the sacral wound and cleansed the wound with wound cleanser and gauze. She removed gloves and did not perform hand hygiene before placing new gloves. She dressed sacral wound and then removed gloves and did not perform hand sanitizing. LVN A then reached into the medication cart and removed a bottle of cream for another treatment. She came back into room and washed her hands with soap and water then put on gloves before continuing with Resident #228's treatments. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 12/18/2024 at 9:40 a.m., LVN A stated she had training on infection control. She stated she should have sanitized her hands in between glove change and after removing gloves. She did not know why she did not perform hand hygiene. She stated not performing hand hygiene could cause cross contamination infections. Record review of Resident #19's electronic face sheet dated 12/19/2024 revealed she was a [AGE] year-old female admitted into the facility on [DATE] and most recently on 11/4/2024 with diagnoses to include retention of urine. Record review of Resident #19's quarterly MDS dated [DATE] revealed: BIMS score of 12 which indicated moderate cognitive impairment. Further review of MDS revealed Resident #19 had an indwelling catheter appliance for bladder and urinary continence was not rated because resident had a catheter. Record review of Resident #19's electronic physician orders dated 9/25/2024 revealed an order for indwelling foley catheter and an order for foley catheter care to be completed by CNA every shift. During an observation on 12/18/2024 at 9:34 a.m., CNA B and CNA C performed foley catheter care for Resident #19. There was no EBP signage outside of Resident #19's door or PPE outside of door. CNAs entered the room and performed hand hygiene and placed on gloves. They performed foley catheter care without using a gown. CNA B and CNA C disposed of gloves and performed hand hygiene after foley catheter care. During an interview on 12/19/2024 at 10:26 a.m., LVN B stated she was the IP. She stated her expectation would be for staff to perform hand hygiene with ABHR or soap and water in between glove changes and after gloves were removed. She stated not sanitizing hands could cause infections from cross contamination. LVN B stated staff had been educated on hand hygiene and are responsible for carrying out hand hygiene. She stated both she and the DON performed in-services and boot [NAME] to teach staff how to perform hand hygiene appropriately. She stated boot [NAME] are held every 3 months and all direct care staff were required to attend. She stated both her and the DON watch staff perform tasks during boot camp to make sure they are knowledgeable about infection control. She stated facility does utilize EBP for residents that have indwelling catheters such as foley catheter. She stated there should have been an EBP sign outside of Resident #19's door to let staff know how to use PPE during care including gown. She stated charge nurses were responsible for making sure EBP sign and PPE were available outside of residents' rooms when EBP should be used during resident's care. She stated she and the DON monitored that EBP sign and PPE were outside of rooms when required. She stated Resident #19 had a EBP sign and PPE outside of her room, but they were removed when she went to the hospital. She stated EBP sign and PPE should have been placed outside of door when Resident #19 returned and that was an oversite by nursing and her. She stated not following EBP or performing hand hygiene when removing gloves could cause infection spread. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 12/19/2024 at 11:51 a.m., the DON stated she expected staff to sanitize their hands after gloves were removed including during glove changes. She stated gowns should be used during foley catheter care as part of EBP. She stated CNAs and nurses were responsible for performing hand hygiene when appropriate. She stated she and the IP monitored that CNAs and nurses used appropriate hand hygiene when providing care to residents. The DON stated both her and the IP were responsible for training staff on infection control. She stated EBP sign and PPE should be outside of rooms that staff should use EBP when providing care to residents that have an indwelling catheter. She stated not sanitizing hands when removing gloves and now wearing gown when caring for a foley catheter could increase risk for infection. Record review of facility policy titled Hand Hygiene/Hand Washing dated May 15, 2023 revealed: Hand hygiene is the most important component for preventing the spread of infection. Proper hand washing technique will be used when hand washing is indicated .2. Wash Hands: A. When hands are visibly soiled. B. Before starting work. C. Before putting on gloves, when changing into a fresh pair of gloves, and immediately after removing gloves. Review of facility policy titled Infection Prevention and Control Policies and Procedures dated May 15, 2023 revealed: Enhanced Barrier Precautions (EBP) 1. Enhanced Barrier Precautions expand the use of PPE (gowns and gloves) during high-contact resident care activities that provide opportunities for transfer of MDROs to staff hands and clothing. a. EBP will be implemented for All residents with the following: i. Infection or colonization with an MDRO when Contact Precautions do not otherwise apply ii. Wounds and/or indwelling medical devices (central lines, urinary catheter, feeding tube, tracheostomy/ventilator) regardless of MDRO colonization status b. EBP will be implemented during the following high-contact resident care activities: i. Dressing ii. Bathing/showering iii. Transferring iv. Providing hygiene v. Changing linens vi. Changing briefs or assisting with toilet vii. Device care or use: central lines, urinary catheter, feeding tube, tracheostomy/ventilator c. EBP requires the following PPE: i. Gloves (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	ii. Gown iii. Face protection is performing activity with risk of splash or spray iv. All PPE is donned and doffed with appropriate hand hygiene and disposable after individual use or when visible soiled