STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675444	A. Building B. Wing	05/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Reunion Plaza Senior Care and Rehabilitation Cente	1401 Hampton Rd Texarkana, TX 75503

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, 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 1 of 4 residents (Resident #1) reviewed for infection controlThe facility failed to ensure the Treatment Nurse A and ADON C wore appropriate PPE (gown and gloves) while performing wound care on Resident #1 on 05/07/26. Resident #1 was on Enhanced Barrier Precautions also known as EBP (an infection control strategy implemented in nursing homes to reduce the spread of multidrug-resistant organisms also known as MDROs).This failure could place any resident at the facility at risk for cross-contamination and the spread of infection.Finding included:Record review of Resident #1's face sheet, dated 05/07/26 indicated he was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses which included, a wedge compression fracture (a spinal injury where the front (anterior) part of a vertebra collapses, creating a wedge-shaped bone while the back remains intact), heart failure (where the heart muscle cannot pump blood effectively to meet the body's needs for oxygen), stroke and high blood pressure. Record review of Resident #1's significant change MDS assessment, dated 03/10/26, indicated Resident #1 understood at times and was sometimes understood by others. Resident #1's BIMS score was 09 which indicated his cognition was moderately impaired. The MDS indicated Resident #1 required assistance with his ADLs. The MDS indicated Resident #1 was always incontinent of bladder. The MDS did not indicate a wound.Record review of Resident #1's comprehensive care plan, dated 05/07/26, indicated, Resident #1 had a non-pressure wound to his lower back. The intervention was for staff to do his treatment as ordered.Record review of Resident #1's Physician order, dated 05/04/26, indicated:*Cleanse wound to lower back with normal saline or wound cleaner. Pat dry. Apply Collagen sheet (medication used for wounds), cover with gauze dressing daily and as needed.*Enhanced barrier precautions every shift.During an observation and attempted interview on 05/07/26 at 11:56 a.m., Resident #1 was lying in his bed. Resident #1 had a cart inside his room which contained gloves, mask, and gowns. Resident #1 also had a blue name tag on his door. Resident #1 did not answer when asked about the cart inside his door, and was not able to say if he had a wound or not. During an observation on 05/07/26 at 12:00 p.m., Treatment Nurse A went into Resident #1's room to perform wound care. She explained what she was going to do, washed her hands, and applied gloves. ADON C assisted Treatment Nurse A to turn Resident #1 on his side. Treatment Nurse A began to perform his wound treatment by removing his old dressing, performed hand hygiene, and applied new gloves. She then cleaned the area, performed hand hygiene, applied new gloves, applied Collagen, and a dressing. Treatment Nurse A nor ADON C wore a gown while performing wound care.During an interview on 05/07/26 at 12:12 p.m., Treatment Nurse A said Resident #1 was on EBP. She said she was supposed to have worn a gown and gloves to prevent the transmission of infection. She said she was aware she needed to wear a gown and gloves, but just forgot. She said she had been in-serviced over infection control. She said she was aware of who required EBP because of the bins inside or outside the door and the residents who had blue tape on their names were the residents who required PPE.During an interview on (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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	05/07/26 at 1:12 p.m., ADON C said she had been employed at the facility for about a week. She said she was not aware she was supposed to wear a gown when performing or assisting Treatment Nurse A with wound care until after they completed the wound care. She said she had been trained on infection control, but since she was new, it did not click in her mind that she and Treatment Nurse A were supposed to wear gowns and gloves while performing wound care. She said Resident #1 had the cart inside his room and his name plate was blue indicating he was on EBP precautions. She said without wearing the proper PPE (gown and gloves), it placed Resident #1 at risk of infection.During an interview on 05/07/26 at 7:55 p.m., ADON B, who was the Infection Preventionist, said he had trained the staff on PPE. He said all staff were supposed to wear PPE while performing care for residents who required EBP. He said he did in-services with staff randomly, and spot checks weekly to ensure residents had name plates that were blue and the carts were either inside their room or outside the door. He said failure for staff to wear PPE (gown and gloves) could cause infection.During an interview on 05/07/26 at 8:09 p.m., the DON said she expected staff to wear gowns and gloves when performing care to residents who required EBP. She said staff were aware if a resident required EBP because their name tag was in blue and the residents had a bin inside or outside their door. She said the infection preventionist oversaw the infection control process. She said she could not recall the last in-service, but believed it was in February of 2026. She said staff should wear proper PPE (gown and gloves) when caring for residents on EBP to prevent infection and cross-contamination.During an interview on 05/07/26 at 8:18 p.m., the Administrator said he expected all staff to wear PPE as needed. The Administrator said the nurse management were responsible for ensuring staff were trained on EPB and infection control. He said by not wearing the proper PPE (gown and gloves), it could place residents at risk for cross-contamination or infection.Record review of the facility's policy titled, Isolation Precautions, dated February 2025, indicated, Policy: To prevent unprotected exposure of residents, visitors, and staff to potentially infectious microorganisms or diseases and to decrease the spread of healthcare or community acquired infections. Enhanced Barrier Precautions: Used when the resident does not require Transmission Based Precautions but-has a higher risk or known colonization with Multi-Drug-Resistant organisms. See Specific Policy for EBP. Record review of the facility's policy titled, Enhanced Barrier Precautions, dated February 2025, indicated, Policy: Many residents in nursing homes are at increased risk of becoming colonized and developing infections with multi-drug-resistant organisms (MDROs). 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. A. indications.2. Wounds and/or indwelling medical devices even if the resident is not known to be infected or colonized with an MDRO.3. High Contact Resident Care Activities: included: a. Dressing f. Changing briefs or assisting with toileting. H Wound Care: any skin opening requiring a dressing (not for superficial wounds requiring an adhesive bandage, such as a skin tear or skin break).