| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 675462 | A. Building<br>B. Wing | 05/09/2024 |

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| Parkview Nursing and Rehabilitation Center | 3200 Parkway<br>Big Spring, TX 79720 |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 03896<br><br>Based on observation, interview and record review, the facility failed to ensure that the resident environment remained as free of accident hazards as was possible in 2 of 4 common resident baths (200 and 400), and 1 of 4 halls (400) in that:<br><br>The facility failed to ensure chemicals were not accessible to residents and were not stored with resident toiletries and personal items in 2 of 4 common resident baths (200 and 400), and 1 of 4 halls (400).<br><br>These failures could lead to chemical associated resident injuries.<br><br>The findings include:<br><br>On 5/8/24 at 2:32 PM an observation was made of the Hall 200 bath. The door was locked but there were cleaners stored on the lower shelf of the unlocked cabinet among resident use items. These cleaners were stored next to toilet tissue, hair conditioner, and body wash. The specific cleaners/chemicals were as follows:<br><br>-Fabulosa (two bottles) labeled, Caution: May irritate eyes. If swallowed. Contact poison control center or doctor immediately.<br><br>-Mean Green Super Strength Cleaner and Degreaser labeled, Warning: eye irritant. Ingest: . Contact poison control center, physician or emergency room immediately.<br><br>-Diversity Crew Clean Toilet Bowl Cleaner labeled, . Danger: Corrosive .<br><br>-Aerosol can of [NAME] Duz all Dust and Shine labeled, . Danger: Harmful or fatal if swallowed. Danger: Extremely flammable.<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 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | On 5/8/24 at 2:49 PM an observation was made of a housekeeping cart unattended in hall 400 outside room [ROOM NUMBER]. There was a male resident walking in the corridor near room [ROOM NUMBER] at the time. Housekeeper A was inside room [ROOM NUMBER] and not observing the cart. There was a spray bottle of cleaner hooked on the exterior of the cart and there was a container of Clorox Hydrogen Peroxide Cleaner Wipes on top of the cart and both items were accessible to residents. The wipes were labeled Caution: Causes moderate eye irritation . The spray bottle contained Ecolab Rapid Multi Surface Disinfectant Cleaner. The bottle was labeled, Do not drink. Causes moderate eye irritation .<br><br>On 5/08/24 at 2:52 PM Housekeeper A exited room [ROOM NUMBER] stated, Sorry I should have put it (chemicals) away. Housekeeper A she added, I was not intending to stop (at the room). She stated residents would need to get checked out or taken to the emergency room if they came in contact with the assessable chemicals.<br><br>On 5/8/24 at 2:57 PM an observation was made of hall 400 bath. The door to the bath was a jar. The cabinet inside was unlocked. The lower cabinet top shelf had a spray bottle of Ecolab Peroxide Multi-Surface Cleaner and Disinfectant on the shelf next to mouthwash, an unlabeled spray bottle of clear liquid, spray deodorant, lotion, and a hairbrush. Below the top shelf (on the lower shelf) was an open plastic cabinet drawer containing hair conditioner. The lower shelf also contained fabric freshener, Mean Green Cleaner, body wash, and hair conditioner stored next to each other.<br><br>On 5/8/24 at 3:04 PM CNA B was interviewed regarding the chemicals in the 400 bath cabinet. At that time, she was observed, spraying the shower chair with the peroxide multi-surface cleaner and then placing the spray bottle back on the lower shelf with toiletries. She stated the unlabeled spray bottle with clear liquid contained water. She added, staff usually kept cleaners on the bottom shelf of the cabinet. She said that she had been working in the facility approximately a year. She stated someone could mistakenly grab it (chemical) and spray it on a resident as a result of the chemicals being stored among resident items.<br><br>On 5/9/24 at 9:24 AM an interview was conducted with LVN A in the hall 200 bath. Observation with LVN A revealed that the same chemicals were stored as they were the day before, with chemicals stored on the same cabinet shelf with toilet tissue and hair conditioner. All the same cleaners were present which included Fabulosa cleaner, Mean Green Cleaner, and toilet bowl cleaner. She stated the chemicals could leak and harm residents. She added, We need to be educated on this (chemical storage in baths).<br><br>On 5/9/24 at 11:43 AM an interview was conducted with the Housekeeping Supervisor. She stated staff should have kept the chemicals in the cart and locked them in the cart. She added, staff should have stayed in sight of the cart while they were in the room. She stated, at the time of the incident, Housekeeper A had just stopped for a moment and was heading to disinfect her cart when she left the cart unattended in hall 400. She stated the housekeeping supervisor was responsible for ensuring that chemicals were not accessible to residents. She stated she made rounds to ensure chemicals were stored safely and not accessible to residents. She stated, residents could sustain skin injury, death, chemical burns, and respiratory problems as a result of chemicals being accessible to residents.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | On 5/9/24 at 12:03 PM an interview was conducted with the DON regarding chemical storage in baths. She stated nursing staff were taught that housekeeping chemicals should be stored separate from resident items and not accessible to residents. She stated staff possibly stored the chemicals, as observed, for convenience. She stated, nursing staff conducted compliance rounds and the Quality Assurance nurses had worksheets that were used. She added, the worksheets needed to be more specific and include the bath storage cabinets. She stated there was a potential that residents could come in contact with the chemicals as a result of chemicals stored with resident toiletries and items.<br><br>On 5/9/24 at 4:07 PM, an interview was conducted with the Administrator. She stated staff carelessness was the reason for the chemical accessibility and storage issues. She stated the Housekeeping Supervisor, Administrator, and DON were responsible for ensuring that chemicals were stored in a safe manner in the facility. She stated, chemicals could spill on residents and dementia residents could get into the chemicals if they were not stored in a safe manner and inaccessible.<br><br>Record review of the Safety Data Sheet for Ecolab Peroxide Multi Surface Cleaner and Disinfectant dated 9/13/21 revealed the following documentation, .<br><br>Section 2. Hazards identification.<br><br>Product at use dilution.<br><br>Eye irritation.<br><br>Product at use dilution.<br><br>Signal word: Warning.<br><br>Hazard Statements: Causes eye irritation.<br><br>Precautionary Statements:<br><br>Prevention: Wash skin thoroughly after handling.<br><br>Response: IF IN EYES: Rinse cautiously with water for several minutes. Remove contact lenses, if present and easy to do. Continue rinsing. If eye irritation persists: get medical advice/attention .<br><br>Section 11. Toxicological information.<br><br>Product at use dilution.<br><br>Eyes: Causes eye irritation .<br><br>Record review of the Census List dated 5/9/24 submitted by Administrative Nurse A revealed that 65 residents were independently ambulatory either by walking or wheelchair. Of those 65 residents, 10 were documented as confused. Two of the 10 confused and independently ambulatory residents resided on Hall 400.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Record review of the current undated facility policy, titled Storage Areas, Environmental Services, revealed the following documentation, Housekeeping, and laundry department storage areas shall be maintained in a clean and safe manner. Interpretation and Implementation. 3. Cleaning supplies, etc., shall be stored in area separate from food storage and shall be stored as instructed on the labels of such products. |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.<br><br>03896<br><br>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 in 1 of 1 kitchen reviewed for dietary services.<br><br>1) The facility failed to ensure foods were stored under sanitary conditions.<br><br>2) The facility failed to ensure food and nonfood contact surfaces were clean.<br><br>3) The facility failed to ensure foods were in sound condition<br><br>4) The facility failed to ensure food storage areas were clean and good condition<br><br>5) The facility failed to ensure food contact items were stored in a sanitary manner<br><br>6) The facility failed to ensure hair restraints were worn in food areas<br><br>7) The facility failed to ensure manufacturers guidelines were followed regarding food retention<br><br>These failures could place residents at risk for food contamination and foodborne illness.<br><br>The findings included:<br><br>The following observations were made during a kitchen tour on 5/07/24 that began at 10:50 AM and concluded at 12:30 PM:<br><br>*The fryer had gummy buildup on the sides.<br><br>*In the walk-in refrigerator there was a zip lock bag of cooked breakfast food, which contained eggs and sausage, stored on top of a box of raw bacon. The bag was marked 5/7/24. The exterior of the box was stained.<br><br>*The underside of the steamtable top shelf was rusted and soiled.<br><br>*There were drinking glasses stacked wet on a cart on the clean side of the dishwasher and not stored in a manner to effectively air dry.<br><br>*Containers of juice (Styrofoam cup with lid) and shakes were stored in a bin that was in undrained iced on the service line.<br><br>The following observations were made during a kitchen tour on 5/07/24 that began at 12:43 PM and concluded at 1:00 PM:<br><br>(continued on next page) |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | *There were 2- #10 (large) cans of unsweetened applesauce that was badly dented on the rim and There was one #10 (large) can of pears that was badly dented on the rim. These cans were stored in the can rack with other cans of in use foods.<br><br>*There was a container of cottage cheese in the walk-in refrigerator that was labeled by the manufacturer Best by 4/29/24.<br><br>*The walk-in refrigerator had rusted racks.<br><br>The following observations were made during a kitchen tour on 5/07/24 that began at 4:09 PM and concluded at 4:39 PM:<br><br>*The upright dicer had dried food on the blades. It was stored on a rear kitchen table.<br><br>*A rear kitchen table lower shelf had a rusty surface. The table was located next to the convection oven and food equipment was stored on this shelf.<br><br>*In the walk-in there was still a container of cottage cheese that was labeled Best by 4/29/24<br><br>The following observations were made during a kitchen tour on 5/07/24 that began at 5:02 PM and concluded at 6:00 PM:<br><br>There were health shakes stored in a bin of undrained ice on the service line.<br><br>*Facility staff were entering the kitchen without hair restraints, dispensing drinks from the drink dispenser, retrieving cups and other containers. In this area was a large tea urn that was uncovered/lid removed. Housekeeper B wore no hair restraint and was filling cups with juice from the drink dispenser and the tea dispenser urn was uncovered. CNA A entered the kitchen and retrieved dispensed drinks and retrieved cups as the tea urn was uncovered in the area. She wore no hair restraint.<br><br>*Dietary staff A was observed caring bags of potato chips up against her chest and shirt and then placed them in a bin at the service line.<br><br>-The following observations and interviews were made during a kitchen tour on 5/08/24 that began at 11:23 AM and concluded at 12:24 PM:<br><br>* Cartons of shakes were stored in a bin of undrained ice at the service line.<br><br>*The walk-in floor underneath the racks had a buildup of food and debris.<br><br>*There was a zip lock bag of cooked breakfast food stored on top of a box of raw bacon in the walk-in refrigerator. The box was stained/soiled. This bag was labeled 5/8/24.<br><br>*There was a box of cooked sliced beef stored on top of a box of raw ground beef in the walk-in refrigerator.<br><br>*There was still the same container of cottage cheese present that was labeled Best by 4/29/24 by the manufacturer.<br><br>(continued on next page) |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | *There were clean glasses stacked wet on the clean side of the dishwasher.<br><br>During an interview with the Dietary Manager on 5/8/24 at 11:39 AM, she stated the bag that was on top of the box of raw bacon was cooked breakfast foods. She stated These are the foods from breakfast. We use it the next day for purees.<br><br>During an interview and observations on 5/9/24 at 10:47 AM with the Dietary Manager. She stated since her employment, staff had stored cooked food on top of boxes of raw foods. She further stated the dietary department had been short staffed and she tried to do rounds daily. She stated she removed the dented cans and she and the staff go through and check the cans. She stated, everyone had to wear a hair restraint when they entered the main kitchen from the rear wall to the front wall (excluding front and rear entry corridors). She added staff thought they could be in the front corridor area where the drinks were because nothing was uncovered. She stated she had not reviewed anything with staff regarding the storage of foods in undrained ice. She added she had told staff not to stack glasses wet. Observation at that time revealed the dicer still had dried food on the blades and the shelves were rusted in the walk-in and on a rear kitchen table. In the walk-in there was an approximately 6 x 6 area of the floor that had a missing metal section, which caused a depression in the floor and was not easily cleanable. The floor was soiled with food debris under the racks. The Dietary Manager stated, Yes the dicer needed cleaning. She added the dietary department was getting a new floor for the walk-in but had no timeframe for the installation. Regarding the staff member caring bags of chips against her chest, she stated, the Dietitian had mentioned carrying tablecloth against the body, but there was no mention of foods. She stated the dietary issues occurred due to staff not knowing or not being aware. She said that her dietary monitoring system was making rounds. She added the person responsible for ensuring dietary policies and procedures were followed was the Dietary Manager. She stated that she conducted in-services and had done one yesterday (5/08/24); the in-service discussed not propping the door open. She stated, during initial dietary staff training, they wait until staff were comfortable, then they let them go on their own and were monitored. She added the dietary issues observed could place residents at risk for foodborne illness. She further stated staff did not know about not holding things against their shirts and what was on the shirt could get on the food. She also stated she had reviewed hair restraints with staff.<br><br>During an interview on 5/9/24 at 4:07 PM, the Administrator stated she was not aware of the issue with containers of cooked foods stored directly on top of containers of raw foods. Regarding the hair restraints, she stated she thought staff could go by the wall (entrance corridor). She stated the Dietary Manager and Administrator was responsible for ensuring that correct procedures were followed in the dietary department. She stated these issues could place residents at risk for foodborne illness. She added that the facility was getting an estimate for the walk-in floor repair and that staff had been storing drinks in undrained ice for years.<br><br>Record review of the in-service training report dated 4/11/24 revealed that the subject of the in-service was Dietary and conducted by the Dietary Manager and Administrator. Items covered were listed as:<br><br>1. Make sure you are wearing a hairnet at all times.<br><br>2. Sign cleaning schedule and actually do the cleaning.<br><br>3. Make sure you are labeling and dating everything you put in the walk-in and freezer<br><br>(continued on next page) |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | 4. Clean up after yourself - if you drop or spill something make sure you clean it right away not later .<br><br>Record review of the facility undated current policy titled, Sanitation, and Food Handling, revealed the following documentation, Procedures. 1. The Food Service Director will provide work schedules and cleaning assignments to be carried out . |

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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** 49279<br><br>Based on observations, interviews, and record review, the facility failed to maintain an infection control program designed to provide a safe, comfortable, and sanitary environment to help prevent the development and transmission of diseases for 2 of 3 residents (Residents #50 and #76) reviewed for infection control.<br><br>1. CNA C failed to utilize proper hand hygiene during incontinence care for Resident #50.<br><br>2. CNA D failed to utilize proper hand hygiene during incontinence care for Resident # 76.<br><br>These failures could place residents at risk for infection and cross contamination.<br><br>Findings included:<br><br>Resident # 50<br><br>Record review of Resident #50's undated face sheet revealed a [AGE] year-old female originally admitted on [DATE]. Resident #50 had the following medical history: retention of urine, contracture of the right and left hand, muscle weakness, and hypertension (high blood pressure).<br><br>Record review of Resident #50's care plan dated 10/09/2023, revealed a problem of urinary and bowel incontinence with increased risk for skin breakdown/UTI's. Resident #50 had a goal of Resident will not develop any UTI's for 90 days. Resident #50's approaches revealed, Provide proper peri care after each incontinent episode.<br><br>Record review of Resident #50's MDS dated [DATE] revealed a BIMS score of 7 which indicated Resident #50 had severe cognitive impairment.<br><br>During incontinence care observation on 5/08/2024 at 09:54 AM, CNA C removed Resident #50's dirty brief, cleaned resident's peri area and doffed dirty gloves. CNA C did not wash her hands or utilize alcohol-based hand sanitizer prior to donning clean gloves. CNA C placed a new brief on Resident #50 and doffed dirty gloves. CNA C did not wash her hands or utilize alcohol-based hand sanitizer before donning clean gloves. CNA C readjusted Resident #50 doffed dirty gloves and washed her hands with soap and water.<br><br>CNA C not available for interview on 5/8/2024 and 5/9/2024.<br><br>Resident #76<br><br>Record review of Resident #76's undated face sheet revealed a [AGE] year-old male originally admitted on [DATE]. Resident #76 had the following medical history: acute kidney failure, hydronephrosis (condition where one or both kidneys become stretched and swollen), urinary tract infection and benign prostatic hyperplasia (enlarged prostate).<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 Resident #76's care plan dated 2/14/2024 revealed problem onset, bowel incontinence, increased risk for skin breakdown/UTI's. Resident #76 had a goal stating .will not develop any UTI's over the next 90 days. Resident #76 approaches revealed, provide proper peri- care after each incontinent episode. Resident #76's care plan revealed increased risk for UTI due to indwelling catheter (catheter that remains in the bladder to drain urine). Resident #76's approach revealed catheter care every day and as needed.<br><br>Record review of Resident #76's MDS dated [DATE] revealed a BIMS score of 7 which indicated Resident #76 had severe cognitive impairment.<br><br>Record review of physician orders dated 2/14/2024 revealed an order for Foley catheter care every shift.<br><br>During incontinence care observation on 5/08/2024 at 10:32 AM, CNA D was observed removing Resident #76's dirty brief, cleaned around resident's peri area and doffed dirty gloves. CNA D did not utilize alcohol-based hand sanitizer or wash her hands prior to donning clean gloves. CNA D turned resident onto his side, cleaned his buttocks and doffed dirty gloves. CNA D did not wash her hands or utilize alcohol-based hand sanitizer.<br><br>During an interview with CNA D on 5/8/2024 at 1045 AM, she stated she was trained to wash her hands before and after resident care, after grabbing soiled items, bodily fluids, and between distributing meal trays in between residents. She stated she should have washed her hands between glove changes. She stated the risk of not utilizing proper handwashing technique was spreading bacteria from one resident to another, or to staff. She stated her infection preventions was the ADM. She stated her last training was 1/2024.<br><br>During an interview with the ADM on 5/8/2024 at 12:45pm she stated staff is trained on handwashing upon hire, and annually with in services in between as needed. She stated the risk of improper handwashing could be spreading infection. She stated the DON is the infection preventionist. The ADM stated they monitor compliance with annual competencies and as needed. The ADM stated she was not aware of CNA C and CNA D not washing their hands between glove changes.<br><br>During an interview with the DON on 5/8/2024 at 1:10pm, she stated staff are trained to wash their hands between glove changes. She stated staff are trained during in-services, skills checkoff, as needed and annually. The DON she stated the last training was 5/6/2024. She stated the risk of staff not washing their hands between glove changes would be contamination of the hands when removing their gloves. She stated the DON is the infection preventionist. The DON stated they monitor staff for handwashing compliance through any opportunity for observation with resident direct care. She stated RN A is the QA nurse and she monitors the halls primarily for handwashing. She stated she was not aware of staff not washing their hands between glove changes.<br><br>Record review of the facility's policy titled Infection Prevention and Control Guideline dated 2/2023 revealed:<br><br>.A. Hand Hygiene: The single most important component to infection prevention in all circumstances and should always be practiced in addition to other measures outlined in this policy.<br><br>1. Includes the use of alcohol-based hand rub and the use of soap and water.<br><br>(continued on next page) |

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| (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 | Record review of facility's undated policy titled Hand-washing Guideline revealed:<br><br>When to was hands Guidelines: .7) After handling items potentially contaminated with residents' blood, body fluids, excretions, secretions.<br><br>.Alcohol based sanitizer may be used in place of soap and water.<br><br>Record review of Internet CDC Handwashing Guidelines titled Hand Hygiene in the Healthcare Setting last revised January 8, 2021, revealed:<br><br>The CDC Guideline for Hand Hygiene in Healthcare Settings recommends:<br><br>During Routine Patient Care .Use an Alcohol-Based Hand Sanitizer .Immediately after glove removal. |