STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675614	A. Building B. Wing	11/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ballinger Healthcare and Rehabilitation Center	2001 6th St Ballinger, TX 76821

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 30057 Based on observation, interview and record review the facility failed to ensure, in accordance with State and Federal laws, all drugs and biologicals were stored in locked compartments under proper temperature controls, and permitted only authorized personnel to have access to the keys for 1 of 2 treatment carts (Hall 4 cart) reviewed for medication storage. The facility failed to ensure the nurses' treatment cart was not left unlocked and unsupervised for 10 minutes on hall 4. This failure could place residents at risk of loss, diversion or accidental ingestion of medications. The findings include: During an observation on 11/20/24 at 09:10 AM till 09:20 AM revealed RN A left the nurse's treatment cart unlocked and unattended for approximately 10 minutes while she entered a resident's room to attend to them. The cart contained several ointments, nail clippers, dressings and several other normal saline bottles. The cart was facing the hall. During an interview on 11/20/24 at 11:05 AM, RN A said she was not aware she left the treatment cart unlocked. RN A said she always was very good about locking her cart when walking away from it, but she had just plain missed it today. RN A said if the cart was left unlocked then someone could get into the cart and into the supplies used for wound care and medication administration. During an interview on 11/21/24 at 03:30 PM the DON said it was expected for nursing staff to lock their medication carts when not using them. The DON said the nurse had probably forgotten to lock the cart when she went back into the resident's room to perform the resident care. The DON said if the cart were left opened then other unauthorized people or residents could have access of the cart. During an interview on 11/21/24 at 04:22 PM, the Administrator said it was expected for nursing staff to lock their medication carts when not using them. The Administrator said if the cart was left unattended and unlocked it could lead to drug diversions and other people having access to the items in the cart. The Administrator said the failure probably occurred because the staff had gotten nervous due to being observed by the state surveyor. (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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the facility's policy titled Medication Carts, dated 2003, indicated: The carts are to be locked when not in use or under the direct supervision of the designated nurse. Record review of the facility's policy titled Medication Administration Procedures, dated 2003, indicated : After the medication administration process is completed, the medication cart must be completely locked or otherwise secured.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 26221 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 the facility's only kitchen reviewed for food and nutrition services. 1. The facility failed to ensure chicken was thawed under running water or in the refrigerator. 2. The facility failed to ensure staff appropriately cleaned and sanitized the thermometer prior testing food temperatures. 3. The facility failed to ensure sick staff wore an appropriate face mask. 4. The facility failed to ensure staff wore effective hair restraints. 5. The facility failed to ensure food was stored in a manner that was not opened to the air. These failures could place residents at risk for food borne illness and cross contamination. Findings include: Observation and interview on 11/19/24 at 9:53 a.m. revealed: A bag of chicken thawing on the counter of the industrial sink, it was not in running water. There was a bag of chicken thawing in running water immediately next to it. Upon moving the thawing bag of chicken, a puddle of pink chicken juices the size of the bag (5 gallons) was observed. [NAME] B stated she took the bag of chicken out at 6 a.m. that morning and left it by the sink. [NAME] B was observed wearing a face mask on. The face mask covered her mouth but not her nose. [NAME] B started coughing she covered her mouth with her arm, [NAME] B stated she did not know what was wrong. [NAME] B was actively prepping food. Observation of the freezer during initial tour revealed a box of chicken with a bag of exposed chicken. Observation of the dry storage during initial tour area revealed a 50-pound bag of dry milk on the floor. Observation and interview on 11/21/24 at 11:08 a.m. revealed some spices on the spice shelf that were open to the air. The DM said they were used the night before and were not closed or wiped off because the other cooks were not paying attention. The DM stated they should be wiped and covered after food preparation. [NAME] C's hair net slid up and left half her hair hanging out, approximately an inch and a half of hair out of net. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 11/21/24 at 11:20 a.m. revealed the DM gave [NAME] C a paper towel with the instructions that if there were large particles of food on the thermometer to wipe off the food prior to cleaning off the thermometer with the alcohol pad [NAME] C had on the counter in front of her. [NAME] C cleaned the thermometer with the paper towel between eight separate dishes. In an interview on 11/21/24 at 11:25 a.m., [NAME] C stated she used the paper towel because she was really a nurse and the DM gave it to her but she normally uses an alcohol wipe. [NAME] C stated the paper towel did not adequately clean the thermometer and it caused cross contamination between dishes. The DM who was also present stated we all make mistakes. Observation at 12:45 p.m. an unidentified dietary staff came in through the dirty dish area with no hair net on while the lunch serving task was still being completed. The staff was holding a hair net and did not put it on until she reached the other side of the kitchen. In an interview on 11/21/24 at 4:07 p.m., the DM stated she did not feel the kitchen did not go well this year because there were a lot of mistakes. The DM stated the mistakes included the raw chicken on the counter and temperature thing with the paper towel. The DM stated she did not think [NAME] B was really sick on 12/19/24 because there was no coughing on 11/20/24 or 11/21/24. The DM stated she was in the process of putting the dry milk up when the State Surveyors came into the kitchen which was why it was on the floor. The DM said she had it on the rack of cans and got it down so she could pour it into the appropriate container. The DM stated the consequence to the thawing chicken improperly was the growth of bacteria and it would do the same thing with the thermometer and the cross contamination. The DM stated she did not say anything to [NAME] C at the time because she did not want [NAME] C to feel like she was being scolded. The DM said hair restraints were supposed to be put on immediately upon entering the kitchen and they weren't supposed to take it off until they left the kitchen. The DM said if the hair net was half on it was not effective because there was hair hanging out and it could fall into the food. In an interview on 11/21/24 at 4:26 p.m the Administrator was informed of all of the kitchen findings. He stated he had no rebuttal to the findings. Record review of the facility's policy and procedure dated 2012, on Thawing Foods revealed: All foods will be thawed in a safe and sanitary manner. Procedure: Foods may be thawed in the following manner: under potable running water of a temperature of 70 degrees or below, with sufficient velocity to agitate and float off loose food particles into the overflow, in a sealed package. All raw meats will be thawed separately from each other, and separately from any other foods. Record review of the facility's, undated, policy and procedure on Dry Storage and Supplies, revealed: All facility storage areas will be maintained in an orderly manner that preserves the condition of food and supplies. We will ensure storage areas are clean, organized, dry and protected from vermin, and insects. Procedure: Storerooms are to be well lighted, ventilated, and temperature controlled. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	b. All food and supplies are to be store six (6) inches above the floor on surfaces which facilitate thorough cleaning. Record review of the facility's policy and procedure dated 2012, on Infection Control, revealed: We will ensure that all employees practice infection control in the Dietary Service Department, and maintain sanitary food preparation. All dietary service employees will follow Infection Control Policies as established and approved by the Infection Control committee. Procedure. b. Clean hair is required. It is to be totally covered with an effective hair restraint. Food preparation: A, Frozen items are thawed in refrigeration or under cold running water in a draining sink.

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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** 26221 30057 Based on observation, interview 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 2 of 3 residents (Residents #2 and #5) reviewed for infection control. 1. RN A failed to wash her hands or use hand sanitizer between glove changes during wound care for Resident #5. 2. RN A failed to wash her hands or use hand sanitizer between glove changes during medication administration and PEG tube dressing change for Resident #2. These failures could place resident's risk for cross contamination and the spread of infection. Finding include: 1. Record review of Resident #2's admission record, dated 11/20/2024, indicated a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #2 had diagnoses which included gastrostomy status (a surgical procedure for inserting a tube through the abdomen wall and into the stomach) and cerebral palsy (A disorder that affect a person's ability to move, maintain balance, and posture). Record review of Resident #2's Order Summary Report dated 11/20/2024, indicated in part: Sucralfate Oral Suspension 1 GM/10ML (Sucralfate) Give 10 ml via PEG-Tube four times a day for ulcer of esophagus. Enteral Feed Order one time a day Cleanse peg tube site with normal saline and gauze, pat dry, apply barrier ointment around stoma, cover with T drain sponge. Order date 08/22/2024. Record review of Resident #2's quarterly MDS, dated [DATE], indicated in part: Cognitive Skills for Daily Decision Making = Severely impaired - never/rarely made decisions. Nutritional Approaches Check all of the following nutritional approaches that apply - Feeding tube. Record review of Resident #2's care plan dated 08/23/24 indicated in part: Focus: The resident requires tube feeding related to difficulty swallowing. GOAL: The resident will remain free of side effects or complications related to tube feeding through the review date. Interventions: Check for tube placement and gastric contents/residual volume per facility protocol and record. Hold feed if greater than 80 ml aspirate. Clean insertion site daily as ordered, monitoring for symptoms of infection or breakdown such as redness, pain, drainage, swelling, and/or ulceration and report to doctor if symptoms arise. (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 observation on 11/20/24 at 08:55 AM, RN A administered Resident #2's medications via PEG tube and also changed her PEG tube site dressing. RN A prepared the resident's medication on her treatment cart then entered the resident's room. Without first sanitizing or washing her hands she put on a pair of gloves and proceeded to administer the medication via Resident #2's PEG tube. RN A removed her gloves and went to the supply room to obtain a towel and also obtained a dressing from her treatment cart. RN A returned to Resident #2's room and put on a pair of clean gloves without first washing or sanitizing her hands. RN A then removed the old PEG tube dressing, cleaned the PEG site area and while still wearing the same gloves applied the new dressing to the resident. RN A then removed her gloves and stated she was done and proceeded to move to her next assignment without washing or sanitizing her hands. During an interview on 11/20/24 at 11:05 AM, RN A said during Resident #2's medication administration she had not sanitized or washed her hands in between glove changes because she stayed in the same room and provided care for the same resident care. RN A was made aware of the times she went back to the medication cart and the supply closet to obtain items and when she put on clean gloves again, she was not noted to have washed or sanitized her hands. RN A said she was sorry she had not washed or sanitized her hands when she changed her gloves. RN A said if she did not sanitize or wash her hands she could possibly spread germs or infections. During an interview on 11/21/24 at 03:24 PM, the DON said it was expected for nursing staff to wash or sanitize their hands before putting gloves on and after taking them off. The DON said RN A should have sanitized or washed her hands during Resident #2's patient care. The DON said if staff did not wash or sanitize their hands, that could lead to the spread of infections. The DON said she monitored the staff by conducting rounds and in-services regarding hand washing and glove use. During an interview on 11/21/24 at 04:18 PM, the Administrator said it was expected for nursing staff to wash or sanitize their hands before putting gloves on and after taking them off. The Administrator said it could lead to infections if the staff did not wash or sanitize their hands. The Administrator said the failure probably occurred because the nurse got nervous due to the state surveyor observing them. 2. Record review of Resident #5's Admission Record, dated 11/21/24, revealed a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #5 had diagnoses which included local infections of the skin and subcutaneous tissue (under the skin); debility (weakness); and dementia (A disorder in which a person can lose the ability to think, remember, and reason to the point that it interferes with their daily life). Record review of Resident #5's Quarterly MDS Assessment, dated 10/25/24, revealed: She had long and short-term memory impairment with severely impaired decision-making abilities. At the time of the assessment, there were no skin tears identified. Record review of Resident #5's care plan, revised on 11/11/24, revealed Resident #5 had the potential for impaired skin integrity related to incontinence, impaired mobility, dementia, and fragile skin with decreased safety awareness. The identified goal was the resident would maintain or develop clean, intact skin by the review date. The identified interventions included: follow facility protocols for treatment of injury. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #5's Order Summary, dated 11/21/24, revealed orders: Start date 11/12/24: Skin tear to right calf, cleanse with wound cleanser apply steri-strips. Cover with soft dressing daily. May leave open to air if no drainage present. Record review of Resident #5's Weekly Skin Assessment, dated 11/18/24, revealed: Resident has a healing skin tear to right calf. During an observation on 11/19/24 at 2:23 PM revealed Resident #5 was in bed asleep on a low bed. Resident #5 had a fall mat in place and there were wound care supplies (gloves, gauze, tape, tape) on the fall mat with no barrier in place. During an observation on 11/19/24 at 2:29 PM revealed RN A brought in a linen (porous) towel and placed it on the fall mat. RN A placed the wound care supplies from the fall mat onto the towel. Without any hand-hygiene practices, RN A donned gloves. RN A hooked her left arm under Resident #5's knee and pulled off the dirty dressing. RN A took off the right glove, but not the left. Resident #5 had an approximately 2-inch skin tear to the back of her right shin held together with steri-strips. With no hand hygiene, RN A placed another glove on her right hand and cleaned Resident #5's skin tear. RN A removed the right glove only. With no hand hygiene, RN A donned the right glove, patted Resident #5's skin tear dry. RN A took off her right glove. With no hand hygiene, RN A donned a glove to her right hand and applied antiseptic wound cleanser with an applicator. RN A took off her right glove. Without hand hygiene RN A place a non-adherent dressing on a dressing retention tape and placed on Resident #5's skin tear. RN A then gathered the piled of used gloves/dirty wound care supplies and the towel. RN A threw the gloves/dirty wound care supplies in the trash of the treatment cart, put the towel in the dirty linen barrel and then sanitized her hands with alcohol gel. During an interview on 11/20/24 at 10:46 AM, RN A stated she remembered she removed the old dressing, put it in the glove and took off the glove. RN A said she donned a new glove, cleaned the wound with normal saline, held the wet gauze in the glove and took the glove off. RN A said she put on a new glove, dried the wound, held the gauze and took off the old glove. The RN stated she put on a new glove and applied the antiseptic gel, broke the applicator and took off the glove while holding the applicator. RN A stated then she put the non-stick pad on the tape and applied it. RN A said she threw out the pile of used gloves, put the towel in the dirty linen and sanitized her hands with alcohol gel RN A said she set the wound care supplies up outside the room, so nothing came into the room. RN A said she put the towel on the ground and then placed the wound care supplies on the towel. RN A said the towel was a porous surface so there was not an effective barrier. RN A stated all the supplies were not touching the towel so they were still clean. The State Surveyor reminded her the wound care supplies were on the floor and RN A stated she forgot that part of it and said none of the supplies touched the fall mat before being placed on the towel. RN A said with the supplies laid out on the floor it was not a clean technique. RN A stated she did not remember when she did hand-hygiene prior to doing wound care but she usually did before she entered a room but added she probably did not do it when she left for the towel. RN A said there was no alcohol based hand rub (ABHR) in the room for her to use in between glove changes. RN A thought for a second and then pulled a bottle of ABHR out of her pocket. RN A said she never did hand hygiene between glove changes on the same residents because she was told changing gloves was enough. RN A stated on 11/20/24 when she did wound care Resident #5 was on her side and it was much easier to do. (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 11/20/24 at 1:06 PM, the DON and the Regional RN Consultant stated the expectation was hands were washed prior to starting and gel between dirty to clean. The DON stated the facility expected a non-porous barrier like wax paper or incontinent pad with the plastic backing. The Regional RN stated the corporation's expectation was for the staff to perform hand hygiene, gather their supplies on a tray or wax paper or use a clean bed side table. The Regional RN stated nothing should go into the room unless it could be cleaned, like scissors. The Regional RN said the nurse should put the dry gauze, wet gauze, any medications, date and initial the dressing, put any medication in a cup and get the applicators, gloves, and a bottle of hand sanitizer. The Regional RN stated the staff should bring in a separate trash bag for the dirty supplies. The Regional RN said the corporation expectation was for the staff to apply gloves, take off the dirty dressing, dispose of the dressing, take off gloves, clean hands, don new gloves, clean the wound, pat dry, apply any medications, take off the gloves, gel, don new gloves apply a clean dressing, take off the gloves, sanitize hands, and then get rid of the dirty supplies and clean the resident's area. During an interview on 11/20/24 at 1:35 PM, the Administrator was informed of the 11/19/24 wound care observation. When informed of the supplies on the floor, the Administrator said, you're kidding me? The Administrator stated they saw the issue with infection control. Interview on 11/20/24 at 1:42 PM, the DON stated there were no recent in-services on wound care or infection control. Record review of the facility's policy titled Infection Control Plan, dated 2019, indicated in part: Infection control - the facility will establish and maintain an infection control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. Infection control program - the facility will establish an infection control program under which it - investigates controls and prevents infections in the facility . The facility will require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. Implement hand hygiene (Hand washing) practices consistent with accepted standards of practice to reduce the spread of infections and prevent cross-contamination. Record review of the facility's policy titled Fundamentals of infection control precautions, dated 3/2023, indicated in part: .Hand hygiene continues to be the primary means of preventing the transmission of infection. The following is a list of some situations that require hand hygiene. Before and after assisting a resident with personal care, before and after changing a dressing, upon and after coming in contact with a resident's intact skin, after handling soiled or used dressings, after removing gloves.Wearing gloves does not replace the need for hand washing because gloves may have small inapparent defects or be torn during use and hands can become contaminated during removal of gloves, failure to change gloves between resident contacts is an infection control hazard.