STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675709	A. Building B. Wing	07/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Timberidge Nursing and Rehabilitation Center	315 W Gibson Jasper, TX 75951

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45643 Based on observations, interviews, and record review, the facility failed to provide the necessary services to maintain personal hygiene for 1 of 12 residents reviewed for ADLs (Residents #1.) The facility did not apply moisturizer on the cracked and dry lips of Resident #1. This failure 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 poor care, risk for skin breakdown, feelings of poor self-esteem, lack of dignity, and health. The findings were: Review of Resident #1's Electronic Face Sheet dated 07/24/24 revealed she was admitted to the facility on [DATE] with diagnoses including hypertension (high blood pressure), constipation (passing fewer than three stools a week or having a difficult time passing stool), and hypothyroidism (deficiency of thyroid hormones can disrupt such things as heart rate, body temperature, and all aspects of metabolism). Record review of Resident #1's Significant Change MDS dated [DATE] revealed a BIMS with a score of 00, which indicated resident #1 had severely impaired cognition. The MDS also revealed, Resident #1, required total dependance with personal hygiene. Record review of Resident #1's Care Plan dated 05/02/24 revealed Resident #1 had a problem initiated on 5/02/24 for ADLs. Shows that Resident #1 required assistance with her ADLs. During an interview and observation on 7/22/24 at 1:55 p.m., Resident #1 was observed with dry lips, they were cracked with the skin peeling off the bottom lip. Skin was peeling off from the right side of her lip all the way to the left side of her bottom lip. She said that she didn't know if staff put any type of product on her lips to moisturize them. During an interview and observation on 7/22/24 at 3:48 p.m., Resident #1 was observed with dry cracked lips with the skin peeling off. She said that she licked her lips. She said that no one had put any moisturizer on her lips today. She said that staff told her they couldn't find her moisturizer. She said she doesn't know if anyone had ever put moisturizer on her lips. (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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview and observation on 7/23/24 at 8:12 a.m., Resident #1 was observed with dry cracked lips with the skin peeling off. She said no one had put any moisturizer on her lips since the surveyor talked to her last. During an interview on 7/22/24 at 1:40 p.m., CNA E said that they have medicated lip balm to put on the lips of residents that have dry lips. She said that Resident #1 sometimes avoided getting some of her ADLs taken care of. During an interview on 7/23/24 at 9:32 a.m., the DON she said she expected that resident's dependent for care would not have dry cracked lips. She stated that it was the responsibility of the CNAs to ensure residents had a moisturizing product applied to their lips if they were dry and cracked. She said that she had product in her room that was there just for her lips to be moisturized. During an interview on 7/23/24 at 9:39 a.m., the ADM said she expected that resident's dependent for care have their activities of daily living tended to. She said that she expected that if a resident presented with dry lips that the facility staff would assist them by applying some kind of moisturizer. Review of an undated facility policy and procedure on care of Mouth Care - Brushing Teeth/Care of, Oral Care revealed that A resident should be assisted with mouth care as needed. Policy provided by facility did not specifically address application of moisturizer to a resident's lips.

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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 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** 48958 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 2 of 4 (Resident's #6 and #38) reviewed for infection control. 1. CNA B did not change her gloves when going from dirty to clean after performing incontinent care. CNA B did not sanitize or wash her hands after performing incontinent care when she applied Resident #6's clean brief. 2. LVN A did not change her gloves when going from dirty to clean when providing indwelling urinary catheter care. LVN A did not sanitize or wash her hands after performing Resident #38's indwelling urinary catheter care when she changed her gloves. These failures could place residents at risk of exposure to communicable diseases, cross-contamination, and infections. Findings included: 1. Record review of Resident #6's undated face sheet indicated she was a [AGE] year-old female that admitted [DATE] with diagnoses that included: urinary tract infection (an illness in any part of the urinary tract, the system of organs that makes urine), hemiplegia following cerebral infraction affect right nondominant side (a symptom that causes severe or complete paralysis on one side of the body), need for assistance with personal care (is a type of care that can help people with their bodies, hygiene, appearance and movement), and displaced fracture of lesser trochanter of right femur, sequela (a rare injury with good prognosis). Record review of Resident #6's physician's orders indicated: 2/19/20 required 1 personal staff assist with ADL's/transfers. Record review of the admission MDS dated [DATE] indicated Resident #6 had clear speech, understood others, and was understood by others. She had a BIMS score of 6 indicating severe cognitive impairment. She required partial/moderate assistance with personal hygiene. Record review of the care plan dated 10/6/23 indicated Resident #6 was to be observed for bleeding (hematuria, tarry stools, blood-tinged urine, ect). The care plan dated 4/24/24 indicated active range of motion to the right upper extremity every day to reduce risk of contracture development related to right hemiparesis. During an observation on 07/23/24 at 10:55 AM, CNA B performed incontinent care on Resident #6 and was assisted by CNA E. CNA B failed to perform hand hygiene and don clean gloves after removing Resident #6's soiled brief and prior to applying a clean brief to Resident #6. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 7/23/24 at 11:00 AM CNA B said she should have removed her gloves before she applied the clean brief on Resident #6. She said she was nervous, but not removing the gloves could cause infections with the resident. During an interview on 7/23/24 at 11:03 AM CNA E said CNA B should have removed her gloves before she applied the clean brief on Resident #6. She said that could cause infections with the residents. During an interview on 07/24/24 at 9:41 AM CNA G said after incontinent care was performed the dirty gloves should have been removed and used hand sanitizer, then apply clean gloves. She said after clean gloves were applied, then the clean brief applied to the resident. CNA G said after the brief was applied to finish dressing the resident or reposition them in bed. She said if dirty gloves were not changed after incontinent care that could cause cross contamination. During an interview on 07/24/24 at 9:46 AM, LVN F said after incontinent care was performed, the CNA should have changed their gloves and sanitized their hands, then applied clean gloves before the clean brief was applied to the resident to prevent transferred infections. 2. Record review of the undated face sheet revealed Resident #38 was a [AGE] year-old male that admitted [DATE]. Record review of the physician's orders dated July 2024 revealed Resident #38 had diagnoses that included: bladder neck obstruction (abnormal emptying of bladder, incomplete emptying of bladder, urgency or pain), vascular dementia (cognitive difficulty with memory loss and poor judgement), mild intellectual disabilities (slower in all areas of conceptual development including social and daily living skills), and anxiety disorder (excessive worry and feelings of fear, dread, and uneasiness). Record review of the quarterly MDS dated [DATE] revealed Resident #38 had unclear speech, was sometimes understood by others, and sometimes understood others. His BIMS score was a 99 indicating severe cognitive impairment in that he was unable to complete the interview. Resident #38 was dependent on staff for toileting hygiene (required staff to perform) and had an indwelling urinary catheter. Record review of the care plan dated 7/3/24 indicated Resident #38 had an indwelling urinary catheter due to bladder-neck obstruction and required indwelling urinary catheter care every shift. The care plan indicated Resident #38 required 1 person assist for ADL's. During an observation on 07/23/24 at 9:11, LVN A performed indwelling urinary catheter care for Resident #38. After performing indwelling urinary catheter care she did not change her gloves or wash/sanitize her hands. She then pulled up his clean brief, repositioned him touching his hip, and his shirt. LVN A then changed her gloves but did not wash or sanitize her hands. During an interview on 07/23/24 at 9:19 AM, LVN A said she should have changed her gloves after Foley [indwelling urinary catheter] care and before touching Resident #38's brief, shirt, and hip. She said she was nervous. She said she should have changed her gloves and sanitized or washed her hands to prevent infection, or the resident getting a UTI. She said failing to change gloves or wash her hands could cause infection. She said she was taught to change gloves and wash or sanitize her hands after a dirty procedure. She said she did not use hand sanitizer when she changed her gloves because she did not have any. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 7/23/24 at 1:52 PM, CNA B said she would always change her gloves and wash her hands after performing indwelling uninary catheter care and before touching anything clean. She said using dirty gloves to touch clean items or a resident could cause an infection control issue which could cause a lot of problems. She said staff had to wash or sanitize hands with every glove change. During and interview on 7/23/24 at 2:01 PM, LVN C said after performing indwelling urinary catheter care, she would change gloves and wash her hands before touching anything clean, including the resident. She said if dirty gloves were used to touch clean things it could be a risk of infection to the resident and to staff. She said she learned how to properly perform indwelling urinary catheter care in nursing school and then again at this facility. During an interview on 7/23/24 at 2:21 PM, the ADON said after performing indwelling urinary catheter care or incontinent care, staff should take their gloves off, use hand sanitizer or wash hands, and re-glove before touching the resident's clean brief, clothing, or the resident. She said after performing indwelling urinary catheter care staff gloves would be considered dirty. She said the resident, resident's clothing, and brief would be considered clean. She said using dirty gloves to touch a resident, resident's brief, or resident's clothing would be an infection control problem. She said it could spread infection and germs to the resident and to other staff. During an interview on 07/24/24 at 8:27 AM, the DON said after performing incontinent care or indwelling urinary catheter care staff should take off their gloves, sanitize or wash their hands, and re-glove for infection control sanitation purposes. She said if staff used gloves that were considered dirty to touch the resident's clothing, brief, or the resident there was a risk of spreading infection to the resident or staff and could make the resident sick. During an interview on 7/24/24 at 8:33 AM, the ADM said after performing incontinent care or Foley [indwelling urinary catheter] care, gloves would be considered soiled, so staff should take off their gloves, wash or sanitize their hands, and re-glove before touching the resident, resident''s clothing, or the resident's brief. She said if staff did not change their gloves and clean their hands, they would be contaminating everything they touched. During an interview on 7/24/24 at 9:24 AM, CNA D said after performing incontinent care or [indwelling urinary] catheter care his gloves would be considered dirty and he was taught staff cannot touch anything considered clean with dirty gloves. He said after performing incontinent care or indwelling urinary catheter care he would always take his dirty gloves off, sanitize his hands, and put on clean gloves before touching the resident, resident's clothing, resident's brief, or anything considered clean. He said if he touched clean things with dirty gloves there was a risk of infection to the resident and staff. Record review of a Hand Hygiene policy dated May 2023, provided by the ADM on 7/23/24 indicated .Policy: Staff involved in direct resident contact will perform proper hand hygiene procedures to prevent the spread of infection to other personnel, residents, and visitors . 6.a. The use of gloves does not replace hand washing. Wash hands before donning and after removing gloves . (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of an undated Incontinence Care Procedure provided by the ADM did not address washing hands or changing gloves after removing a resident's soiled brief and before applying a clean brief to a resident. Record review of an undated Urinary Catheter Care policy provided by the ADM indicated after indwelling urinary catheter care was performed indicated .10. Discard disposable items into designated container. Remove gloves and discard into designated container. Wash hands. 11.Position the resident for comfort and safety. 12.Wash your hands . Record review of an Infection Prevention and Control Program Policy dated May 2023, provided by the ADM indicated .Policy: This facility has established and maintains 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 as per accepted national standards and guidelines .7. a. All staff shall assume that all residents are potentially infected or colonized with an organism that could be transmitted during the course of providing resident care services. b. Hand hygiene shall be performed in accordance with our facility's established hand hygiene procedures . 35295