

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  675729	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  02/05/2025
NAME OF PROVIDER OR SUPPLIER  Stonecreek Nursing & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE  451 S El Camino Crossing San Augustine, TX 75972	

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)
<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 43994</p> <p>Based on observations, interviews, and record reviews the facility failed to develop and implement a comprehensive person-centered care plan that includes measurable objectives and time frames to meet a resident's medical and nursing needs and describes the services that are to be furnished to attain or maintain the residents highest practicable physical, mental, and psychosocial well-being for 2 of 12 residents (Residents #16 and Resident #34) reviewed for care plans in that:</p> <p>The facility failed to develop a comprehensive care plan for the use of side rails for Resident #16 that were in use on 2/4/2025.</p> <p>The facility failed to develop a comprehensive care plan for the use of side rails for Resident #34 that were in use on 2/3/25.</p> <p>This deficient practice could place residents in the facility at risk of not receiving the necessary care or services and having personalized plans developed to address their needs.</p> <p>Findings included:</p> <p>1. Record review of an Admission Record dated 2/4/2025 for Resident #16 indicated she admitted to the facility on [DATE] and was [AGE] years old with diagnoses of diastolic congestive heart failure (heart not being able to pump blood effectively throughout the body), dementia, malignant neoplasm of right breast (breast cancer), and type 2 diabetes.</p> <p>Record review of active physician orders dated 2/4/2025 for Resident #16 indicated there were not any orders for the use of bed rails.</p> <p>Record review of an Annual MDS assessment dated [DATE] for Resident #16 indicated she had severe impairment in thinking with a BIMS score of 3. She required substantial/maximal assistance with rolling left and right. The use of physical restraints for bed rails was not coded.</p> <p>Record review of a care plan for Resident #16 dated 8/3/2022 revealed she was not care planned for the use of bed rails. She was at risk for falls related to history of frequent falls with interventions to maintain safe environment.</p> <p>(continued on next page)</p>

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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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of assessments for Resident #16 indicated she did not have any assessments completed for bed rails.</p> <p>During an observation on 2/4/2025 at 8:28 AM, Resident #16 was in her bed resting with eyes closed. There were side rails up on both sides of the bed with two at the at the head and two at the foot of the bed.</p> <p>During an observation on 2/4/2025 at 9:07 AM, Resident #16 was still in bed asleep with all four rails up on both sides of the bed.</p> <p>During an observation on 2/4/2025 at 9:20 AM, Resident #16 was still in bed asleep with all four rails up on both sides of the bed.</p> <p>During an observation on 2/4/2025 at 9:32 AM, Resident #16 was in bed asleep, CNA A was in the room to provide incontinent care and when care was provided, she lowered the bed rails on both sides of the bed. Once care was completed she raised the top two rails and kept the two rails at the foot of the bed lowered.</p> <p>2. Record review of an Admission Record dated 2/4/25 for Resident #34 indicated that he admitted to the facility on [DATE] and was [AGE] years old with diagnosis of multiple sclerosis (a chronic autoimmune disease that affects the central nervous system, which includes the brain, spinal cord, and optic nerves).</p> <p>Record review of active physician orders dated 2/4/25 for Resident #34 indicated that there were not any orders for the use of bed/assist rails.</p> <p>Record review of a Quarterly MDS assessment dated [DATE] for Resident #34 indicated that he had a BIMS score of 14 which indicated no cognitive impairment. He required partial/moderate assistance for most ADLs. He was always continent of bowel and bladder. The use of physical restraints for bedrails was not coded in the assessment.</p> <p>Record review of a care plan for Resident #34 dated 7/10/22 revealed he was not care planned for the use of bed/assist rails. He was at risk for falls related to a history of falls and physical limitations with interventions to maintain a safe environment.</p> <p>Record review of assessments for Resident #34 indicated he did not have any assessments completed for bed rails.</p> <p>During an observation on 2/3/25 at 9:21 am Resident #34's bed was observed with 1/2 rail noted on left side of bed.</p> <p>During an interview on 2/5/25 at 10:41 am Resident #34 said he used the rail to assist himself when turning in bed. He said it helped him roll over when he needed to.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 2/4/2025 at 9:47 AM, CNA A said she had been employed at the facility for a month. She said when she started her shift that morning, Resident #16 was in the bed and all four of the rails on her bed were up and that could be a form of restraint. She said she kept all four rails up because she thought therapy would be getting Resident #16 up but was told she was sick and when she was not alert, they keep her in bed. She said most mornings when she arrived for her shift, Resident #16 would only have the top two rails up. She said they used the top rails all the time for Resident #16. She said the staff were to report to the charge nurse when they saw that all four of the rails were up and it had happened in the past.</p> <p>During an observation on 2/4/2025 at 1:15 PM, Resident #16 was still asleep in bed with two rails up on both sides of the bed at the head of bed.</p> <p>During an interview on 2/4/2025 at 2:10 PM, the DON said RN H was responsible for completing the care plans for the residents and completed the initial and quarterly assessments. The DON said if something needed immediate attention, then she would update them. She said if care plans were not being updated then staff would not be able to provide adequate care for their needs. She said bed rails should be care planned to reflect the use of bed mobility.</p> <p>During an interview on 02/5/2025 at 12:14 PM, RN H said she primarily helped with care plans. She said bed rails should be on care plans, especially if they were being used.</p> <p>During an interview on 2/5/2025 at 1:39 PM, the Administrator said care plans were the responsibility of the IDT, but RN H completed a lot of the care planning along with the DON and ADON. She said bed rails should be care planned and that was the facility's plan on how they cared for the residents. She said if things were not put in correctly then staff would not know how to effectively perform patient care for those residents.</p> <p>Record review of a facility policy titled Care plan, comprehensive dated March 2022 indicated, .A comprehensive, person-centered plan that included measurable objectives and timetables to meet the residents' physical, psychosocial and functional needs is developed and implemented for each resident. 2. The comprehensive, person-centered care plan is developed within seven days of the completion of the required MDS assessment. 3. The care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment. 7. The comprehensive person-centered care plan: a. includes measurable objectives and timeframes; c. includes the resident's stated goals upon admission and desired outcomes .</p>		

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<p>F 0700</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 43994</p> <p>46273</p> <p>Based on observation, interview, and record review the facility failed to attempt to use appropriate alternatives prior to installing a side or bed rail, assess the resident for risk of entrapment from bed rails prior to installation for 2 of 5 residents (Resident #16 and Resident #34) reviewed for bed rails.</p> <p>The facility failed to obtain an order or complete an assessment for the use of bedrails for Resident #16 who had full bed rails on both sides of her bed on 2/4/2025.</p> <p>The facility failed to obtain an order or complete an assessment for the use of assist rail for Resident #34 who had a 1/2 rail in place to the left side of his bed on 2/3/25.</p> <p>These failures could place residents at risk of entrapment or injury.</p> <p>Findings included:</p> <p>1. Record review of an Admission Record dated 2/4/2025 for Resident #16 indicated she admitted to the facility on [DATE] and was [AGE] years old with diagnoses of diastolic congestive heart failure (heart not being able to pump blood effectively throughout the body), dementia, malignant neoplasm of right breast (breast cancer), and type 2 diabetes.</p> <p>Record review of active physician orders dated 2/4/2025 for Resident #16 indicated there were not any orders for the use of bed rails.</p> <p>Record review of an Annual MDS assessment dated [DATE] for Resident #16 indicated she had severe impairment in thinking with a BIMS score of 3. She required substantial/maximal assistance with rolling left and right. She was always incontinent of urine and bowel. The use of physical restraints for bed rails was not coded in the assessment.</p> <p>Record review of a care plan for Resident #16 dated 8/3/2022 revealed she was not care planned for the use of bed rails. She was at risk for falls related to history of frequent falls with interventions to maintain safe environment.</p> <p>Record review of assessments for Resident #16 indicated she did not have any assessments completed for bed rails.</p> <p>During an observation on 2/4/2025 at 8:28 AM, Resident #16 was in her bed resting with eyes closed. There were side rails up on both sides of the bed with two at the at the head and two at the foot of the bed.</p> <p>(continued on next page)</p>		

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<p>F 0700</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an observation on 2/4/2025 at 9:07 AM, Resident #16 was still in bed asleep with all four rails up on both sides of the bed.</p> <p>During an observation on 2/4/2025 at 9:20 AM, Resident #16 was still in bed asleep with all four rails up on both sides of the bed.</p> <p>During an observation on 2/4/2025 at 9:32 AM, Resident #16 was in bed asleep, CNA A was in the room to provide incontinent care and when care was provided, she lowered the bed rails on both sides of the bed. Once care was completed she raised the top two rails and kept the two rails at the foot of the bed lowered.</p> <p>2. Record review of an Admission Record dated 2/4/25 for Resident #34 indicated that he admitted to the facility on [DATE]and was [AGE] years old with diagnosis of multiple sclerosis (a chronic autoimmune disease that affects the central nervous system, which includes the brain, spinal cord, and optic nerves).</p> <p>Record review of active physician orders dated 2/4/25 for Resident #34 indicated that there were not any orders for the use of bed/assist rails.</p> <p>Record review of a Quarterly MDS assessment dated [DATE] for Resident #34 indicated that he had a BIMS score of 14 which indicated no cognitive impairment. He required partial/moderate assistance for most ADLs. He was always continent of bowel and bladder. The use of bed rails was not coded in the assessment.</p> <p>Record review of a care plan for Resident #34 dated 7/10/22 revealed he was not care planned for the use of bed/assist rails. He was at risk for falls related to a history of falls and physical limitations with interventions to maintain a safe environment.</p> <p>Record review of assessments for Resident #34 indicated he did not have any assessments completed for bed rails.</p> <p>During an observation on 2/3/25 at 9:21 am Resident #34's bed was observed with 1/2 rail noted on left side of bed.</p> <p>During an interview on 2/5/25 at 10:41 am Resident #34 said he used the rail to assist himself when turning in bed. He said it helped him roll over when he needed to.</p> <p>During an interview on 2/4/2025 at 9:47 AM, CNA A said she had been employed at the facility for a month. She said when she started her shift that morning, Resident #16 was in the bed and all four of the rails on her bed were up and that could be a form of restraint. She said she kept all four rails up because she thought therapy would be getting Resident #16 up but was told she was sick and when she was not alert, they keep her in bed. She said most mornings when she arrived for her shift, Resident #16 would only have the top two rails up. She said they used the top rails all the time for Resident #16. She said the staff were to report to the charge nurse when they saw that all four of the rails were up and it had happened in the past.</p> <p>During an observation on 2/4/2025 at 1:15 PM, Resident #16 was still asleep in bed with two rails up on both sides of the bed at the head of bed.</p> <p>(continued on next page)</p>		

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<p>F 0700</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 2/4/2025 at 1:57 PM, LVN B said she had been employed since March 2024 and worked 6 am-6 pm. She said she made rounds on Resident #16 that morning and she was resting in the bed with the side rails up on both sides of the bed at the head of bed. She said she was not aware that Resident #16 had all four rails up that morning and said having all four up was a form of restraint. She said she had talked to the nurse aides in the past about not putting up all four rails up on Resident #16's bed. She said she had never completed a bed rail assessment for any residents in the facility and was not told to do so. She said there was an option in the charting system for bed rail assessments. She said if all four rails were up on the bed, it was a form of restraint, and the resident could hurt herself if she tried to get up. She said the staff used the rails to assist the resident with positioning and bed mobility.</p> <p>During an interview on 2/4/2025 at 2:10 PM, the DON said Resident #16 had the bed that she was in for over a year. She said she was not aware that staff were putting up all four bed rails on her bed. She said bed rail assessments were done for residents but not documented and it was in her head. She said she was not aware they needed an order for bed rails. She said the Maintenance Supervisor checked the bed rails and mattresses quarterly. She said the bed rails were used for the resident's safety to promote independence.</p> <p>During an interview on 2/4/2025 at 2:31 PM, the Maintenance Supervisor said he had been employed at the facility since June 2024. He said he checked the bed rails and mattresses quarterly. He said he checked the placements and measurements of the bed rails from the mattress to the rail and headboard. He said the purpose of checking the bed rails was to ensure safety while using them as restraint and so the residents will not be able to get body parts stuck in them.</p> <p>Record review of Bed/Bed rail safety audit from April 2024-January 2025 was conducted by the Maintenance Supervisor quarterly.</p> <p>During an interview on 2/5/2025 at 10:56 AM, the ADON said she was told about the use of bed rails for Resident #16 on yesterday 2/4/2025 when all four of her rails were up and was only supposed to have 1/2 rails at the top up. She said residents could be at risk for restraints, psychosocial well-being, entrapments, injury or falls if all four rails were used.</p> <p>During a follow-up interview on 2/5/2025 at 11:30 AM, the DON said residents could be at risk for injury if all four bed rails were up on the beds and if the resident tried to get out. She said she conducted an in-service with staff on yesterday 2/4/2025 about the use of bed rails. She said they removed the bottom two rails from Resident #16's bed. She said Resident #34 used his rails. She said bed rail assessments should be done quarterly and prn. She said the facility tried to use assist bars (bars on the side of the bed to assist with bed mobility) with Resident #16 before and she could not use them effectively. She said they tried to use the least restrictive measures and move up if that did not work. She said Resident #34 was not able to use the assist bar when they tried in the past due to dexterity in his hand.</p> <p>Record review of an in-service sign in sheet dated 2/4/25 on use of restraints; assistive devices and equipment, use of side rails as an assistive device was conducted at the facility.</p> <p>(continued on next page)</p>		

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<p>F 0700</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 02/05/25 at 12:14 pm RN H said she helped with care plans and assessments. She said she had been made aware of a resident that had fallen through the cracks with assessments but did not specify which resident. She said the assessment had been addressed and corrected. She said she primarily helped with care plans. She said bed rail assessments should be done at least quarterly. She said residents could be at risk of restraint or at risk for injury.</p> <p>During an interview on 2/5/2025 at 1:39 PM, the Administrator said she was made aware of Resident #16 having all the rails up on her bed on yesterday 2/4/2025. She said for all the hospital beds that were in the facility they removed the rails on yesterday 2/4/2025. She said the bed rails assessments were to be completed on admission, if an order was received, quarterly and if there were any significant changes that may prompt a need for one. She said residents could be at risk for entrapments, injury, and bodily harm if bed rails were used and could be a form of restraint.</p> <p>Record review of a facility policy titled Use of Side Rails as an Assistive Device dated 1/1/2024 indicated, . The use of side rails as an assistive device will be implemented based on individual resident assessments, ensuring safe promoting independence, and enhancing the overall well-being of residents. 1. Assessments and Documentation a. Initial assessment: conduct a comprehensive assessment of the resident's physical and cognitive status, mobility, and risk of falls. Document the need for side rails as an assistive device. b. Ongoing assessment: reassess the resident's condition quarterly and on an as needed basis and update the care plan as needed. 4. Alternatives to Side Rails a. Explore and document alternatives ensuring the least restricted device is being used. 6. Training and education a. Provide ongoing training for staff on the proper use, installation, and maintenance of side rails .</p>

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 46273</p> <p>Based on observations, interviews, and record review, the facility failed to ensure drugs and biologicals used in the facility were stored in locked compartments and permit only authorized personnel to have access to the keys for 1 of 6 residents (Resident #50) reviewed for medication storage.</p> <p>The facility did not ensure Caladryl lotion was not stored at the bedside for Resident #50 on [DATE].</p> <p>This failure could place all residents at risk of misuse of medication and decreased quality of life.</p> <p>Findings included:</p> <p>Record review of a facility face sheet dated [DATE] for Resident # 50 indicated that he was an [AGE] year-old male admitted to the facility on [DATE] with diagnosis of influenza.</p> <p>Record review of a comprehensive MDS dated [DATE] for Resident #50 indicated that he had a BIMS score of 14 which indicated that he was cognitively intact. He required substantial/maximal assistance with most ADLs. He was always incontinent of bowel and bladder. MDS did not indicate any skin alterations.</p> <p>Record review of a physician's order summary report dated [DATE] for Resident #50 indicated that he did not have an order for Caladryl lotion.</p> <p>Record review of a comprehensive care plan dated [DATE] for Resident #50 indicated that he was not care planned to self-administer medications and the care plan did not address the use of Caladryl lotion.</p> <p>During an observation on [DATE] at 9:26 am a bottle of Caladryl lotion was observed on a bedside table in Resident #50's room. Resident was not in his room at this time.</p> <p>During an observation and interview on [DATE] at 10:13 am Resident #50 was observed in his room sitting in a wheelchair. He said he had recently returned to the facility from the hospital and since then he had had a rash on his lower back. He said he had been using the lotion to apply to the rash. He said he had been applying it himself.</p> <p>During an observation on [DATE] at 1:57 pm Caladryl lotion was still observed on bedside table in Resident #50's room.</p> <p>(continued on next page)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on [DATE] at 3:47 pm LVN E was shown the Caladryl lotion in Resident #50's room. She said his family must have brought it in. She said he did not have an order for it. She said he did have an order for hydrocortisone cream to apply to the rash. She said they did not have any residents allowed to self-administer any medication. She said there was a risk of other residents that may have dementia wandering into the room and possibly drinking it. She said anything that said keep out of reach of children should not be left unattended where residents have access to it. She immediately removed Caladryl lotion from resident's room.</p> <p>During an interview on [DATE] at 10:58 am ADON said medications should not be left unattended in resident's rooms. She said there could be a risk of improper usage of the medication, residents potentially using expired medication, and possible medication interactions since it would not be monitored by staff. She said administrative staff usually just take turns checking residents' rooms for any possible hazards. She said floor staff are also trained to check for any possible hazards as well.</p> <p>During an interview on [DATE] at 11:30 am DON said medications should be stored in the medication room or nurse cart. She said she was not aware of the medication in Resident #50's room until it was pointed out by the surveyor. She said no residents were allowed to keep medications in their rooms and no residents were allowed to self-medicate. She said there was a risk of other residents getting the medication. She said his sitter had brought him the medication and did not notify the facility. She said the medication was removed and stored in the medication room.</p> <p>During an interview on [DATE] at 11:44 am Administrator said nurses and CNAs should be making rounds and ensuring no medications are left in resident's rooms. She said everyone including housekeeping, laundry, dietary, etc. were all trained to know that medications were not supposed to be in residents' rooms. She said residents could be at risk of misusing medications, overdose, and interactions, especially since staff would not be aware they were using it.</p> <p>Record review of facility policy titled Medication Labeling and Storage dated 2001 read .The facility stores all medications and biologicals in locked compartments under proper temperature, humidity and light controls. Only authorized personnel have access to keys . and .Medication Storage: 2. The nursing staff is responsible for maintaining medication storage and preparation areas in a clean, safe, and sanitary manner .</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 50071</p> <p>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 safety requirements and kitchen sanitation</p> <ol style="list-style-type: none"> <li>1. The facility failed to ensure foods stored in the freezer were labeled, dated, and sealed.</li> <li>2. The facility failed to ensure dented cans were separated from non-dented cans.</li> </ol> <p>These failures could place residents at risk of foodborne illness and food contamination.</p> <p>Findings included:</p> <p>During an observation on [DATE] at 8:48 am, the following was identified by the DM in the freezer:</p> <ul style="list-style-type: none"> <li>*15-pound box of Smithfield bacon open/uncovered and not in a sealed container.</li> <li>*1 package of chili with no date or label.</li> <li>*1 package of sweet potato fries with no date or label.</li> <li>*1 package of hashbrowns with no date or label.</li> <li>*1 bag of curly fries with no date or label.</li> <li>*1 bag of Italian breaded zucchini sticks with no date or label.</li> <li>*1 bag of zucchini squash with no date or label.</li> <li>*1 bag of yellow squash with no date or label on it.</li> <li>*1 box of cheese sticks not sealed (packaging open).</li> </ul> <p>During an observation on [DATE] at 8:54 am the following was identified in the pantry:</p> <ul style="list-style-type: none"> <li>*1 6lbs-10 oz dented can of tomato sauce not kept separate from non-dented cans</li> </ul> <p>During an interview on [DATE] at 1:40pm, the DM said food items should be checked immediately off the truck to make sure all items are good, not out of date, dated and labeled the same day and stored appropriately the same day of delivery. She said all dented cans should be separated from the non-dented cans . She said dates and labels tell the staff that food items are good and when to discard expired foods.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on [DATE] at 1:50pm the DA G said kitchen staff are supposed to date and label food as it comes into the kitchen. She said all dented cans are to be separated from the non-dented cans .</p> <p>During an interview on [DATE] at 1:58pm the [NAME] said staff should label and date on the same day food arrives at the facility. She said all dented cans are to be separated from the non-dented cans.</p> <p>During an interview on [DATE] at 2:05pm DA F said food should be dated and labeled as soon as it's delivered to the facility and stored properly. She said if a can is dented it should not be stored with undented cans.</p> <p>During an interview on [DATE] at 10:57am ADON said she was not aware that food in the refrigerator or freezer was not dated or labeled. She said she was told on [DATE] that the condensation in the refrigerator and freezer causes the dates not to stay on the packages. She said food should be dated and labeled immediately upon arrival. She said that not properly dating, labeling, or storing foods provides a risk of expired products being served to residents and could cause food borne pathogens to be passed to residents and cause illness.</p> <p>During an interview on [DATE] at 11:51am Administrator said all foods should be dated immediately once the food is received at the facility. She said if food is removed from its original box the food should be immediately dated and labeled to assure food is served prior to the expirations date and the correct food is served.</p> <p>She said food not properly being dated, labeled or stored could cause food borne illness, cross contamination, and serving outdated foods. She said she would like to see everything dated/labeled and stored properly according to policy in the future to ensure resident safety.</p> <p>Record review of the facility Food Storage Policy dated [DATE] titled Food Storage indicated, Frozen foods-All foods should be covered, labeled, and dated. All foods will be checked to assure that foods will be consumed by their safe use by dates or discarded Food will be stored and handled to maintain the integrity of the packaging until ready for use.</p> <p>Record review of an in-service titled DIETARY INSERVICE dated [DATE] stated *Food Storage. We ALL know that food must be labeled. Dated with use by dates and rotated appropriately. We ALL know that frozen foods must be sealed and dated</p> <p>Record review of the Food and Drug Code dated 2022 indicated,</p> <p>,d+[DATE].11 Food Labels.</p> <p>(A) FOOD PACKAGED in a FOOD ESTABLISHMENT, shall be labeled as specified in</p> <p>LAW, including 21 CFR 101 - Food labeling, and 9 CFR 317 Labeling, marking</p> <p>devices, and containers.</p> <p>(B) Label information shall include:</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>(1) The common name of the FOOD, or absent a common name, an adequately descriptive identity statement;</p> <p>,d+[DATE].11 Compliance with Food Law.</p> <p>(C) PACKAGED FOOD shall be labeled as specified in LAW, including 21 CFR 101 FOOD Labeling, 9 CFR 317 Labeling, Marking Devices, and Containers, and 9 CFR 381 Subpart N Labeling and Containers, and as specified under S ,d+[DATE].18</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 43994</p> <p>46273</p> <p>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 3 of 6 residents (Resident #16, Resident #26, and Resident #20) and 3 of 5 staff (CNA A, CNA C, and CNA D) reviewed for infection control.</p> <p>The facility failed to ensure CNA A washed or sanitized her hands when passing out meal trays to residents on Hall B on 2/3/2025.</p> <p>CNA A did not sanitize or wash her hands between glove changes when incontinent care was provided to Resident #16 on 2/4/2025.</p> <p>The facility failed to ensure a Yaunker suction tip (an oral suctioning tool) for Resident #20 was not left open and uncovered on a bedside table.</p> <p>The facility failed to ensure enhanced barrier precautions were in place for Resident #26. CNA C and CNA D did not wear appropriate PPE for enhanced barrier precautions when incontinent care was provided to Resident #26 on 2/4/25.</p> <p>These failures could place residents at risk of exposure to infectious diseases due to improper infection control practices.</p> <p>Findings included:</p> <p>1. During an observation of meal service on 2/3/2025 from 11:59 AM to 12:20 PM, CNA A did not wash or sanitize her hands prior to entering/exiting rooms or handling meal trays for the next room for the following rooms on Hall B: room [ROOM NUMBER] took the meal tray into the room, set up tray and opened the utensils, room [ROOM NUMBER] placed tray on over bed table, room [ROOM NUMBER] placed tray on over bed table, room [ROOM NUMBER] set tray on over bed table, went back into room [ROOM NUMBER] when the resident called for her and asked for her to cut his steak up into pieces, exited the room and walked down the hallway to the linen cart and grabbed a towel and went into room [ROOM NUMBER] and placed the towel on the bed and washed her hands in the sink in the room, sat down by bed in a chair and fed resident in room [ROOM NUMBER] his lunch.</p> <p>During an interview on 2/3/2025 at 1:53 PM, CNA A said she had been employed at the facility for a month and worked 12-hour shifts on days from 6 am-6 pm. She said during the observation of passing lunch trays earlier, she should have sanitized or washed her hands between residents. She said she had not had any check offs by staff and had worked at the facility in the past a few times. She said she had hand sanitizer in her pocket and forgot to use it between residents. She said residents could get sick if staff did not wash or sanitize their hands after providing assistance to them.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>2. Record review of an Admission Record dated 2/4/2025 for Resident #16 indicated she admitted to the facility on [DATE] and was [AGE] years old with diagnoses of diastolic congestive heart failure, dementia, malignant neoplasm of right breast (cancer in the breast), and type 2 diabetes.</p> <p>Record review of a care plan for Resident #16 dated 8/3/2022 indicated she had an ADL self-care performance deficit due to muscle wasting and atrophy with interventions for bed mobility: she required x1 staff participation. She had urine and bowel incontinence with interventions to provide pericare after each incontinent episode.</p> <p>Record review of an Annual MDS Assessment for Resident #16 indicated she had severe impairment in thinking with a BIMS score of 3. She required substantial/maximal assistance with rolling left and right. She was always incontinent of urine and bowel.</p> <p>During an observation on 2/4/2025 at 9:32 AM, in the room of Resident #16, CNA A was present to provide incontinent care. CNA A sanitized her hands, went into the hallway, and gathered supplies. Supplies were placed on a towel on the over bed table, and she washed her hands at the sink in the room. She placed gloves on both hands and pulled the linens down to the foot of the bed. She opened the brief and pulled it down between Resident #16's legs. CNA A removed a wipe from the package and wiped across the lower abdomen and placed it in the trash and removed another wipe and wiped down the vagina from top to bottom and placed the wipe in the trash. She rolled Resident #16 onto her left side and removed another wipe and wiped her rectal area from front to back and rolled an under pad underneath the resident along with a clean brief. She rolled the resident onto her right side and pulled the dirty brief and under pad and placed them in the trash and then she pulled the clean under pad and brief under the resident's buttocks. She removed her gloves and placed them in the trash. She did not wash or sanitize her hands and placed clean gloves on and secured the brief on Resident #16. She removed her gloves and placed them in the trash. Resident #16 was repositioned in bed and she placed linens back over the resident. She washed her hands in the sink in the resident's room.</p> <p>During an interview on 2/4/2025 at 9:47 AM, CNA A said during the incontinent care provided to Resident #16, she did not sanitize or wash her hands between glove changes. She said she should have changed her gloves after she removed the dirty brief and underpad and before she placed clean items on the resident. She said no one checked her off on skills or watched her perform incontinent care since she started about a month ago. She said she had sanitizer in her pocket but was nervous and forgot to use it. She said residents could be at risk for infections if staff did not wash or sanitize their hands.</p> <p>3. Record review of a facility face sheet dated 2/4/25 for Resident #20 indicated that he was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses of flaccid hemiplegia affecting left nondominant side (paralysis affecting the left side of the body due to neurological injury, often resulting from a stroke).</p> <p>Record review of a Quarterly MDS for Resident #20 dated 12/8/24 indicated that he had a BIMS score of 1, indicating that he had severe cognitive impairment. He was dependent with most of his ADLs. He was incontinent of bowel and bladder.</p> <p>Record review of a physician's order summary report dated 2/4/25 for Resident #20 indicated that he had the following physician's order dated 8/8/23: .May suction due to excessive secretions .</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Record review of a comprehensive care plan dated 12/10/23 for Resident #20 indicated that he had a terminal diagnosis and was receiving hospice services with interventions including to provide maximum comfort for the resident.</p> <p>During an observation on 2/3/25 at 9:30 am Resident #20 was observed lying in bed. He had a suction machine on his bedside table with a Yaunker suction tip attached to the tubing for the suction machine. The suction tip was uncovered, not bagged, and lying on the bedside table. Resident was unable to answer questions.</p> <p>During an observation on 2/3/25 at 2:00 pm the suction tip was still observed open but was now lying on top of the suction machine, still unbagged, unlabeled, and undated.</p> <p>During an interview on 2/3/25 at 3:30 pm LVN E said they do not have to suction Resident #20 very often, but they should always use a clean Yaunker when suctioning and it should not be left lying open on his bedside table or on top of the suction machine.</p> <p>During an interview on 2/3/25 at 4:00 pm ADON said the suction tip should not be lying open on the bedside table. She said they are scheduled for replacement on Sunday nights. She said it could cause the resident to be at risk for infection if the suction tip was not stored properly.</p> <p>4. Record review of a facility face sheet dated 2/4/25 for Resident #26 indicated that she was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses of chronic obstructive pulmonary disease (lung and airway diseases that restrict your breathing).</p> <p>Record review of a quarterly MDS dated [DATE] for Resident #26 indicated that she had a BIMS score of 0, which indicated that she had severe cognitive impairment. She was dependent for all ADLs. She was always incontinent of bowel and bladder. She had an indwelling abdominal feeding tube.</p> <p>Record review of a physician's order summary report dated 2/4/25 for Resident #26 indicated that she did not have an order for enhanced barrier precautions in place.</p> <p>Record review of a comprehensive care plan dated 1/23/25 for Resident #26 indicated that she received all nutrition and fluids per G-Tube per MD orders.</p> <p>During an observation on 2/4/25 at 10:30 am CNA C and CNA D were observed to provide incontinent care for Resident #26. CNA C and CNA D did not wear appropriate PPE as required for enhanced barrier precautions. There was not a box of ppe outside of the resident's door or any sign that the resident was on enhanced barrier precautions. They did not wear a gown as required for enhanced barrier precautions.</p> <p>During a joint interview on 2/4/25 at 10:45 am CNA C and CNA D both said they had been trained on enhanced barrier precautions but did not have anyone on their hall at this time that required them. They said residents requiring them would have signs and boxes of PPE outside their door. They both said the facility had not told them Resident #26 required enhanced barrier precautions.</p> <p>During an interview on 2/4/25 at 11:00 am ADON said residents requiring EBP included residents with chronic open wounds and indwelling medical devices.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 2/5/25 at 11:15 am Administrator said she had misread the letter from CMS and did not realize that Resident #26 required EBP. They thought since she did not have secretions from the tube and she'd had it for so long that she did not require them.</p> <p>Record review of a training transcript for CNA A dated 2/3/2025 indicate she completed training on infection control and prevention on 1/5/2025 and hand hygiene on 1/7/2025.</p> <p>Record review of a nurse aide skills performance checklist for CNA A dated 1/14/2025 indicated she had skills check off conducted by the DON and was satisfactory with hand washing/use of hand sanitizer and with providing female perineal care.</p> <p>During an interview on 2/5/2025 at 10:56 AM, the ADON said she was made aware of CNA A not washing or sanitizing her hands between residents when passing meal trays. She said they conducted training with staff on hire on infection control by her and the DON. She said staff were supposed to sanitize their hands between passing meal trays and the facility had multiple sanitizing stations available along with pocket bottles of sanitizer for them to carry with them. She said when staff performed incontinent care hands should be sanitized or washed before care, when changing from dirty to clean and CNA A received that training during her check off on hire. She said she provided training at least quarterly on infection control and hand hygiene with the facility staff and more often if needed. She said residents could be at risk for the potential of organism related infections if staff did not wash or sanitize their hands.</p> <p>During an interview on 2/5/2025 at 11:30 AM, the DON said the ADON was responsible for training staff on infection control and conducted training as needed and yearly. She said she was made aware of CNA A not sanitizing her hands when she passed lunch trays on 2/3/2025 and was told about her not sanitizing her hands or washing them during incontinent care on 2/4/2025. She said hand hygiene should be done when going from dirty to clean, before and after care provided and when gloves were removed. She said hands should be sanitized between residents and before getting another tray. She said residents could be at risk for infections if staff did not sanitize or wash their hands.</p> <p>Record review of in-service dated 2/3/25 indicated the facility staff were trained on hand hygiene.</p> <p>Record review of in-service dated 2/4/2025 indicated the facility staff were trained on standard precautions and peri care.</p> <p>During an interview on 2/5/25 at 10:58 am ADON said residents could be at risk of having MDRO's introduced through indwelling medical devices if enhanced barrier precautions were not followed appropriately.</p> <p>During an interview on 2/5/25 at 11:44 am Administrator said the enhanced barrier precautions were now in place to protect Resident #26 from infections that could be spread from other residents since she had an indwelling medical device. She said the Yaunker suction tip should have not been left uncovered on the table as it could pose an infection risk.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 2/5/2025 at 1:39 PM, the Administrator said the ADON was responsible for training on infection control and was the Infection Preventionist for the facility. She said she was made aware of the incidents with CNA A on 2/3/2025 and 2/4/2025. She said hand hygiene should be done before care, during care, anytime going from dirty to clean, after care, and anytime as needed in between. She said there could be a risk for an increase in infections from bacteria and cross contamination if staff did not wash or sanitize their hands. She said they planned to continue to conduct hand hygiene audits monthly and would do them more frequently with new hires.</p> <p>Record review of a facility policy titled Handwashing/Hand Hygiene revised August 2019 indicated, .This facility considers hand hygiene the primary means to prevent the spread of infections. 2. All personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors. 7. Use an alcohol-based hand rub containing at least 62% alcohol; or alternatively, soap and water for the following situations: b. Before and after direct contact with residents; h. Before moving from a contaminated body site to a clean body site during resident care; m. After removing gloves; p. Before and after assisting a resident with meals .</p> <p>Record review of a facility policy titled Suctioning the Upper Airway (Nasopharyngeal or Oropharyngeal Suctioning) dated 2001 and revised in October 2023 read .General Guidelines: 5. Oropharyngeal suctioning is performed using aseptic technique (clean) .</p> <p>Record review of a facility policy titled Enhanced Barrier Precautions dated 2001 and revised in August 2022 read .Examples of high-contact resident care activities requiring the use of gown and gloves for EBPs include: .d. providing hygiene; .f. changing briefs or assisting with toileting . and .EBPs are indicated (when contact precautions do not otherwise apply) for residents with wounds and/or indwelling medical devices regardless of MDRO colonization .</p>		