STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675814	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arbor Grace Guest Care Center	2700 S Henderson Blvd Kilgore, TX 75662

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45643 Based on observation, interview, and record review the facility failed to ensure each resident received adequate supervision to prevent accidents for 1 of 20 residents (Resident #48) reviewed for adequate supervision. The facility failed to keep prohibited items, isopropyl rubbing alcohol, out of Resident #48's room. This failure could place residents at risk for injury, harm, and impairment or death. Findings included: Record review of Resident #48's Admission Record indicated she was a [AGE] year-old male admitted to the facility on [DATE]. His diagnoses included Amyotrophic Lateral Sclerosis (progressive and fatal neurodegenerative disease that affects the motor neurons in the brain and spinal cord), Chronic Obtrusive Pulmonary Disease (a group of lung diseases that cause progressive airflow obstruction and breathing difficulties), Type 2 Diabetes (a chronic condition where the body does not use insulin effectively or does not produce enough insulin to regulate blood sugar levels). Record review of Resident #48's MDS dated [DATE] revealed that the resident's BIMS score was a 10 indicating mild cognitive impairment. The MDS also revealed, Resident #48, required maximal assistance for all ADLs. Record review of Resident #48's Care Plan revealed a problem initiation on 10/21/2022 for a Moderately impaired vision - not able to read large or small print but can identify objects: nuclear cataracts, cortical senile cataract, myopia with astigmatism and presbyopia of both eyes (you have a combination of age-related vision changes, including clouding of the lens, nearsightedness, blurry vision at all distances, and difficulty focusing on near objects). During an observation and interview on 3/31/25 at 9:26 a.m., Resident #48 had a bottle of isopropyl alcohol on his bedside table. He said that he has always had that bottle on his bedside table and uses it to clean up. During an observation on 4/1/25 at 3:04 p.m. Resident #48 had a bottle of isopropyl rubbing alcohol on his bedside table. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675814	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/02/2025
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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/1/25 at 3:08 p.m. LVN C said residents were not allowed to have any over the counter medications or rubbing alcohol in their rooms . She said there was a risk that a resident could swallow the rubbing alcohol. She said that they would need to call poison control if a resident swallowed rubbing alcohol. During an interview on 4/2/25 at 12:25 p.m., the Director of Nurses said that residents were not allowed to have prohibited medications or medical products in their rooms. She said that rubbing alcohol was a prohibited item and residents could not keep that unsecured in their rooms. She said there was a risk that a resident could drink the alcohol and call poison control. She said it was the responsibility of all staff to ensure prohibited items are not in resident rooms. During an interview on 4/2/25 at 12:28 p.m., the Administrator said that residents were not allowed to have prohibited medical related items in their rooms. She said that rubbing alcohol was a prohibited item and residents could not keep it unsecured in their rooms. She said there was a risk that a resident could be harmed She said it was the responsibility of all staff. Record review of a facility policy dated 2001 entitled Hazardous Areas, Devices and Equipment, All hazardous areas, devices and equipment in the facility will be identified and addressed appropriately to ensure resident safety and mitigate accident hazards to the extent possible As part of the facility's overall safety and accident prevention program, hazardous areas and objects in the resident environment will be identified and addressed by the safety committee A hazard is defined as anything in the environment that has the potential to cause injury or illness. Examples of environmental hazards include, but are not limited to the following: Access to toxic chemicals

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46929 Based on observation, interview, and record review the facility failed to ensure a resident who was incontinent of bladder received appropriate treatment and services to prevent urinary tract infections for 1 of 2 residents (Resident #4) reviewed for appropriate treatment and services to prevent urinary tract infections (an infection in any part of the urinary system, the kidneys, bladder, or urethra (is a hollow tube that lets urine leave your body)). The facility failed to ensure Resident #4's indwelling suprapubic catheter (drains urine from your bladder into a bag outside your body) had a catheter securement device to anchor the catheter to her leg. This failure could place residents at risk for urinary tract infections. Findings included: Record review of Resident #4's face sheet, dated 04/01/25, indicated she was a [AGE] year-old female, admitted to the facility on [DATE]. Her diagnoses included retention of urine (a condition where a person is unable to completely empty their bladder), and Alzheimer's disease (a progressive neurodegenerative disorder that primarily affects memory, thinking, and behavior, and is the most common cause of dementia in older adults). Record review of Resident #4's quarterly MDS assessment, dated 01/25/25, indicated she had a BIMS score of 11, which indicated moderate cognitive impairment. The MDS assessment further indicated she had an indwelling catheter and an ostomy (a surgically created opening, or stoma, in the abdominal wall that allows waste (stool or urine) to exit the body when the normal digestive or urinary pathways are damaged or removed). Record review of Resident #4's Order Summary Report, dated 04/01/25, indicated she had an order for Suprapubic catheter privacy bag and securement device. Ensure placement every shift. The start date was 02/04/25. Record review of Resident #4's undated care plan, included a focus of [Resident #4] has the potential for complications with UTI related t osupra-pubic catheter secondary to retention of urine, dysfunction of bladder, and overactive bladder. The focus was initiated on 06/12/2019 and last revised on 12/05/20. Interventions included monitor placement of catheter leg strap every shift, initiated on 04/24/24. During an observation on 04/01/25 at 9:56 AM, LVN C provided catheter care to Resident #4. Resident #4 had a suprapubic catheter. Prior to the care Resident #4 did not have a catheter securement device in place. During an interview on 04/01/25 at 10:00AM. LVN C said Resident #4 should always have a catheter securement device in place. She said she was not sure why the resident did not have a catheter securement device in place. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 04/01/25 at 10:43AM, LVN C said Resident #4 was supposed to have a catheter securement device in place. She said it was important to have a catheter securement device in place because it avoids the catheter pulling and helps keep it in place. She said the nurse was responsible for ensuring the device was in place. She said it was the responsibility of the nurse to check for the device each shift. During an interview on 04/02/25 at 12:15 PM, ADON A said she expected Resident #4 to have a catheter anchor in place. She said it was important to keep the anchor in place so the catheter did not pull out. She said the risk to the resident was that without the catheter, it could pull and cause pain, an injury, or even an infection. During an interview on 04/02/25 at 12:26 PM, the DON said Resident #4 should have had a catheter securement device in place. She said the nurse should verify the anchor was in place each shift. She said it was important for the anchor to be in place to prevent the catheter from being pulled out. She said the risk was infection and pain. During an interview on 04/02/25 at 12:37 PM, the Administrator said she expected the resident to have a catheter securement device in place. She said the catheter could have been pulled out. She said the risk to the resident was pain and a possible infection. Record review of the facility's undated policy, Catheter Care, Urinary, stated: .Ensure that the catheter remains secured with a securement device to reduce friction and movement at the insertion site .

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48958 Based on observations, interviews, and record review the facility failed to ensure all drugs were stored and disposed of properly, for 1 of 6 residents (Resident #56) reviewed for medication storage. 1.The facility failed to ensure Resident #56's humlin ,d+[DATE] insulin was properly stored in the refrigerator. 2. The facility failed to ensure Resident #56's humlin ,d+[DATE] insulin with an expired date was disposed of. This failure could place residents at risk of not receiving the therapeutic benefit of medications and adverse reactions to medications due to improper storage. Findings included: 1.Record review of Resident #56's face sheet, dated [DATE], indicated a [AGE] year-old male who initially admitted to the facility on [DATE] with diagnoses which included type 2 diabetes mellitus with hyperglycemia(a condition where the body does not use insulin effectively, leading to high blood sugar levels), muscle weakness, unspecified severe protein calorie malnutrition (a condition where a person does not consume enough calories and protein to meet their nutritional needs) and chronic kidney disease (longstanding disease of the kidneys leading to renal failure). Record review of Resident #56's quarterly MDS assessment, dated [DATE], indicated he was able to make himself understood and understood others. Resident #56 had a BIMS score of 11, which indicated her cognition was moderately impaired. Resident #56 required dependent assistance with ADL's . Resident #56 was always incontinent of bladder and bowel. Record review of Resident #56's physician orders, dated [DATE], indicated humlin ,d+[DATE] subcutaneous suspension (,d+[DATE]) 100unit/ milliliter (Insulin NPH Isophane and Reg (Human). Inject 5 units subcutaneously at bedtime for diabetes mellitus, hold for blood sugar less than 100. Record review of Resident #56's care plan dated [DATE] indicated resident was at risk for frequent infections, pressure/venous/stasis ulcers, vision impairment, hyper/hypoglycemia, renal failure, cognitive/ physical impairment/ skin desensitized to pain or pressure, slow healing process related diagnosis of Diabetes Mellitus. Interventions were for staff to observe resident for signs of hyperglycemia (blood glucose >140mg/di; increase thirst, increase urination; increase appetite followed by lack of appetite; nausea, vomiting) and observe for signs of hypoglycemia (blood glucose<60mg/deciliter; sweating; cold; clammy skin; numbness of fingers, toes, mouth; rapid heartbeat; nervousness; tremors, faintness, dizziness). (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on [DATE] at 9:30 A.M., with LVN K in back hall medication room. There were three bottles of humlin ,d+[DATE] insulin with Resident #56's information on it in a cabinet. Two of the bottles were not opened but one bottle had an expired date [DATE] on it which indicated been used. During an interview on [DATE] at 10:02 A.M., LVN I said the insulin should have been stored in the refrigerator until it was opened. She said after an insulin was opened it was good for 20 days. She said she believed that the insulin found in the cabinet and not refrigerated came from Resident #56's home. She said the facility used the insulin until the resident's meds came from their pharmacy. She said the insulin should have been disposed of or sent back home with the family if the facility was not going to use it. She said since the insulin was improperly stored if it was used for Resident #56 it would not have been effective. During an interview on [DATE] at 10:10 A.M., LVN K said insulin should be stored in the refrigerator if it had not been used. She said if insulin was not stored properly the effectiveness of the insulin would be at risk. She said the resident would not get the desired effect, which would be to decrease the blood sugar level. During an interview on [DATE] at 11:35 A.M., LVN/ADON A said the insulin should have never been stored in the cabinets. She said unused insulin should be stored in the refrigerator. She said the nurses were responsible for the storage of the medications. She said improper storage of insulin would make the medication ineffective for the resident. During an interview on [DATE] at 12:05 P.M., the DON said the insulin was a medication Resident #56 brought from home. She said the staff should have sent the medication back home with the family or destroyed it. She said an insulin improperly stored would not be effective for a resident. She said all unused insulin should be stored in the refrigerator until use. She said the facility has started an in-service over medication storage. During an interview on [DATE] at 12:43 P.M., the ADM said she expected staff to properly store medications. She said the insulin should have been stored in the refrigerator or sent home with the family. She said improper storage of insulin would not be effective for the desired use of insulin. Record review of the facility's policy, Medication Labeling and Storage, undated, stated: The facility stores all medications and biologicals in locked compartments under proper temperatures, humidity, and light controls. Only authorized personnel have access to keys. .3. If a medication has discontinued, outdated, or deteriorated medications or biologicals, the dispensing pharmacy is contacted for instructions regarding returning or destroying these items . .6. Medications requiring refrigeration are stored in a refrigerator located in the medication room at the nurse's station or other secured location. Medications are stored separately from food and are labeled accordingly .

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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** 35295 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 4 of 18 residents reviewed for infection control practices (Resident #'s 56, 4, 7, 28). 1.The facility failed to ensure the treatment nurse changed her gloves and performed hand hygiene appropriately while providing wound care to Resident #56. 2. The facility failed to ensure LVN C donned a gown before performing catheter care on Resident #4. 3.The facility failed to ensure LVN F donned a gown when she gave Peg-tube medications to Resident #7. Resident #7 was on enhancement barrier precautions. 4. The facility failed to ensure CNA E changed her gloves or sanitize her hands after performing incontinent care and applying clean brief for Resident #28. She touched a clean brief with her dirty gloves. These failures could place residents at risk of exposure to communicable diseases, cross-contamination, and infections. Findings included: 1.Record review of the undated Admission Record indicated Resident #56 was a [AGE] year-old male that admitted [DATE]. Record review of the physician's orders dated 4/1/25 indicated Resident #56 had diagnoses that included: unspecified severe protein-calorie malnutrition (a person consumes inadequate amounts of protein and calories for an extendedperiodextended period , leading to significant health problems), type 2 Diabetes Mellitus with hyperglycemia (the body does not produce enough insulin or does not use insulin effectively, leading to high blood sugar levels), heart failure (the heart does not pump as much blood as it should), and anxiety (intense, excessive, and persistent worry and fear about everyday situations.) The physician's orders indicated: 3/10/25, Wound care: Sacrum: Stage 4 pressure wound, cleanse with normal saline or wound cleanser, pat dry. Apply collagen sheet to fit wound bed, followed by dry dressing. Apply barrier cream containing zinc ointment to peri-wound (area of skin surrounding a wound) tissue. Record review of the admission MDS dated [DATE] indicated Resident #56 had clear speech, understood others and was understood by others. The MDS indicated he had a BIMS of 11 indicating moderate cognitive impairment and admitted with a stage 4 pressure ulcer (a pressure injury that extends through all layers of the skin and into underlying tissues, such as muscle, tendons, or bone.) (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 the care plan dated 2/19/25 indicated Resident #56 had a pressure ulcer. The goal was he would have no evidence of further skin breakdown/irritation and current wounds would heal without signs or symptoms of infection . During an observation on 4/01/25 at 9:42 AM, the treatment nurse performed wound care on Resident #56. She did not change her gloves when performing wound care. With her dirty gloves she touched the collagen sheet placed on the wound and the outer dry dressing. She touched his clean brief, his blanket, and his comforter with the same gloves . She removed her gloves and without washing or sanitizing her hands adjusted the bed with the bed control. During an interview on 4/1/25 at 9:50 AM, the treatment nurse said she was supposed to change her gloves after cleaning Resident #56's wound, a dirty procedure, and before going to the clean procedure. She said she was trained to change her gloves to prevent the risk of infection. She said failing to change her gloves or wash/sanitize her hands was an infection risk to the resident and to anyone else that touched the items she had touched with her dirty gloves. Record review of a Competency Assessment, Dressings, Dry/Clean dated 9/30/24 indicated the treatment nurse was proficient in wound care. During an interview on 4/01/25 at 4:01 PM, ADON B said when doing wound care, staff should change gloves after a dirty procedure and before going to a clean procedure. She said there should be 3 glove changes during wound care. She said not changing gloves and cleaning hands could cause an infection control issue/risk for staff and residents. During an interview on 4/01/25 at 4:06 PM, ADON A said it would be an infection control risk for staff and for residents if a staff did not change gloves after performing a dirty procedure and before going to a clean procedure during wound care. She said staff were taught to change their gloves after a dirty procedure to prevent infection transmission to staff and residents. During an interview on 4/2/25 at 11:50 AM, the DON said when performing wound care the treatment nurse or staff should change their gloves after performing a dirty procedure and before going to a clean one to prevent infection to residents and staff. She said touching the bed control with hands that were not sanitized or washed was also an infection control issue. During an interview on 4/02/25 at 12:09 PM, the ADM said she expected staff to change their gloves after a dirty procedure and before going to a clean procedure to prevent infection. She said during wound care gloves should be changed several times. She said not changing gloves and washing hands could possibly cause an infection control issue to residents and staff. The ADM said staff have been trained to change their gloves when going from a dirty procedure to a clean one. 2. Record review of Resident #4's face sheet, dated 04/01/25, indicated she was a [AGE] year-old female, admitted to the facility on [DATE]. Her diagnoses included retention of urine (a condition where a person is unable to completely empty their bladder), and Alzheimer's disease (a progressive neurodegenerative disorder that primarily affects memory, thinking, and behavior, and is the most common cause of dementia in older adults). (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 #4's quarterly MDS assessment, dated 01/25/25, indicated she had a BIMS score of 11, which indicated moderate cognitive impairment. The MDS assessment further indicated she had an indwelling catheter. Record review of Resident #4's Order Summary Report, dated 04/01/25, indicated she had an order for Enhanced Barrier Precautions. The start date was 04/17/24. Record review of Resident #4's undated care plan, included a focus of [Resident #4] has the potential for complications with UTI related to supra-pubic catheter secondary to retention of urine, dysfunction of bladder, and overactive bladder. The focus was initiated on 06/12/2019 and last revised on 12/05/20. Interventions included enhanced barrier precautions, initiated on 04/18/24. During an observation on 04/01/25 at 9:56 AM, LVN C provided catheter care to Resident #4. There was a EBP sign on the Resident's door. LVN C did not don (put on) a gown before providing catheter care to Resident #4. Resident #4 had a suprapubic catheter. During an interview on 04/01/25 at 10:14AM, LVN C said she should have worn a gown while providing care to Resident #4. She said it was important to follow EBP to protect residents from infection. During an interview on 04/02/25 at 12:15 PM, ADON A said LVN C should have worn a gown when providing catheter care. She said it was important to protect the resident from infection. She said it is easier for the resident with a catheter to catch an infection. During an interview on 04/02/25 at 12:26 PM, the DON said she expected LVN C to wear a gown while providing care to Resident #4. She said he risk to the resident was possible infection. She said a resident with medical devices can catch an infection easier. During an interview on 04/02/25 at 12:37 PM, the Administrator said she expected LVN C to wear a gown while providing care to Resident #4. She said the risk was a potential infection. 3.Record review of Resident #7's face sheet, dated 4/1/25, indicated a [AGE] year-old female who initially admitted to the facility on [DATE] with diagnoses which included muscle weakness, unspecified dementia (a group of thinking and social symptoms that interferes with daily functioning), cerebrovascular disease (a medical emergency that encompasses a range of conditions affecting the brain's blood vessels and blood flow) and aphasia following unspecified cerebrovascular disease (a language disorder that affects a person's ability to communicate). Record review of Resident #7's quarterly MDS assessment, dated 2/4/25, indicated she was rarely able to make herself understood and rarely understood others. No BIMS score was conducted for Resident #7. Resident #7 required dependent assistance with ADL's. Resident #7 was always incontinent of bladder and bowel. Record review of Resident #7's care plan dated 2/21/25 indicated resident required enhancement barrier precautions related to indwelling catheter, feeding tube, and wound. Resident #7's interventions required staff to correctly put on gown and gloves and gown and gloves are used during high-contact sessions. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During observation on 04/01/2025 at 7:34 A.M., LVN F checked Resident #7's residual from peg-tube and did not apply PPE; the resident was on enhanced barrier precautions. During observation on 04/01/2025 at 7:36 A.M., LVN F administered Resident #7's morning medication per peg-tube and did not apply PPE before giving medications; the resident was on enhanced barrier precautions. During an interview on 04/01/25 at 9:03 A.M., LVN F said she knew she missed up during her med pass earlier. She said Resident #7 was on enhanced barrier precautions and she forgot to apply her PPE, because she was nervous. She said staff were supposed to wear PPE for enhanced barrier precautions for residents with feeding tubes, catheters, and wounds. She said staff wear the PPE for infection control. She said if PPE was not applied during contact care staff could transfer germs and it was a risk for infections for the residents. 4.Record review of Resident #28's face sheet, dated 4/2/25, indicated an [AGE] year-old female who initially admitted to the facility on [DATE] with diagnoses which included muscle weakness, unspecified dementia (a group of thinking and social symptoms that interferes with daily functioning) and chronic obstructive pulmonary disease (a group of lung diseases that block airflow and make it difficult to breathe). Record review of Resident #28's quarterly MDS assessment, dated 1/17/25, indicated she was able to make herself understood and understood others. Resident #28 had a BIMS score of 10, which indicated her cognition was moderately impaired. Resident #28 required moderate assistance with toileting hygiene and showers. Resident #28 was frequently incontinent of bladder and always incontinent of bowel. Record review of Resident #28's care plan dated 8/28/23 indicated resident have a potential for impaired skin integrity related to decreased mobility, incontinence, low albumin level and low protein intake. Intervention was to keep resident clean, dry and sheets wrinkle free. Record review of CNA D's: Clinical Proficiency-Incontinence Care sheet dated 2/17/25 indicated CNA D had met the requirements. The competency was signed by evaluator, LVN/ADON A. Record review of CNA E's: Clinical Proficiency-Incontinence Care sheet dated 2/17/25 indicated CNA E had met the requirements. The competency was signed by evaluator, RN/ADON B. During an observation on 04/01/25 at 9:47 A.M., CNA D and CNA E performed incontinent care on Resident #28. While the CNA's performed incontinent care; CNA E performed incontinent care on Resident #28 but did not remove her dirty gloves before applying a clean brief. During an interview on 04/01/25 at 12:03 P.M., CNA E said she was very nervous with surveyor watching her and she had someone helping her, but she was use to performing the incontinent care alone. She said she did not change her gloves before applying the clean brief and she felt like she did not clean Resident #28 good enough during the care. She said after performing the incontinent care she should have removed her dirty gloves, sanitized her hands and applied clean gloves before applying the clean brief. She said not changing gloves after incontinent care could put the resident at risk for infection. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675814	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/02/2025
NAME OF PROVIDER OR SUPPLIER: Arbor Grace Guest Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 2700 S Henderson Blvd Kilgore, TX 75662	

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 04/01/2025 at 3:24 P.M., CNA D said she saw when CNA E messed up during incontinent care with Resident #28. She said the proper way to do peri care was to wash your hands and have 3 bags. She said two things were missed, she said CNA E did not put drape over the resident and did not change her gloves or sanitize her hands, before applying the clean brief on Resident #28. She said improper hand hygiene could cause infections or an UTI. During an interview on 04/02/2025 at 9:04 A.M., CNA G said when she worked with residents on enhanced barrier precautions; she wore her PPE. She said wearing the PPE decreased the risk of any contact with infections for the staff and the residents. She said when performing incontinent care staff should sanitize their hands and apply clean gloves after performing incontinent care, before they move on to the next step. She said proper hand hygiene prevent cross contamination. During an interview on 04/02/2025 at 9:14 A.M., CNA H said if staff does not wear the correct PPE they could possibly contract what the resident has or the staff could transfer germs to the residents. She said after performing incontinent care staff should wash their hands and change gloves before a clean brief was applied. She said that would prevent cross contamination and infection. During an interview on 04/02/2025 at 9:24 A.M., LVN I said she wear her PPE with resident that were on enhancement barrier precautions to prevent cross contamination. She said after performing incontinent care staff should perform hand hygiene and change gloves, before a clean brief is applied. She said proper hand hygiene prevents infection. During an interview on 04/02/2025 at 9:41 A.M., LVN J said she wears PPE for resident on enhancement barrier precautions for protection, because the residents have some kind of open area. She said not wearing the PPE could spread bacteria for the resident and herself. She said wearing the PPE was for infection control. She said during incontinent care anytime going from dirty back to clean staff should remove dirty gloves, sanitize or wash their hands and then apply clean gloves before a clean brief was applied. During an interview on 04/02/2025 at 11:35 A.M., LVN/ADON A said the facility always encourage the staff to wear PPE for enhancement barrier precaution residents. She said the precautions are in place to prevent cross contamination. She said after peri care the aides should be sanitizing or washing and changing their gloves. She said anytime staff touched something clean they should have clean gloves on. She said improper hand hygiene could put the resident at risk for infections. During an interview on 04/02/2025 at 12:05 P.M., the DON said she expected the staff to gown up and use gloves when doing any physical activities with residents that were on enhancement barrier precautions. She said not wearing the appropriate PPE could put the residents at risk for infections. She said she excepted the staff to perform proper hand hygiene while performing care. She said CNA E should have removed her dirty gloves and performed hand hygiene before applying a clean brief. She said improper hand could cause infections with the resident. During an interview on 04/02/2025 at 12:43 P.M., the ADM said she expected the staff to wear PPE with residents that were on enhancement barrier precautions. She said if staff do not wear the proper PPE that could make the residents acceptable to infections. She said she excepted the staff to perform proper hand hygiene while performing care. She said CNA E should have removed her dirty gloves and performed hand hygiene before applying a clean brief. She said improper hand could cause infections with the resident. (continued on next page)

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