STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675821	A. Building B. Wing	12/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Madisonville Care Center	411 E Collard Madisonville, TX 77864

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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45070 Based on observation, interview and record review, the facility failed to ensure the residents' right to privacy during personal care for 1 of 3 residents (Resident #172) reviewed for privacy The facility failed to ensure RN B provided privacy by drawing the privacy curtain during wound care for Resident #172. This failure could place residents at risk of a lack of privacy and not having residents rights acknowledged. The findings include: Record review of Resident #1's face sheet dated 12/19/24 revealed an [AGE] year-old male who was admitted to the facility on [DATE]. His diagnoses were, Acute hematogenous osteomyelitis (Bone Infection) , Dementia, Type 2 diabetes, Elevated white blood cell count, Hypertension, Cellulitis (Bacterial infection of the skin) of left lower limb, Local infection of the skin and subcutaneous tissue and Puncture wound with foreign body, left foot. Record review of Resident #172's face sheet dated 12/19/24 revealed he was admitted 2 days ago and his MDS assessment was not completed. Record review on 12/19/24 of Resident #172's care plan dated 12/17/24 reflected resident had Cellulitis of left foot and relevant intervention was treating wound as per facility protocol. During an observation and interview on 12/19/24 at 9:30 am RN B and RN C had provided wound care to Resident #172 in his room. Neither RN B nor RN C drew the privacy curtain during the wound care. The wound care would have been fully visible to anyone who entered the room or anyone in the hallway, if the door was opened during the wound care. When the wound care was progressing, a friend of Resident #172 (as stated by the visitor) and about 5 minutes later one FM of Resident #172 entered the room. Both visitors observed the wound care and remained in the room until the wound care was completed. Initially it was not known if Resident #172 was OK them seeing the wound and the wound care however during an interview at 10:10 am ,Resident #172 stated their presence had not distorted his privacy and/or dignity as they were very close to him in relationships. (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

Printed: 03/27/2025
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675821	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/19/2024
NAME OF PROVIDER OR SUPPLIER Madisonville Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 411 E Collard Madisonville, TX 77864	

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/19/24 at 11:10 am RN B stated she was the ADON at the facility and was also the in charge for wound care. She stated it was a mistake that the privacy curtain was not closed. RN B said she was thinking that it was OK to keep it open as Resident #172 was not sharing the room with anyone else. She stated the wound care was observed by the visitors and as a matter of fact it would have been visible to anyone who was entering the room. RN B said the privacy of the resident would be less compromised by closing the privacy curtain as there would be sufficient time to redirect if anyone entered the room unexpectedly . During an interview on 12/19/24 at 11:15 am RN C stated she started working at the facility recently however was an experienced RN. She stated she should have closed the privacy curtain of Resident #172 while providing the wound care. RN C said, by not closing the curtain, the privacy and dignity of Resident #172 were compromised as anyone opened the door to the room could see the wound on his body and the wound care. During an interview on 12/19/24 at 11:30 am the CCN stated it was mandatory to respect and maintain privacy and dignity of residents during nursing care that includes wound care, by closing the door and windows and drawing privacy curtains. She stated the privacy curtain of Resident #172 should have been closed completely by the nurses before commencing the wound care. She said the trainings were ongoing process and resident rights was one of them. The CCN stated the facility ensured all the new hires had gone through skill checks. She said, as per plan every nursing staff also had to complete an annual evaluation to ensure their nursing skills and knowledge including competency in respecting resident's rights. Record review of undated facility policy Resident Rights reflected: A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life recognizing each resident's individuality The resident has a right to personal privacy and confidentiality of his or her personal and medical records. Personal privacy includes medical treatment , personal care.

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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** 45070 Based on observation, interview and record review, the facility failed to maintain an infection and prevention control program that included, at a minimum, a system for preventing and controlling infections for 2 of 4 residents (Residents #17 and Resident #3) reviewed for infection control, as indicated by: MA A did not clean and disinfect the blood pressure monitor while using it on residents. This failure could place the residents at risk of transmission of disease and infection. Findings included: Record review of Resident #17's face sheet on 12/19/24 revealed a [AGE] year-old male who was admitted to the facility on [DATE]. His diagnoses were, Cerebral infarction (stroke), Deficiency of other vitamins, Chronic kidney disease (kidney failure with slow progression) , Type 2 diabetes, and Hypertension. Record review on 12/19/24 of Resident #17's initial MDS assessment, dated 11/26/24 revealed it was in the process of completion and the BIMS was yet to be conducted. Record review on 12/19/24 of Resident #17's care plan dated 12/13/24 indicated resident had hypertension and relevant intervention was obtaining blood pressure readings at least weekly unless ordered by the physician to be obtained more frequently. Record review of the MAR for December 2024 revealed: Carvedilol Oral Tablet 25 MG (Carvedilol): Give 1 tablet by mouth two times a day related to Essential Hypertension. Hold if SBP < 110 or HR < 60. Record review of Resident #3's face sheet on 12/19/24 revealed a [AGE] year-old male who was admitted to the facility on [DATE]. His diagnoses were, ,Type 2 diabetes, Hypertension, Muscle weakness, Acute kidney failure (Kidney failed to work) , Unsteadiness on feet, and Dizziness and giddiness Record review on 12/19/24 of Resident #3's initial MDS assessment dated [DATE] revealed it was in the process of completion and the BIMS was yet to be conducted. Record review on 12/19/24 of Resident #3's care plan dated 11/26/24 indicated resident had hypertension and relevant intervention was obtaining blood pressure readings at least weekly unless ordered by the physician to be obtained more frequently. Record review of the MAR for December 2024 revealed: (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Metoprolol Tartrate Tablet 50 MG: Give 1 tablet by mouth two times a day related to essential (primary) hypertension. Hold SBP less than 90, DBP less than 50, Pulse less than 50 and notify charge nurse/MD. An observation on 12/18/24 at 9:19 am revealed, MA A failed to sanitize the blood pressure monitor before using it on Resident #17, in between Resident #3 and Resident #17 and after Resident #3. MA A took the blood pressure monitor from the top of the med cart and without sanitizing it she took the blood pressure of Resident #17. MA A then moved on to Resident #3 and took his blood pressure with the same blood pressure monitor without sanitizing it. After completing the measurement on Resident #3, without cleaning the blood pressure monitor ,she kept it on the top of the med cart and moved to next resident for taking blood pressure and medication administration. During an interview on 12/18/24 at 10:50 am, MA A stated she had been working at the facility for about two weeks, however she had experience as a MA for many years. She said it was essential to minimize the risk of spreading contagious diseases by sanitizing the blood pressure cuff in between the residents. MA A stated she did not receive any training since started working at the facility. During an interview on 12/19/24 at 11:35 am the CCN stated MA A should have sanitized the blood pressure cuff immediately after she used it on residents. She said this was necessary to stop spreading contagious disease . The CCN stated MA A was working at a sister facility before joining this facility . The CCN said MA A reported to her that MA A did not need any refreshing training on any subjects related to nursing care as she was up to date with them from the previous facility. She added, for that reason the facility had not provided any training on disinfecting medical equipment. The CCN stated the facility did not have a policy available specifically for disinfecting durable medical equipment like stethoscope and blood pressure monitors, in between residents. The CNN stated MA A's noncompliance to infection control practice had the risk of spreading contagious diseases. Record review of undated facility policy Fundamentals of Infection Control Precautions reflected : A variety of infection control measures are used for decreasing the risk of transmission of microorganisms in the facility. These measures make up the fundamentals of infection control precautions Consistent use by staff of proper hygienic practices and techniques is critical to preventing the spread of infections