| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 675838 | A. Building<br>B. Wing | 06/18/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Birchwood Nursing and Rehabilitation | 110 W Hwy 64<br>Cooper, TX 75432 |

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0582<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure each resident was informed before, or at the time of admission, and periodically during the residents stay, of services available in the facility and of changes for those services, which included changes for services not covered under Medicare/Medicaid or by the facility's per diem rate for 1 of 3 residents (Resident #108) reviewed for Medicare/Medicaid coverage.<br><br>The facility failed to ensure Resident #108 was given a SNF ABN when discharged from skilled services at the facility prior to covered days being exhausted.<br><br>This failure could place residents at risk for not being aware of changes to provided services.<br><br>Findings include:<br><br>Record review of Resident #108's face sheet, dated 06/17/25, reflected Resident #108 was an [AGE] year-old male, readmitted to the facility on [DATE] with a diagnosis of pneumonitis (inflamed lung tissue) due to inhalation of food and vomit.<br><br>Record review of Resident #108's quarterly MDS assessment, dated 04/29/25, reflected Resident #108 made himself understood and understood others. Resident #108's BIMS score was 4, which indicated his cognition was severely impaired.<br><br>Record review of Resident #108's SNF Beneficiary Protection Notification Review reflected Resident #108 was receiving Medicare Part A services starting on 02/02/25, and the last covered day of Part A services was 03/09/25.<br><br>During an interview on 06/18/25 at 10:14 a.m., the MDS Coordinator stated she was responsible for ensuring Resident #108 was issued a SNF ABN. The MDS Coordinator stated Resident #108 had 40 skilled benefit days remaining. The MDS Coordinator stated the form should have been issued if the resident had skilled benefit days remaining and was being discharged from Part A services and continued in the facility. The MDS Coordinator stated Resident #108 representative was informed of the services that might not be covered but it was not documented on a SNF ABN form. The MDS Coordinator stated it was important for the resident to receive the form so he would know what he was responsible for paying.<br><br>(continued on next page) |

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|

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| F 0582<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on 06/18/25 at 10:44 a.m., the Administrator stated the MDS Coordinator was responsible for ensuring the SNF ABN was completed. The Administrator stated he expected the SNF ABN to be handed out if the resident had days remaining in the facility. The Administrator stated it was important for the resident to receive the form so they would know what they were responsible for.<br><br>During an interview on 06/17/25 at 3:50 p.m., the Regional Compliance Nurse stated the facility did not have a policy regarding SNF ABN. |

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| F 0637<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Assess the resident when there is a significant change in condition<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to complete a significant change MDS assessment within 14 days after a significant change in the resident's mental and physical condition for 2 of 17 residents (Resident #12 and Resident #17) reviewed for assessments.<br><br>1. The facility failed to complete a Significant Change in Status MDS Assessment after Resident #17 admitted to hospice services on 04/12/2025.<br><br>2. The facility failed to complete a Significant Change in Status MDS Assessment after Resident #12 admitted to hospice services on 02/26/2025.<br><br>These failures could place residents at risk of having inaccurate assessment, not having individual needs met and decreased quality of life.<br><br>Findings included:<br><br>1. Record review of a face sheet dated 06/18/2025 indicated Resident #17 was a [AGE] year-old male initially admitted to the facility on [DATE] and re-admitted on [DATE] with diagnoses which included encephalopathy (brain disease, damage, or malfunction that causes an altered mental state) and unspecified protein-calorie malnutrition (condition where not enough essential nutrients are consumed which can lead to significant health issues, including muscle and fat loss, impaired immune function, and overall decline in health status).<br><br>Record review of Resident #17's Order Summary Report dated 06/18/2025 indicated he had an order to admit to hospice services with an order date of 04/12/2025.<br><br>Record review of Resident #17's care plan with a date initiated of 04/14/2025 indicated he had a terminal prognosis and received hospice services.<br><br>Record review of Resident #17's electronic health record did not indicate a Significant Change in Status MDS Assessment was completed after Resident #17 admitted to hospice services on 04/12/2025.<br><br>Record review of the Texas Medicaid Hospice Program Individual Election/Cancellation/Update Form 3071 indicated hospice services were started 04/12/2025.<br><br>During an interview on 06/17/2025 at 2:43 PM, the MDS Coordinator said she was responsible for completing the MDS assessments for the residents. The MDS Coordinator said she did not complete a Significant Change in Status MDS Assessment for Resident #17 because she did not think he needed one. The MDS Coordinator said Resident #17 admitted to hospice services, but he did not have a change in his condition. The MDS Coordinator said she missed completing the Significant Change in Status MDS Assessment on Resident #17. The MDS Coordinator said it was important for the Significant Change in Status MDS Assessments to be completed as required so the state and staff knew about the change in the resident's condition.<br><br>(continued on next page) |

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| F 0637<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 2. Record review of Resident #12's face sheet dated 06/17/25, indicated an [AGE] year-old female who initially admitted to the facility on [DATE], with diagnoses which included dementia (memory loss) and post-traumatic stress disorder (mental disorder that develops from experiencing a traumatic event).<br><br>Record review of Resident #12's quarterly MDS assessment dated [DATE], indicated she was understood and understood others. Resident #12 had a BIMS score of 9, which indicated her cognition was moderately impaired. The MDS assessment indicated Resident #12 received hospice care.<br><br>Record review of Resident #12's comprehensive care plan revised on 03/05/25, indicated Resident #12 had a terminal prognosis and/or was receiving hospice services. The care plan interventions included if resident was receiving hospice services, to work cooperatively with hospice team to ensure the resident's spiritual, emotional, intellectual, physical needs were met.<br><br>Record review of Resident #12's order summary report dated 06/17/25, indicated she had an order to admit to [hospice company] for Alzheimer's/dementia with an order start date of 02/26/25.<br><br>Record review of Resident #12's electronic health record did not indicate a Significant Change in Status MDS Assessment was completed after Resident #12 admitted to hospice services on 02/26/2025.<br><br>During an interview on 06/17/25 at 2:53 PM, the MDS Coordinator said Resident #12 admitted to hospice services in February 2025. She said she was responsible for completing the Significant Change in status MDS assessments. She said a Significant Change in Status MDS assessment should have been completed for Resident #12 within 14 days of her being admitted to hospice. She said she had not been educated on completing a Significant Change in Status MDS assessments when a resident was admitted to hospice services. She said she thought the resident had to have 2 qualifying changes in status to warrant a Significant Change in Status MDS assessment. She said she was not aware being admitted to hospice services only required one change in status. The MDS Coordinator said there was no risk to Resident #12 not having a Significant Change MDS assessment completed.<br><br>During an interview on 06/17/2025 at 3:48 PM, the Regional Reimbursement Nurse said a Significant Change in Status MDS Assessment should be completed within 14 days of a resident's admission to hospice services. The Regional Reimbursement Nurse said the MDS Coordinator was responsible for completing the MDS assessments as required. The Regional Reimbursement Nurse said she did not oversee the MDS Coordinator she was just her corporate support, and she was new to the position. The Regional Reimbursement Nurse said she was not aware the MDS Coordinator had not completed the Significant Change in Status MDS Assessments. The Regional Reimbursement Nurse said not completing a Significant Change in Status MDS Assessment did not affect the residents.<br><br>During an interview on 06/18/2025 at 11:35 AM, the Administrator said the MDS Coordinator was responsible for completing the MDS assessments as required. The Administrator said he expected the MDS Coordinator to complete the MDS assessments on time and when appropriate. The Administrator said it was important for the Significant Change in Status MDS Assessments to be completed as required for continuity of care.<br><br>During an interview on 06/18/2025 at 11:39 AM, the ADON said the facility did not have a policy on completion of the MDS assessments. The ADON said they followed the RAI manual.<br><br>(continued on next page) |

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| F 0637<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Record review of the Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual Version 1. 18.11 dated October 2023, indicated, An SCSA is required to be performed when a terminally ill resident enrolls in a hospice program (Medicare-certified or State-licensed hospice provider) or changes hospice providers and remains a resident at the nursing home. The ARD must be within 14 days from the effective date of the hospice election (which can be the same or later than the date of the hospice election statement, but not earlier than). An SCSA must be performed regardless of whether an assessment was recently conducted on the resident. |

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| F 0644<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 2. Record review of Resident #41's face sheet, dated [DATE], reflected Resident #41 was a [AGE] year-old male, admitted to the facility on [DATE] with diagnoses which included psychotic disorder with delusions (a disconnect from reality, where an individual holds strongly to false beliefs that are not based in reality).<br><br>Record review of Resident #41's annual MDS assessment, dated [DATE], reflected Section A1500 (Preadmission Screening and Resident Review (PASRR)) asked Is the resident currently considered by the state level II PASRR process to have serious mental ill ness and/or intellectual disability or a related condition? This section was marked 0 which meant No. Section A.1510 Level II Preadmission Screening and Resident Review (PASRR) Conditions did not have A. Serious mental illness, B. Intellectual Disability, or C. Other related conditions checked. Resident #41 sometimes made himself understood, and sometimes understood others. Resident #61 had a BIMS score of 3, which indicated his cognition was severely impaired.<br><br>Record review of Resident #41's comprehensive care did not address PASRR in the care plan.<br><br>Record review of the PASRR Level 1 Screening form, dated [DATE], reflected Resident #41 had no evidence or indicator of mental illness.<br><br>During a telephone interview on [DATE] at 3:36 p.m., the PASRR Manager stated if a diagnosis was added that was not previously there, she expected a Form 1012 and a new PASRR Level 1 Screening to be submitted to alert the local authority that the resident required a PASRR evaluation because of a qualifying diagnosis. The PASRR Manager stated the MDS Coordinator was responsible for ensuring a Form 1012 and a new PASRR Level 1 Screening was submitted. The PASRR Manager stated it was important for the residents to be screened for PASRR to ensure their evaluated for eligibility and services.<br><br>During an interview on [DATE] at 3:50 p.m., the Regional Compliance Nurse stated the facility did not have a policy regarding PASRRs.<br><br>During an interview on [DATE] at 10:14 a.m., the MDS Coordinator stated she was responsible for ensuring that the local authority was notified of the new diagnosis. The MDS Coordinator stated when Resident #41 was admitted he had no psychiatric diagnoses or medications but two weeks later he received a new order for Zyprexa (psychiatric medication) and a diagnosis of Psychotic Disorder due to behaviors. The MDS Coordinator stated either a Form 1012 or another PASRR Level 1 Screening should have been submitted to alert the local authority of change in PASRR status. The MDS Coordinator stated, it was missed. The MDS Coordinator stated it was important for the residents to be screened for PASRR to ensure their evaluated for eligibility and services.<br><br>During an interview on [DATE] at 10:44 a.m., the Administrator stated he expected the MDS Coordinator to submit either a Form 1012 or a new PASRR Level 1 Screening to notify the local authority of the new mental health diagnosis. The Administrator stated it was important for the residents to be screened for PASRR to ensure their evaluated for eligibility and services.<br><br>(continued on next page) |

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| F 0644<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Based on interview, and record review, the facility failed to ensure individuals with mental health disorders were provided an accurate Preadmission Screening and Resident Review (PASRR) Screenings for 2 of 8 residents (Resident #12 and Resident #41) reviewed for PASRR.<br><br>1. The facility failed to refer Resident #12 for PASRR review following new mental illness diagnosis of posttraumatic stress disorder (mental disorder that develops from experiencing a traumatic event) on [DATE].<br><br>2. The facility failed to refer Resident #41 for PASRR review following a mental illness diagnosis of psychotic disorder with delusions (a disconnect from reality, where an individual holds strongly to false beliefs that are not based in reality) on [DATE].<br><br>These failures could place residents at risk of not receiving needed assessments (PASRR Evaluation), individualized care, and specialized services to meet their needs.<br><br>Findings included:<br><br>1.Record review of Resident #12's face sheet dated [DATE], indicated an [AGE] year-old female who initially admitted to the facility on [DATE], with diagnosis of post-traumatic stress disorder, onset date of [DATE].<br><br>Record review of Resident #12's quarterly MDS assessment dated [DATE], indicated she was understood and understood others. Resident #12 had a BIMS score of 9, which indicated her cognition was moderately impaired. The MDS indicated Resident #12 had an active diagnoses of post-traumatic stress disorder.<br><br>Record review of Resident #12's comprehensive care plan revised on [DATE], indicated Resident #12 had a history of trauma that may have a negative impact. The trauma was related to loss of [family member #1] while in the care of her older [family member #2], resident's [family member #2] died in her 20's from measles, [family member #3], [family member #4], and [family member #5] died in a wreck and [family member #6] died in a diabetic coma. The care plan interventions included to monitor for escalating anxiety, depression, sleep disturbance, substance abuse, or suicidal thoughts and report immediately to the physician and to the mental health care provider if applicable.<br><br>Record review of Resident #12's PASRR Level 1 screening dated [DATE], indicated No if there was evidence Resident #12 had a mental illness, intellectual disability, or developmental disability.<br><br>Record review of Resident #12's order summary report dated [DATE], indicated she had an order for prazosin 1mg give one capsule daily at bedtime for nightmares/PTSD with an order start date of [DATE].<br><br>Record review of Resident #12's medication administration record dated [DATE]-[DATE], indicated she had received one capsule of prazosin 1mg daily at 7:00PM.<br><br>Record review of Resident #12's EMR on [DATE] did not reveal a Form 1012 (Mental Illness/Dementia Resident Review) completed or a new PASRR Level 1.<br><br>(continued on next page) |

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| F 0644<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on [DATE] at 2:53 PM, the MDS Coordinator said Resident #12 did not require a new PASRR Level 1 or a Form 1012 to be completed because PTSD was not a mental illness. She said she looked at the PASRR Evaluation form and PTSD was not listed as a qualifying diagnosis for mental illness therefore a new PASRR Level 1 or a Form 1012 was not needed.<br><br>During an interview on [DATE] at 3:35 PM, the PASRR Program Manager said if a resident had a new mental diagnosis a Form 1012 was to be completed to determine if further screening was needed. He said PTSD was a qualifying diagnosis for mental illness. He said the MDS Coordinator was responsible for completing a new PASRR Level 1 or a Form 1012. He said it was important for those to be completed for an individual with a mental illness. He said by not completing a new PASRR Level 1 or a Form 1012, the resident could have been eligible for PASRR services and would not receive them.<br><br>During an interview on [DATE] at 3:41 PM, the Regional Reimbursement Nurse said the diagnosis of PTSD was not specifically stated on the PASRR level 1 or the Form 1012 so she could see how it could have been missed. She said she would have completed a new PASRR Level 1 or a Form 1012. The Regional Reimbursement Nurse said it was important to complete a new PASRR Level 1 or a Form 1012 to see if the resident qualified for PASRR services. She said if the resident did qualify, she could have missed receiving those services. She said the MDS Coordinator was responsible for completing a new PASRR level one or a Form 1012. The Regional Reimbursement Nurse said other Regional Reimbursement Nurses and herself completed quarterly audits to ensure PASRRs were being completed. |

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| F 0759<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure medication error rates are not 5 percent or greater.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure that it was free of medication error rate of 5 percent or greater. The facility had a medication error rate of 5.56%, based on 2 errors out of 36 opportunities, which involved 1 of 6 residents (Resident #43) reviewed for medication administration.<br><br>The facility failed to ensure MA A administered Resident #43's Artificial Tears and followed the physician's order for Resident #43's Moxifloxacin Ophthalmic Solution (antibiotic eye drops) on 06/17/2025.<br><br>These failures could place residents at risk of not receiving therapeutic effects of their medications and possible adverse reactions.<br><br>Findings included:<br><br>Record review of a face sheet dated 06/18/2025 indicated Resident #43 was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses which included dementia (deterioration of memory, language, and other thinking abilities with behaviors) and candidiasis of skin and nail (fungal infection of skin and nail).<br><br>Record review of the Quarterly MDS assessment dated [DATE] indicated Resident #43 understood others and was understood by others. The MDS assessment indicated Resident #43's BIMS score was a 12, which indicated her cognition was moderately impaired. The MDS assessment indicated Resident #43 used an antibiotic.<br><br>Record review of Resident #43's Order Summary Report indicated the following orders:<br><br>Artificial Tears Ophthalmic (eye) Solution 1 % Instill 1 drop in both eyes five times a day with a start date of 02/16/2024.<br><br>Moxifloxacin (antibiotic) Ophthalmic Solution 0.5 % Instill 1 drop in left eye four times a day with a start date of 02/16/2024.<br><br>Record review of Resident #43's June 2025 MAR indicated her Moxifloxacin 0.5% solution scheduled for 7:00 AM and Artificial Tears scheduled at 9:00 AM were administered by MA A.<br><br>Record review of Resident #43's care plan last reviewed 04/24/2025 indicated she had an eye infection related to candidiasis of the eye to give therapeutic ointments, drops as ordered by the physician.<br><br>During an observation of medication administration on 06/17/2025 starting at 7:45 AM, MA A administered one drop of Moxifloxacin 0.5% solution in both of Resident #43's eyes and did not administer Resident #43's Artificial Tears.<br><br>(continued on next page) |

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| F 0759<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on 06/17/2025 at 10:18 AM, MA A said she administered Resident #43's Moxifloxacin in both eyes because she misread the order. MA A said she got caught up in trying to get Resident #43's medications together and forgot to administer Resident #43's Artificial Tears. MA A said when she administered medications she should check the prescription with the computer, ensure it was the right resident, amount, time, and how many times the medication was given. MA A said it was important to administer medications as ordered because something could go wrong with the resident and their health.<br><br>During an interview on 06/18/2025 at 11:15 AM, the DON said the ADON and herself monitored the nurses and medication aides to ensure they were administering medications correctly by conducting the annual check offs and as needed. The DON said if medications were not administered per the doctors' orders the problem or reason the medication was intended for was not going to be resolved.<br><br>During an interview on 06/18/2025 at 11:35 AM, the Administrator said he expected for medications to be administered per the doctors' orders and for there not to be any mistakes. The Administrator said the DON and ADON were responsible for monitoring to ensure medication errors did not occur. The Administrator said medication errors could affect any residents in the facility.<br><br>During an interview on 06/18/2025 at 11:50 AM, the ADON said she helped monitor the nurses and medication aides to ensure they administered medications correctly. The ADON said a couple times a month she randomly observed them when they administered medications to ensure they were doing it correctly. The ADON said MA A had only been a MA for about two weeks. The ADON said she had checked off MA A on medication administration, and she had done fine. The ADON said if the residents did not receive medications per the doctors' orders it could be detrimental to their health because they would not be receiving what they needed.<br><br>Record review of the facility's undated policy titled, Medication Administration and General Guidelines, indicated, Medications are administered as prescribed, In accordance with State Regulations using good nursing principles and practices and only by persons legally authorized to do so .Checklist for completing proper steps in the administration of medications .Adheres to the 6 rights of Medication Administration: 1) Right Dose 2) Right Route 3) Right Resident 4) Right Medication 5) Right Time 6) Right Documentation . |

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|---|---|
| Birchwood Nursing and Rehabilitation | 110 W Hwy 64<br>Cooper, TX 75432 |

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 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide and implement an infection prevention and control program.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment to help prevent the development and transmission of communicable diseases and infections for 1 of 2 residents (Resident #107) reviewed for infection control.<br><br>The facility did not ensure LVN B performed hand hygiene while providing wound care to Resident #107.<br><br>This failure could place residents at risk for cross contamination and the spread of infection.<br><br>Findings included:<br><br>Record review of Resident #107's face sheet, dated 06/18/25, reflected Resident #107 was a [AGE] year-old male, admitted to the facility on [DATE] with a diagnosis which included hypothyroidism (thyroid gland doesn't produce enough thyroid hormone).<br><br>Record review of Resident #107's admission MDS, dated [DATE], reflected Resident #107 made himself understood and understood others. Resident #107's BIMS score was 9, which reflected her cognition was moderately impaired. Resident #107 had an open lesion other than ulcers, rashes, and cuts.<br><br>Record review of Resident #107's comprehensive care plan, revised on 05/13/25 reflected Resident #107 had potential/actual impairment to skin integrity related to lesion on right cheek. The care plan interventions included avoid scratching, keep hands, and body parts from excessive moisture, encourage good nutrition/hydration and keep skin clean and dry.<br><br>Record review of Resident #107's order summary report, dated 06/18/25, reflected an active physician's order to clean wound to right side of face with normal saline (wound cleanser), apply xeroform gauze (wound dressing) and cover with gauze island (wound dressing) with border one time a day and as needed for wound healing with a start date 05/16/25.<br><br>During an interview and observation on 06/17/25 at 8:13 a.m., LVN B applied a set of gloves and gathered wound care supplies from treatment cart. LVN B doff (off) and don (on) new gloves without cleansing her hands or using hand sanitizer. LVN B cleaned the wound with normal saline, doff gloves and don gloves without cleansing her hands or using hand sanitizer. LVN B dried the wound using a gauze, doff and don new gloves without cleansing her hands or using hand sanitizer. LVN B applied a xeroform gauze to the wound and finished up the wound care. LVN B stated she should have performed hand washing between gloves changes. LVN B stated I don't know when asked why she did not perform hand hygiene. LVN B stated it was important to perform hand hygiene between glove changes to prevent the spread of infection.<br><br>During an interview on 06/18/25 at 10:27 a.m., the DON stated she expected LVN B to sanitize her hands between each glove changes. The DON stated she was the Infection Control Preventionist, and she monitored by annual check off and random spot checks. The DON stated if there was an issue noted staff was in-service on the spot. The DON stated she has never had any issues with LVN B providing wound care. The DON stated it was important to perform hand hygiene to prevent the spread of infection.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 675838 | A. Building<br>B. Wing | 06/18/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Birchwood Nursing and Rehabilitation | 110 W Hwy 64<br>Cooper, TX 75432 |

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 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on 06/18/25 at 10:44 a.m., the Administrator stated he expected hand hygiene to be performed between gloves changes. The Administrator stated the DON was responsible for monitoring and overseeing. The Administrator stated it was important to ensure infection control practices were followed to prevent the spread of infection.<br><br>Record review of a licensed nurse proficiency audit dated 01/03/25 reflected LVN B had been checked off on proper handwashing technique.<br><br>Record review of the facility's undated policy titled, 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 . 1. Hand Hygiene . After removing gloves . |