STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675880	A. Building B. Wing	09/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sterling County Nursing Home	309 Fifth St Sterling City, TX 76951

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. (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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that a resident who needs respiratory care was provided such care, consistent with professional standards of practice for 2 (Resident #9 and Resident #12) of 6 residents observed for oxygen management. The facility failed to ensure oxygen in use signage was on Resident #9's and Resident #12's doorway. This failure could place residents at risk of hazards such as explosions which could lead to physical harm.The findings included: Record review of Resident #9's admission record, dated 09/10/2025, indicated she was admitted to the facility on [DATE]. Diagnosis included COPD ((chronic obstructive pulmonary disease) (A group of lung diseases that cause airflow obstruction and breathing problems)). She was [AGE] years of age. Record review of Resident #9's quarterly MDS assessment, dated 06/26/2025, indicated in part: BIMS = 10 indicating the resident was moderately impaired. Section O - Special Treatments, Procedures, and Programs = Oxygen therapy while a resident. Record review of Resident #9's order summary report, dated 09/10/25, indicated Resident #9 had an order for oxygen at 2 lpm (Liters per minute) via nasal cannula effective 04/17/25. Record review of Resident #9's undated care plan indicated in part: Resident is unable to lay flat r/t (related/to) will become SOB. May have oxygen at 2-4L/min (L/min = liters per minute) via nasal cannula PRN oxygen below 90%. Date revised: 07/29/2025. During an observation and interview on 09/10/2025 at 09:48 AM, indicated no oxygen sign posted outside of Resident #9's door. Resident #9 was sitting up in her room on her recliner. The resident was observed wearing a nasal cannula that was connected to the oxygen concentrator. On the back of her wheelchair was an oxygen tank as well. Resident #9 said she had been using oxygen for a long time. Record review of Resident #12's admission record, dated 09/10/2025, indicated he was admitted to the facility on [DATE]. Diagnosis included chronic obstructive pulmonary disease (A group of lung diseases that cause airflow obstruction and breathing problems). He was [AGE] years of age. Review of Resident #12's quarterly MDS assessment, dated 08/25/2025, indicated, in part a BIMS score of 15 indicating the resident was cognitively intact. Record review of Resident #12's order summary report, dated 09/10/25, indicated Resident #12 had an order for oxygen at 2 lpm via nasal cannula effective 04/17/25. Record review of Resident #12's undated care plan indicated in part: Resident is at risk for ineffective breathing pattern and activity intolerance r/t Dx: COPD, CHF, Atrial Fibrillation, and is an active smoker. May have oxygen at 2-4L/min via nasal cannula PRN oxygen level below 90%. Date revised: 08/01/2025. During an observation and interview on 09/10/2025 at 09:58 AM, Resident #12 was observed outside in the smoking area sitting up in his wheelchair. The resident was wheeling himself back into the facility. Resident #12 said he used oxygen when he was in his room and when he went to bed. Observation of Resident #12's door reflected there was no oxygen signage displayed. During an interview on 09/10/2025 at 11:05 AM, LVN C said Resident #12 wore his oxygen whenever he was in his room due to shortness of breath. The LVN said the resident did spend a lot of time sitting outside in the smoking area but when he was in his room, he would use the oxygen. LVN C said Resident #12 wore his oxygen most of the time and also when he went to bed. During an interview on 09/11/2025 at 2:02 PM, the DON said it was expected for oxygen signs be posted outside of resident rooms that were using oxygen. The DON said she was not sure why there were no signs on the 2 rooms as they usually had them posted. She said the signs might have fallen off. The DON said the signs were supposed to be posted for safety of the residents or fires. During an interview on 09/11/2025 at 2:22 PM, the Administrator was made aware of the observation of the resident rooms without oxygen signs posted outside of the doors. The Administrator said it was expected for those resident rooms to have the signs and that they must have forgotten to post them. Record review of the facility undated policy, titled Oxygen administration, indicated in part: Supplies/equipment - appropriate oxygen signs for door and room. Place appropriate oxygen signs per facility policy.

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. (continued on next page)

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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 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, and record reviews, the facility failed to ensure food was prepared in a form designed to meet individual needs for two of five residents (Residents #5 and #11) reviewed for food meeting residents' needs, in that: Resident #5 did not receive a puree diet (a diet consistency of highly blended food) as recommended by the physician.Resident #11 did not receive a puree diet as recommended by the physician. This deficient practice could place residents at risk of choking, poor intake, and/or weight loss. The findings included:Resident #5Record review of Resident #5's admission Record, dated 9/11/25, revealed she was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses including dementia (a neurological disorder affecting memory) dysphagia (difficulty swallowing) and protein-calorie malnutrition (a condition where the body does not absorb protein and may use resident tissue including muscle to replace the depleted nutrient) Review of Resident #5's Quarterly MDS Assessment, dated 9/1/25, revealed a BIMS of 9 of 15 indicating she was moderately cognitively impaired and was on a mechanically altered diet. Review of Resident #5's Care Plan Report, updated 8/12/25, revealed: Problem: Resident #5 was at risk for imbalanced nutritional status related to a diagnosis of dysphagia, Vitamin B-12 deficiency, and hypomagnesemia (low magnesium level). She had diagnoses of protein calorie malnutrition and weight loss may be unavoidable related to terminal diagnosis. The identified goal was Resident #5 would be offered an appropriate substitute if less than half of her meal was consumed or if Resident #5 had a problem with the food that was being served, initiated 8/20/2020. Identified interventions included: Serve diet as ordered: Pureed texture, Resident #5 may have mechanical soft solids at her request, initiated 9/9/25. Review of Resident #5's Care Plan Report, updated 4/23/25, revealed: Problem: Aspiration (choking): Resident #5 was at risk for aspiration related to diagnosis of Dysphagia revised on 4/23/25. Goal: Resident #5 would not aspirate during review period, revised 7/22/25. Identified interventions included: Serve diet as ordered per doctor: Puree. Review of Resident #5's Order Summary Report, dated 9/11/25, revealed orders:Puree texture, regular consistency, Patient may have mechanical soft solids at her request. Start date 9/9/25. Review of the Meal Service Report, dated 9/9/25, revealed Resident #5 had an order for a Pureed diet and resident could have mechanical soft on request. Resident #11Review of Resident #11's admission Record, dated 9/11/25, revealed she was a [AGE] year-old female admitted to the facility on [DATE] with diagnosis including moderate protein-calorie malnutrition, Barrett's Esophagus with Dysplasia (the lining of the lower esophagus resembles the lining of a small intestine developing pre-cancerous changes),and dysphagia. Review of Resident #11's Annual MDS Assessment, dated 8/6/25, revealed:She scored a 3 of 15 on her BIMS (indicating severe cognitive impairment) and was on a mechanically altered diet. Review of Resident #11's Care Plan, revised 7/29/25, revealed:Problem: Resident #11 was at risk for imbalanced nutritional status related to mechanically altered diet and diagnosis of Dysphagia. Resident #11 had a diagnosis of Moderate Protein Calorie Malnutrition. Goal: Resident #11 would maintain adequate nutritional status as evidenced by stable weights. Interventions included: Puree diet, plate guard with meals to help reduce food spillage. Review of Resident #11's Order Summary Report, dated 9/11/25 revealed:Regular diet puree texture. Start dated 7/11/25. Review of the Meal Service Report, dated 9/9/25, revealed Resident #11 had an order for a puree texture. Observation and interview of the noon meal on 09/09/2025 at 11:46 AM, revealed Resident #5 had puree diet that showed the meat portion blended to rice sized pieces and the pasta serving looked like it was chopped up (approximately 1/4 inch pieces) and a piece of regular bread. Interview with LVN E stated the facility was offering Resident #5 both mechanical soft and a puree diet. Interview and observation on 09/09/2025 at 11:57 AM, the Speech Therapist looked at Resident #5's plate. The Speech Therapist stated the puree serving should be a little smother. The Speech therapist stated the chunks of food had a chance of choking Resident #5. The Speech Therapist stated Resident #5 had an order for a mechanical soft diet on request. The Speech Therapist said it was not the safest, but it was Resident #5's choice. The Speech Therapist said she was more worried about Resident #11 choking. The Speech Therapist said she did not know who was responsible for training the dietary staff on how to do the right consistency diet. The Speech Therapist said she fed residents prior to the observation and had not identified an issue with puree diets. Observation on 9/11/25 at 12:00 PM revealed the residents on a puree diet (Resident #5 and#11) did not get the recommended bread serving (the cook failed to follow the menu and provide the recommended calories to the resident) and were served regular (soft) potatoes, including

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	**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 #2) reviewed for infection control, 26 of 26 cans of foam hand sanitizer reviewed for expiration dates and 2 of 2 bottles of gel hand sanitizer reviewed for expiration dates. CNA A failed to change her gloves after they became contaminated during incontinent care while assisting Resident #2. The facility failed to prevent the use of expired alcohol-based hand sanitizer (foam and gel). These failures could place residents at risk for cross contamination and the spread of infection. Findings included: INCONTINENT CARE Record review of Resident #2's electronic admission record dated [DATE] indicated he was admitted to the facility on [DATE] with diagnosis of cerebral palsy (A group of conditions that affect movement and posture). He was [AGE] years of age. Record review of Resident #2's quarterly MDS dated [DATE] indicated in part: Cognitive Skills for Daily Decision Making = 3. Severely impaired - never/rarely made decisions. Bladder and bowel: Urinary continence = Always incontinent. Bowel continence = Always incontinent. Record review of Resident #2's undated care plan indicated in part: Skin/Pressure Ulcer: Resident is at risk for impaired skin integrity/Pressure Ulcer r/t bowel/bladder incontinence. Provide incontinence care for resident after each incontinent episode. Date revised: [DATE]. During an observation on [DATE] at 2:32 PM, CNA A and CNA B performed incontinent care for Resident #2 in his room. Both CNAs entered the resident's room, washed their hands, put on gloves, and put on PPE such as a disposable gown as the resident was on enhanced barrier precautions. CNA A took some wet wipes and wiped Resident #2's penis and scrotum area. Both CNAs turned the resident on his side and CNA A wiped the resident's rectal area with some wet wipes. While still wearing the same gloves CNA A opened the bed side dresser and took a packet of skin protectant cream and applied it to the resident's buttocks and rectal area. While still wearing the same gloves CNA A took the new brief and fastened it to Resident #2 and helped reposition him in bed. During an interview on [DATE] at 2:44 PM, CNA A said she had thought about changing her gloves once they became contaminated but had not done it as she had gotten nervous. CNA A said not changing her gloves could lead to the spread of infections. CNA A said with her not changing her gloves she possibly contaminated the clean items. CNA A said the failure occurred because she had gotten nervous as the surveyor was watching her perform the care. During an interview on [DATE] at 2:00 PM, the DON was made aware of the observation of the incontinent care performed by CNA A. The DON said it was expected for staff to remove their gloves once they became contaminated and sanitize or wash their hands before putting on a new pair of gloves. The DON said if the staff did not change their gloves once they became contaminated then they could cross contaminate, spread germs and possibly infect all the areas they had touched. During an interview on [DATE] at 2:20 PM, the Administrator was made aware of the observation of the incontinent care performed by CNA A. The Administrator said it was expected for the CNAs to change their gloves once they became contaminated to prevent cross contamination. Record review of the facility's undated policy titled Personal protective equipment - using gloves indicated in part: Purpose - to guide the use of gloves. To prevent the spread of infection, to protect wounds from contamination. When gloves are indicated use disposable gloves single-use gloves. Wash hands after removing gloves, gloves do not replace handwashing. Record review of the facility's undated policy titled Handwashing/hand hygiene a indicated in part: Basic responsibility - To thoroughly cleanse the hands with friction, soap and water. General instructions - wash hands - Before and after resident contact (i.e., meds, treatments, cares). Record review of the facility's undated policy titled Incontinence care: Steps for procedure - perform hand hygiene. Put on gloves. Wash all soiled skin areas washing from front to back, rinse and drywell, especially between skin folds. Remove gloves, perform hand hygiene, Use lightweight plastic protector or incontinence pad as necessary. Replace top linen and position resident comfortably with call light within reach. Record review of the facility's undated policy titled Infection prevention and control guideline indicated in part: Always observe standard precautions or other infection control standards as approved by the appropriate facility committee. Medical director or procedure. Always wash your hands before and after procedures. Follow your facility's hand hygiene protocol. Use alcohol-based hand rub (ABHR) for hand hygiene except when hands are visibly soiled. Follow your facility's hand hygiene protocols. Always wear gloves when working with or expecting to encounter body fluids

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Keep all essential equipment working safely. Based on observation and interview, the facility failed to maintain all mechanical, electrical, and patient care equipment in safe operating condition for 1 of 1 kitchen reviewed for physical environment. The facility failed to ensure the dishwasher met manufacturer's recommendation of 120 degrees Fahrenheit for the wash and sanitize cycle. This failure could place residents at risk of foodborne illnesses and residents and staff. Findings included: Observation and interview on 9/10/25 at 1:38 p.m. revealed DA H said the dish machine was supposed to get up to 120 degrees. DA H ran the machine three times, and the wash temperature got to 100 degrees, the sanitizer level reached 114 degrees. After reading the posted machine instructions DA H stated he needed to report the dish machine not reaching temperature to the Dietary Manager. Observation on 9/10/25 at 1:51 p.m. revealed Dietary Manager verified the machine was not reaching the correct temperature, took a picture of the dial and sent it to the Maintenance Director. Interview on 09/11/2025 at 2:41 PM, DA H stated the dish machine was brand new and he thought they turned down the water temperature because it had not worked correctly since the weekend. DA H said he did not tell anyone because he did not realize it needed to be reported. Interview on 09/11/2025 at 2:51 PM, the Administrator said the dish machine was just changed out. The Administrator said the thought maintenance lowered the temperature to raise the sanitization level. He said he did not know, he was not there. Surveyor requested the policy on dish sanitization if there was one. There was no policy provided. Review of the Dish Machine Logbook for September 2025 (9/1/25 - 9/10/25) revealed: AM Wash Temp AM Final Rinse9/1/25 95 degrees 114 degrees9/2/25 110 degrees 122 degrees 9/3/25 110 degrees 120 degrees 9/4/25 112 degrees 123 degrees 9/5/25 114 degrees 123 degrees9/6/24 115 degrees 120 degrees9/7/25 116 degrees 120 degrees9/8/25 115 degrees 120 degrees9/9/25 116 degrees 120 degrees9/10/25 112 degrees 121 degrees Noon Wash Temp Noon Final Rinse Temp 9/1/25 100 degrees 123 degrees9/2/25 105 degrees 121 degrees9/3/25 110 degrees 120 degrees9/4/25 106 degrees 120 degrees9/5/25 110 degrees 120 degrees9/6/25 110 degrees 121 degrees9/7/25 111 degrees 120 degrees9/8/25 116 degrees 120 degrees9/9/25 115 degrees 120 degrees 9/10/25 114 degrees 119 degrees PM Wash Temp PM Final Rinse Temp9/1/25 105 degrees 125 degrees9/2/25 110 degrees 122 degrees9/3/25 110 degrees 120 degrees9/4/25 111 degrees 120 degrees9/5/25 115 degrees 122 degrees9/6/25 114 degrees 120 degrees9/7/25 115 degrees 122 degrees9/8/25 114 degrees 120 degrees9/9/25 116 degrees 120 degrees Review of the posted General Operating Instructions, undated, by the manufacturer revealed:It is recommended that 140 degrees water be used. Report to your supervisor if it is lower than 120 degrees or higher than 160 degrees.