

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675884	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/26/2024
NAME OF PROVIDER OR SUPPLIER Teague Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 884 Hwy 84 W Teague, TX 75860	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45070</p> <p>Based on observations, interviews, and record review, the facility failed to maintain an infection prevention and control program designated to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infection for 4 (Resident #24, Resident #14, Resident #11, and Resident #86) of 8 residents reviewed for infection control.</p> <p>CNA C and CNA D failed to wash their hands and change their gloves when removing a soiled brief and placing a clean brief during peri care observation for Resident #11.</p> <p>LVN A placed soiled linens and dressing on the Resident #86's floor during wound care.</p> <p>CNA B and LVN A failed to change their gloves or cleanse their hands when removing a dirty brief and placing a clean brief on Resident #86.</p> <p>MA E failed to sanitize blood pressure monitor before, in between and after use on Resident #24 and Resident #14.</p> <p>These failures could place residents at-risk of cross contamination which could result in infections or illness.</p> <p>Findings included:</p> <p>Resident #11</p> <p>Record review of Resident #11's undated face sheet reflected she was a [AGE] year-old female, admitted to the facility on [DATE]. Her diagnoses included cerebral infarction (Stroke a disruption of the blood flow to the brain causing part of the brain to die), dementia (a chronic condition causing a decline in cognitive functioning such as thinking, remembering, and reasoning), and anxiety disorder.</p> <p>Record review of Resident #11's care plan dated 11/02/2022 reflected she had an ADL Self Care Performance (Bed Mobility, Transfers, Eating, Bathing, Dressing, and Personal Hygiene) Deficit. Her goals included: Resident #11 will maintain current level of function in ADL's, through the next review date. Interventions included The resident requires assistance (wash hands, adjust clothing, clean self, transfer onto toilet, transfer off toilet) to use toilet.</p> <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Record review of Resident #11's Quarterly MDS assessment, dated 09/12/2024, reflected she had a BIMS score of 10, which indicated moderate cognitive impairment. Resident #11 was coded always incontinent of bowel and bladder and as dependent for toileting and toileting hygiene indication the helper or CNA does all the effort to complete the activity.</p> <p>In a peri care observation on 11/25/24 at 2:30 PM CNA C and CNA D did not change their gloves or wash their hands when removing a dirty brief and applying a clean brief.</p> <p>In an interview on 11/25/24 at 2:58 PM CNA C and CNA D stated they had been trained on infection control and peri care. They stated the nurses visually check CNA's off on peri care annually with skills training. They just stated they forgot to wash their hands. They stated not changing gloves or washing hands when working from a dirty to clean surface or area could spread germs and bacteria.</p> <p>Resident #86</p> <p>Record review of Resident #86's undated face sheet reflected she was a [AGE] year-old female, originally admitted to the facility on [DATE] and readmitted on [DATE]. Her diagnoses included Pneumonia, Respiratory Failure, Acute Kidney Failure, and Gastro-esophageal reflux (indigestion).</p> <p>Record review of Resident #86's care plan dated 10/19/2023 and revised on 03/07/24 reflected she had a history of urinary tract infections. Interventions included Resident/family/caregiver teaching should include good hygiene practices: Females to wipe and cleanse from front to back, clean peri area well after bowel movement in</p> <p>order to help prevent bacteria in urinary tract.</p> <p>Record review of Resident #86's Admission MDS assessment, dated 11/17/2024, reflected staff assessment of her mental status indicated short term and long-term memory problems. The MDS indicated Resident #86 was able to recall her own room and names of staff. Resident #86 was Substantial/maximal assistance staff assistance with eating, personal hygiene, toileting, and showering. Section H of the MDS Bowel and Bladder indicated resident #86 was always incontinent of bowel and bladder.</p> <p>Record review of Resident #86's Physician Orders Summary Report dated 11/26/24 reflected an order for care to surgical incision to left gluteal fold (left buttocks) that read cleans with wound cleanser and gauze, pat dry with gauze, pack wound with iodoform packing strip (a gauze strip soaked in iodine) and apply dry dressing to wound daily.</p> <p>In a wound care and peri care observation on 11/25/24 at 11:38 AM for Resident #86 LVN A and CNA B removed the soiled brief and linens and place them unbagged on the floor in the room. CNA B cleansed Resident #86 from front to back and placed a new clean brief under resident without washing her hands or changing her gloves. LVN A then removed a soiled dressing from Resident #86's left buttocks and placed the soiled dressing in the pile with the soiled linens and soiled brief on the resident's floor. LVN A then changed her gloves and applied a clean pair. LVN A did not wash her hands or use alcohol-based hand sanitizer between glove changes. LVN A packed wound to left buttocks and applied a clean dressing.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>In an interview on 11/25/24 at 12:00 PM CNA B stated staff do normally use alcohol-based hand sanitizer in between glove changes. She stated they were trained on infection control often. CNA B stated the risk for the resident for not cleansing hands and using clean gloves would be passing germs from one to the other. She stated normally staff keep trash bags available at bedside and put soiled linens in the trash bag. Soiled briefs were placed in the trash can and staff change the liner out when removed. CNA B stated it was not practice putting soiled linens or briefs on the floor. She stated the risk for residents for not cleansing hands and placing soiled linens on the floor would be spreading germs.</p> <p>In an interview on 11/25/24 at 12:10 PM LVN A stated she does not normally perform peri care on residents. I'm not aware of what the policy says about glove changes between dirty and clean surfaces.</p> <p>LVN A stated yes she normally throws soiled linens on the floor if the dirty has been folded up inside. She stated the housekeepers come in and mops the floor. LVN A stated she had thrown soiled wound dressings on the floor if the dirt is on the inside. She stated risk to the residents for not cleaning hands and placing soiled linens on the floor would be spreading germs.</p> <p>Resident #24</p> <p>Record review of Resident #24's face sheet dated 11/26/24 revealed an [AGE] year-old female who was admitted to the facility on [DATE]. Her diagnoses were, Type 2 diabetes, Edema (swelling), Adjustment disorder with mixed anxiety and depressed, Pain in right hip, Chronic obstructive pulmonary disease (difficulty to breath) , Muscle weakness and Lack of coordination,</p> <p>Record review of Resident #24's care plan dated 10/11/24 reflected Resident #24 had hypertension and relevant intervention was giving anti-hypertensive medications as ordered and monitoring side effects such as orthostatic hypotension and increased heart rate.</p> <p>Record review of Resident #24's quarterly MDS assessment, dated 09/17/24 revealed a BIMS score of 14 indicating her cognition was intact.</p> <p>Resident #14</p> <p>Record review of Resident #14's face sheet dated 11/26/24 revealed a [AGE] year-old female who was admitted to the facility on [DATE]. Her diagnoses were Cognitive communication deficit, Anemia, Unsteadiness on feet, Difficulty in walking, Lack of coordination, Type 2 diabetes, Hypertension and Muscle weakness.</p> <p>Record review of Resident #14's care plan dated 09/11/24 reflected, she had hypertension and relevant intervention was giving anti-hypertensive medications as ordered and monitoring side effects such as orthostatic hypotension and increased heart rate and effectiveness.</p> <p>Record review of Resident #14's quarterly MDS assessment, dated 09/06/24 revealed a BIMS score of 01 indicating her cognition was severely impaired.</p> <p>(continued on next page)</p>		

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