

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675902	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/02/2024
NAME OF PROVIDER OR SUPPLIER Pilot Point Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 208 N Prairie St Pilot Point, TX 76258	

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 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47743</p> <p>Based on observations, interviews, and record review, the facility failed to ensure that residents, who needed respiratory care, was provided such care consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences for two (Resident #5 and Resident #9) of two residents reviewed for respiratory care.</p> <p>The facility failed to ensure Resident #5's nasal cannula was changed weekly as per order.</p> <p>The facility failed to ensure Resident #9's nebulizer was changed weekly as per order.</p> <p>These failures could place the residents at risk for respiratory infection and not having their respiratory needs met.</p> <p>Findings included:</p> <p>Resident #5</p> <p>Review of Resident #5's Face Sheet dated 05/02/2024 reflected that resident was a [AGE] year-old female admitted on [DATE]. Relevant diagnoses included chronic obstructive pulmonary disease (COPD (a chronic inflammatory lung disease that causes obstructed airflow from the lungs) and dyspnea (a lung disease that damages the air sacs in the lung causing shortness of breath).</p> <p>Review of Resident #5's Quarterly MDS assessment dated [DATE] reflected resident had a moderate impairment in cognition with a BIMS score of 09. The Comprehensive MDS Assessment also indicated Resident #5's primary medical condition was chronic obstructive pulmonary disease.</p> <p>Review of Resident 5's Comprehensive Care Plan dated 04/05/2024 reflected resident experienced wheezing and coughing and interventions were oxygen at 2 to 5 liters per minute and change oxygen tubing every week.</p> <p>Review of Resident 5's Physician Order on dated 08/25/2022 reflected O2 via nasal cannula. May titrate between 2-5 LPM as needed every shift for shortness of breath and to keep PAO2 > 90%. as needed related to DYSPNEA, UNSPECIFIED. Every shift as needed.</p> <p>Review of Resident 5's Physician Order on dated 08/25/2022 reflected Change oxygen and nebulizer tubing q week on Sunday.</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 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Observation and interview with Resident #5 on 04/30/2024 at 10:09 AM, revealed Resident #5 was on her bed awake. Resident #5 was on oxygen at 3 liters per minute via nasal cannula. The nasal cannula was connected to an oxygen concentrator. Resident #5 said she was on oxygen because she had respiratory issues. She said she was not aware if the nurses were changing her nasal cannula.</p> <p>Resident #9</p> <p>Review of Resident #9's Face Sheet dated 05/02/2024 reflected that resident was a [AGE] year-old female admitted on [DATE]. Relevant diagnoses included chronic obstructive pulmonary disease and acute respiratory failure with hypoxia (insufficient amount of oxygen in the body).</p> <p>Review of Resident #9's Quarterly MDS assessment dated [DATE] reflected that Resident #9 was cognitively intact with a BIMS score of 14. The Quarterly MDS also indicated that the resident had COPD and respiratory failure.</p> <p>Review of Resident #9's Comprehensive Care Plan dated 02/09/2024 reflected resident</p> <p>was at risk of respiratory infection/distress, hypoxia, SOB, and cough related to diagnosis of COPD and one of the interventions was to administer oxygen as ordered.</p> <p>Review of Resident #9's Physician Order dated 06/03/2022 reflected, O2 via nasal cannula every shift PRN. May titrate between 2-5 LPM for shortness of breath and to keep pulse oximetry > 90%. as needed for SOB and to maintain pulse oximetry > 90% every shift as needed.</p> <p>Review of Resident #9's Physician Order dated 06/03/2022 reflected, Change oxygen concentrator humidification bottle weekly or more frequently if needed. Every night shift every Sun.</p> <p>Observation on 04/30/2024 at 10:59 AM, revealed Resident #9 was on her recliner sleeping. It was noted that Resident #9 had an oxygen concentrator behind her recliner. The concentrator had a humidifier with water in it. The humidifier bottle was dated 02/24/24.</p> <p>In an interview with Resident #9 on 04/30/2024 at 1:43 PM, Resident #9 stated only used her oxygen when she needed it. She said she was not sure when was the last time she had it on.</p> <p>Observation and interview with the ADON on 04/30/2024 at 02:05 PM, the ADON confirmed that Resident #9's humidifier bottle was dated 02/24/24. She also acknowledged the humidifier had water in it. The ADON said the humidifier bottle was supposed to be changed weekly. The ADON disconnected the humidifier as well as the nasal cannula connected to it and said she would change everything. The ADON then went to Resident #5's room and checked if the tubing of the nasal cannula was dated. The ADON found the date at the end of the tube connected to the oxygen concentrator. She said Resident #5's nasal cannula was dated 04/12/2024. She said she would also change the nasal cannula for Resident #5. She said the purpose of changing the humidifier and nasal cannula was to prevent infection and not to compromise the resident's breathing pattern. She said the expectation was for the staff to change the humidifier weekly and to put a date on it.</p> <p>(continued on next page)</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview with RN A on 05/01/2024 at 11:44 AM, RN A stated the humidifiers and nasal cannulas should be changed every week to prevent infection and worsening of. She said if the humidifier and the nasal cannula were not changed as ordered, the respiratory system of the resident would be compromised more. She said the order for both was to change them every Sunday.</p> <p>In an interview with the Administrator on 05/02/24 at 07:52 AM, the Administrator stated she was made aware by the ADON regarding the humidifier and the nasal cannula not being changed. She said as per order, the humidifier and the nasal cannula should be changed every week. She said if the resident was not always using the oxygen, the staff should still change the humidifier weekly and not leave with standing water for more than two months. The Administrator continued that there would be a possibility that microorganism and algae could grow and could compromise the lungs of the residents. She said the expectation was for the staff to change the humidifier and the nasal cannula weekly. She said on top of checking if the nasal cannula and the breathing masks were bagged, they would also include checking if they were changed accordingly by checking the date. She concluded that they already did an in-services about changing the tubing and humidifier.</p> <p>In an interview with the DON on 05/02/24 at 08:25 AM, the DON stated the humidifier and the nasal cannula should be changed weekly because bacterial growth could occur that could eventually cause contamination and infection. She added the order specified to change them Sunday night. She added that all the staff were equally responsible in checking if the humidifier and the nasal cannula were changed. She said the expectation was for the staff to change them weekly. She said they already did an in-service about changing the humidifier and nasal cannula on a weekly basis. She concluded that they would also check every day, especially on Mondays, if the nasal cannula and the humidifier were changed and dated.</p> <p>Record review of facility's policy, Oxygen Administration implemented 03/2022 revealed Policy: Oxygen is administered to residents who need it, consistent with professional standards of practice . Policy Explanation and Compliance Guidelines: . Other infection control measures include: . b. Change oxygen tubing and mask/cannula . c. Change humidifier bottle .</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42824</p> <p>Based 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 and to help prevent the development and transmission of communicable diseases and infections for 2 (Resident #4 and Resident #38) of 6 residents observed for infection control.</p> <ol style="list-style-type: none"> The facility failed to ensure that LVN B changed his gloves and performed hand hygiene while providing colostomy care to Resident #4. The facility failed to ensure CNA C and CNA D sanitized the mechanical lift either before or after use with Resident #38 <p>These failures could place the residents at risk of cross-contamination and the development of infection.</p> <p>Findings included:</p> <p>Resident #4:</p> <p>Review of Resident #4's recent change of condition/re-admission Minimum Data Set (MDS) assessment, dated 04/11/2024, revealed she was a [AGE] year-old female readmitted to the facility on [DATE]. She was assessed as severely cognitively impaired via the Brief Interview of Mental Status (BIMS) score of 06. Resident #4 was assessed as dependent upon staff on self-care, toileting, and needed substantial/maximal assistance for showering/bathing. She was incontinent of bladder and had an ostomy for her bowel elimination. Her active diagnoses included cancer, coronary artery disease (blood vessels to the heart are narrowed), heart failure (progressive heart disease that affects the pumping action of the heart muscle), diabetes (group of diseases that affects how the body uses blood sugar), respiratory failure (lung condition resulting in lack of oxygen and too much carbon dioxide in the body), and dementia (group of symptoms that affects memory, thinking, and social abilities),</p> <p>Review of Resident #4's Comprehensive Care Plan, dated 04/04/2024, revealed Resident #4 had an Activities of Daily Living (ADL) self-care deficit related to dementia and required extensive assistance with all or most ADLs. Resident #4 required the use of a colostomy and was at risk for infection and excoriation with interventions that included to change wafer/colostomy bag as ordered, and colostomy care per day and as needed. Additionally, the facility had identified Resident #4 as having a Multi-Drug resistant organism (MDRO) related to colostomy and that staff must use Enhanced Barrier Precautions (EBP) by the use of gown and gloves during high-contact resident care activities that could possibly result in transfer of MDROs to hands and clothing of staff.</p> <p>Review of Resident #4's physician orders revealed:</p> <p>Change colostomy bag . and as needed with a start date of 02/08/2024.</p> <p>Colostomy care every shift and as needed with a start date of 02/08/2024.</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 - Few</p>	<p>EPB: Staff must use gown and gloves during high-contact resident care activities that could possibly result in transfer of MDROs to hands and clothing of staff . with a start date of 04/17/2024.</p> <p>In observation on 04/30/2024 at 10:08 AM, LVN B provided colostomy care to Resident #4. LVN P entered room, performed hand hygiene, and donned a gown and pair of clean gloves. LVN P removed Resident #4's current soiled colostomy bag, and cleaned around the stoma site and applied a cream to the skin around the stoma site. LVN P then removed his gloves and donned a new pair of clean gloves. LVN P then applied a new colostomy bag to Resident #4's abdomen. LVN P failed to perform hand hygiene between glove changes and going from a dirty to a clean area. LVN P then doffed his gown and gloves, performed hand hygiene in Resident #4's sink, and exited the room.</p> <p>In interview with LVN P on 04/30/2024 at 10:24 AM, he stated he removed his gloves and donned new gloves after removing Resident #4's colostomy bag and cleaning her stoma site. He stated he did not perform hand hygiene but did not state why. He stated it was important to perform hand hygiene between glove changes and when moving from a contaminated to clean area to avoid any infection to spread.</p> <p>In interview with the DON on 05/02/2024 at 10:33 AM, she stated her expectations would be for staff to perform hand hygiene between glove changes because it was basic infection control .</p> <p>In interview with the Administrator on 05/02/2024 at 10:48 AM, she stated her expectations would be for staff to perform hand hygiene between glove changes for infection control purposes.</p> <p>In interview with the Administrator and DON on 05/02/2024 at 12:00 PM, they revised their earlier statements by stating that Resident #4's colostomy bag change was a clean procedure and not a sterile procedure and they did not expect LVN P to change gloves nor perform hand hygiene after Resident #4's colostomy bag was removed and prior to the new bag being applied. DON stated the facility's skills checkoff, Validation Checklist Ostomy Care, did not state to perform a glove change and/or hand hygiene at this time in the procedure.</p> <p>Review of facility skills check off document, Validation Checklist Ostomy Care, dated 2023, revealed no evidence that staff should complete glove changes and/or hand hygiene between removal and cleaning of the stoma and stoma bag and the application of the new bag. The document stated: 6. Perform hand hygiene and don appropriate personal protective equipment. 7. Empty pouch. 8. Remove pouch. 9. Clean skin around stoma . Steps 10-16 state to clean around the stoma, to measure and size the stoma appropriately, and to apply the new bag to resident's stoma site. 17. Discard items appropriately. Remove gloves and wash hands.</p> <p>Review of facility reference material, How to Change Your Ostomy Pouch, dated 02/13/2018 revealed no specific directive to change gloves and/or perform hand hygiene going from cleaning the stoma and then the application of the new colostomy bag.</p> <p>Resident #38</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 - Few</p>	<p>Review of Resident #38's Admission MDS, dated [DATE], revealed she was a [AGE] year-old female admitted to the facility on [DATE]. She was assessed as severely cognitively impaired via BIMS score of 06. Resident #38 was assessed as needing some help with self-care, and dependent upon staff for toileting and showering/bathing. She was incontinent of bowel and bladder. Her active diagnoses included diabetes (group of diseases that affects how the body uses blood sugar) and cerebrovascular accident (CVA) (medical term for stroke, where blood flow is blocked.)</p> <p>Review of Resident #38's Comprehensive Care Plan, dated 04/10/2024, revealed Resident #38 had impaired physical mobility related to CVA effects, right side. Resident #38 prefers to be transferred with hooyer lift. Additionally, the facility identified Resident #38 needing EBP, and stated Staff must use gown and gloves during high-contact resident care activities that could possibly result in transfer of MDRO's to hands and clothing of staff.</p> <p>Review of Resident #38's physician orders revealed:</p> <p>EPB: Staff must use gown and gloves during high-contact resident care activities that could possibly result in transfer of MDROs to hands and clothing of staff. with a start date of 04/17/2024.</p> <p>In an observation of CNA C and CNA D on 04/30/2024 between 10:29 AM and 10:37 AM, they transferred Resident #38 from bed to her wheelchair using a mechanical lift LVN C obtained the mechanical lift from the hallway and entered Resident #38's room. CNA C and CNA D then performed hand hygiene, donned appropriate personal protective equipment for EPB precautions, and safely performed the transfer of Resident #38. On 04/30/2024 at 10:36 AM, CNA D exited the resident's room with the mechanical lift and plugged in the mechanical lift's electrical cord into the wall located in the hallway between rooms [ROOM NUMBERS]. Both CNA C and CNA D were observed exiting the hallway to other areas of the facility at 04/30/2024 at 10:37 AM. CNA C failed to sanitize the mechanical lift prior to resident use. CNA D failed to sanitize the mechanical lift after resident use.</p> <p>In interview with CNA C on 04/30/2024 at 10:41 AM, she stated she did not sanitize the mechanical lift prior to use with Resident #38 because she wasn't thinking about it. She stated it was important to sanitize shared use equipment for infection control purposes.</p> <p>In interview with CNA D on 04/30/2024 at 10:49 AM, she stated she did not sanitize the mechanical lift after use with Resident #38 because she forgot and was not thinking about it. She stated it was important to sanitize shared use equipment to prevent the spread of germs.</p> <p>In interview with ADON on 05/02/2024 at 10:25 AM, stated she expected any shared use equipment to be sanitized either before and/or after use with residents. She stated the mechanical lift should have been sanitized by CNA C prior to use with Resident #38, and CNA D should have sanitized the equipment after use with Resident #38. She stated this was important for infection control purposes as it prevented the spread of bacteria.</p> <p>In interview with the DON on 05/02/2024 at 10:33 AM, she stated shared use equipment should be sanitized between resident use to prevent the spread of disease.</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 - Few</p>	<p>Record review of facility policy, Infection Prevention and Control, dated 2023, revealed 10. Equipment Protocol: a. All reusable items and equipment requiring special cleaning, disinfection, or sterilization shall be cleaned in accordance with our current procedures governing the cleaning and sterilization of soiled or contaminated equipment.</p> <p>Review of facility policy Cleaning and Disinfection of Resident-Care Equipment, dated 2023 revealed Resident-care equipment can be a source of indirect transmission of pathogens. Reusable resident-care equipment will be cleaned and disinfected in accordance with current CDC recommendations in order to break the chain of infection . 3. Staff shall follow established infection control principles for cleaning and disinfecting reusable, non-critical equipment . b. Each user is responsible for routine cleaning and disinfection of multi-resident items after each use, particularly before use for another resident.</p>