

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675948	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/03/2024
NAME OF PROVIDER OR SUPPLIER Park Place Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 810 E 13th Ave Belton, TX 76513	

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 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44317</p> <p>Based on observation, interview, and record review, the facility failed to 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 for one of five residents (Resident #2) reviewed for dignity.</p> <p>The facility failed to ensure Resident #2's catheter bag was covered while he was in a communal area on 07/03/24.</p> <p>This failure placed residents at risk of embarrassment and diminished quality of life.</p> <p>Findings included:</p> <p>Review of Resident #2's quarterly MDS assessment, dated 04/16/24, Section A (Identification Information) reflected a [AGE] year-old male originally admitted to the facility 02/15/24 and re admitted on [DATE]. Section I (Active Diagnoses) reflected diagnoses including hypertension, obstructive uropathy, hyperlipidemia (abnormally high level of fats in the blood), seizure disorder, depression, and neoplasm of left kidney (cancer in the kidney). Section C (Cognitive Patterns) reflected a BIMS score of 12 indicating moderately impaired cognition. Section H (Bladder and Bowel) reflected a urinary catheter. Section GG (Functional Abilities) reflected the resident required substantial/maximal assistance with toileting hygiene.</p> <p>Review of Resident #2's comprehensive care plan, revised on 06/24/24, reflected the resident had an indwelling catheter (a tube inserted into the bladder to drain urine from the bladder to a collection bag) related to urinary retention with goals the catheter remained patent (properly working) and the resident have no injuries or complications related to the catheter. Interventions included assessing and maintaining the catheter.</p> <p>Review of Resident #2's order summary report reflected a physician's order dated 07/02/24, Change foley catheter monthly on the 15th and PRN occlusion/leaking. May flush with 30-60cc saline PRN occlusion. 18Fr and 10cc (18Fr refers to the size of the catheter and the 10cc refers to the size of the balloon that holds the catheter in place).</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 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an observation and interview on 07/03/24 at 9:20 AM, revealed Resident #2 sitting in his wheelchair in the doorway of the sunroom. He had a catheter bag hanging towards the back of the wheelchair. The bag and the tubing contained yellow fluid. There was no privacy bag in place. There were two other residents in the sunroom behind him. Resident #2 requested assistance with the tubing to his catheter. He stated he was afraid he was going to step on it when moving his wheelchair and he did not want to pull on it. He stated the catheter was usually in a blue bag and then the tubing was not a problem. He stated he was kind of embarrassed about the whole thing.</p> <p>An observation of 07/03/24 at 9:31 AM revealed LVN C in the hallway talking with Resident #2. She walked away then returned to the resident and applied a privacy cover to his catheter bag. There were three other residents in the hallway.</p> <p>During an interview on 07/03/24 at 2:22 PM, the DON stated residents should have a privacy bag over their catheter bag, any time you can see the bag. She stated if the resident was in bed and the bag was visible from the hall, the privacy bag should have been in place. She stated that during morning rounds, they monitored for privacy bags. She stated Resident #2 usually used a leg bag when he was up in the daytime. She stated he sometimes requested a privacy bag when he did not have one. She stated it did not meet her expectations that the resident was in a common area without a privacy bag. She stated it could be a dignity issue for the resident if not covered.</p> <p>During an interview on 07/03/24 at 2:33 PM, LVN C stated catheters were assessed for output, leaking, securing strap, and privacy bag at least every shift. She stated privacy bags were used any time the resident was out of bed. She stated if the privacy bag was not in place, it could have been humiliating for the resident. LVN C stated Resident #2 had just returned from the hospital so maybe the old privacy bag had been misplaced.</p> <p>Review of the facility's policies, Catheter Care, Indwelling Catheter and Catheter (Indwelling), Insertion and Removal of (Female and Male), both undated, did not address the use of a privacy bag.</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** 44317</p> <p>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 one (Resident #1) of five residents reviewed for infection control practices.</p> <p>CNA A failed to perform proper hand hygiene and glove changes while providing incontinence care to Resident #1 on 07/03/24.</p> <p>This failure could place residents at risk for the spread of infection.</p> <p>Findings included:</p> <p>Review of Resident #1's quarterly MDS assessment, dated 06/16/23, Section A (Identification Information) reflected a [AGE] year-old female originally admitted to the facility 03/11/21 and readmitted on [DATE]. Section I (Active Diagnoses) reflected diagnoses including orthostatic hypotension (low blood pressure when you stand up from sitting or lying down), renal insufficiency (impaired kidney function), hyperlipidemia (abnormally high level of fats in the blood), dementia, depression, dysphagia (difficulty swallowing), and lack of coordination. Section C (Cognitive Patterns) reflected a BIMS score of 3 indicating severely impaired cognition. Section H (Bladder and Bowel) reflected resident was always incontinent of bladder and frequently incontinent of bowel. Section GG (Functional Abilities) reflected resident required partial to moderate assistance with toileting hygiene.</p> <p>Review of Resident #1's comprehensive care plan, revised 06/23/24, reflected resident was incontinent of bowel and bladder and she required assistance with toileting.</p> <p>An observation of incontinence care for Resident #1 on 07/03/24 at 10:52 AM revealed CNA B washed her hands and donned a pair of gloves she pulled out of her pocket before commencing care. CNA A washed her hands then donned clean gloves. Both CNAs unfastened the soiled brief then CNA A removed two disposable wipes from the package. She folded the wipes in half then wiped the right leg crease, she folded the wipes again and wiped the left leg crease. She folded the wipes again, spread the labia and wiped front to back. CNA A told the resident she wanted to apply some cream to the reddened peri-area. She doffed her gloves and without hand hygiene, opened drawers and moved objects looking for cream. She checked the bathroom then left the room to get cream. She returned to the room and donned clean gloves. Both CNAs reposition the resident on her side. CNA A repositioned the dirty brief, moved the clean brief on the bed, then removed a disposable wipe from the package. CNA A wiped one area of the buttocks, folded the wipe, wiped another area of the buttock, folded the wipe again and cleaned the center crease. Without changing gloves, she placed the clean brief under the resident and used her gloved hand to apply cream to the resident's buttocks. CNA A removed the one glove covered with cream, and without hand hygiene, donned a clean glove. Both CNAs completed the application of the new brief. CNA A doffed her gloves and without hand hygiene, donned new gloves. The CNAs repositioned the resident and gathered the trash.</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>During an interview on 07/03/24 at 11:04 AM, CNA A stated she had multiple in-services and trainings regarding Infection control. She stated recently there was one about handwashing. She stated you had to wash your hands for at least 20 seconds. She stated she had not been trained to use a disposable wipe only once and thought it was acceptable to have folded the wipe and used it again. CNA A stated she did not think it was necessary to perform hand hygiene with every glove change. She stated not performing proper hand hygiene could spread infection.</p> <p>During an interview on 07/03/24 at 11:10 AM, CNA B stated she usually kept gloves in her pocket just in case she was in a room and needed gloves. She stated the gloves were stored on the linen carts and those were not always nearby. When asked if it was acceptable to keep gloves in her pocket she said, It's okay isn't it?</p> <p>During an interview on 07/03/24 at 11:22 AM, CNA B stated, keeping gloves in the pocket could have been an infection control problem.</p> <p>During an interview on 07/03/24 at 2:08 PM, the ADM stated she expected staff to follow the policy about hand washing and infection control in general. She stated the Infection Control Preventionist/DON were responsible for training and monitoring infection control practices.</p> <p>During an interview on 07/03/24 at 2:22 PM, the DON stated it did not meet her expectations that hand hygiene was not completed properly and that gloves were kept in pockets. She stated she, the ADON and the scheduler were responsible for training. She stated they had recently done hand hygiene check offs with nursing staff. The DON stated she, the ADON, and MDS nurse were responsible to monitor training and infection control.</p> <p>During an interview on 07/02/14 at 2:33 PM, LVN C stated hand hygiene was performed before and after everything. She stated, you do hand hygiene before you touch a resident, after you touch a resident, before you put on gloves, after you take off the gloves. She stated either you washed your hands or used hand sanitizer. She stated not performing hand hygiene could spread bacteria. She stated she had recent training on infection control and had been observed providing peri-care and catheter care.</p> <p>Review of the facility in-service records reflected training on urinary and fecal incontinence on 03/28/24.</p> <p>Review of the facility skills checks on Washing hands (hand hygiene) reflected training for 56 staff including CNA A.</p> <p>Review of the facility's undated Hand Washing policy reflected in part, Purpose: Hand washing will be regarded by this facility as the single most important means of preventing the spread of infections. Procedure: 1. All personnel will follow the facility's established handwashing procedures to prevent the spread of infection and disease to other personnel, residents, and visitors. 2. Hands should be washed twenty (20) seconds under the following conditions e. Before handling clean or soiled dressings, gauze pads, etc. h. After contact with blood, body fluids, excretions, secretions, mucous membranes, or nonintact skin i. After handling items potentially contaminated with blood, body fluids, excretions, or secretions k. After removing gloves .</p>		