STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675962	A. Building B. Wing	11/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Southland Rehabilitation and Healthcare Center	501 N Medford Dr Lufkin, TX 75901

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40124 Based on observations, interviews, and record review, the facility failed to ensure the residents environment remained as free of accident hazards as possible for 4 of 24 residents reviewed for quality of care. (Residents #20, #26, #31, and #47). The facility failed to remove worn and damaged mechanical lift slings from service. This deficient practice could result in a loss of quality of life due to injuries. Findings included: Record review of a facility face sheet dated 11/05/24 for Resident #20 indicated that he was an [AGE] year-old male admitted to the facility on [DATE] and subsequently readmitted on [DATE] with diagnoses including: type 2 diabetes (uncontrolled blood sugar), absence of left leg, lack of co-ordination and hypertension (high blood pressure). Record review of a quarterly MDS assessment dated [DATE] for Resident #20 indicated that he had a BIMS score of 13, which indicated that he was cognitively intact. Section GG indicated that he was dependent with transfers. Record review of a comprehensive care plan for Resident #20 indicated that he had an ADL self-care performance deficit. Interventions included .TRANSFER: The resident requires 1-2 staff assistance with transfers . and Last Care Plan Review Completed section reflected .9/23/2024 . Record review of a facility face sheet dated 11/06/24 for Resident #26 indicated that she was an [AGE] year-old female admitted to the facility on [DATE] with diagnoses including: type 2 diabetes (uncontrolled blood sugar), muscle weakness, lack of co-ordination and hypertension (high blood pressure). Record review of a quarterly MDS assessment dated [DATE] for Resident #26 indicated that she had a BIMS score of 00, which indicated that she had severe cognitive impairment. Section GG indicated that she was dependent with transfers. (continued on next page)

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

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of a comprehensive care plan for Resident #26 indicated that she had an ADL self-care performance deficit. Interventions included .TRANSFER : The resident requires 1-2 staff assistance with transfers . and Last Care Plan Review Completed section reflected .08/15/2024 . Record review of a facility face sheet dated 11/06/24 for Resident #31 indicated that she was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses including: dementia (deterioration of memory, language, and other thinking abilities), cerebral infarction (stroke), and hypertension (high blood pressure), muscle weakness, and lack of co-ordination). Record review of a quarterly MDS assessment dated [DATE] for Resident #31 indicated that she had a BIMS score of 02, which indicated that she had severe cognitive impairment. Section GG indicated that she was dependent with transfers. Record review of a comprehensive care plan for Resident #31 indicated that she had an ADL self-care performance deficit. Interventions included .TRANSFER : The resident requires 1-2 staff assistance with transfers . and Last Care Plan Review Completed section reflected .10/08/2024 . Record review of a facility face sheet dated 11/06/24 for Resident #47 indicated that he was an [AGE] year-old male admitted to the facility on [DATE] with diagnoses including: dementia (deterioration of memory, language, and other thinking abilities), muscle weakness, and lack of co-ordination). Record review of a quarterly MDS assessment dated [DATE] for Resident #47 indicated that he had a BIMS score of 06, which indicated that he had severe cognitive impairment. Section GG indicated that he was dependent with transfers. Record review of a comprehensive care plan for Resident #47 indicated that he had an ADL self-care performance deficit. Interventions included .TRANSFER : The resident requires 1-2 staff assistance with transfers . and Last Care Plan Review Completed section reflected .10/16/2024 . During an observation and interview on 11/04/24 at 11:05 AM revealed Resident #26 was sitting in the common area watching TV in a wheelchair. A Hoyer sling with faded straps was underneath her. The straps were all a gray color, and the black main strap was faded to a charcoal color. ADON A said the staff received training to pull slings from use if they had rips, tears, or ravels. She said that the Hoyer sling underneath Resident #29 was faded and should probably be removed from service due to the risk of injury to the resident if it failed. During an observation and interview on 11/04/24 at 11:15 AM revealed Resident #20 was sitting in the dining room in a wheelchair. A Hoyer sling with faded straps was underneath him. The straps were all a gray color, and the black main strap was faded to a charcoal color. LVN B said she worked as needed at the facility and had been in-serviced on when to remove slings from service at the other facility she works at. LVN B said the staff should have received training to pull slings from use if they have rips, tears, ravels and faded. She said that the Hoyer sling underneath Resident #20 was faded and should probably be removed from service due to the risk of injury to the resident if it failed. She said the sling was very faded which could indicate it was bleach or had deteriorated. During an observation on 11/04/24 at 11:25 AM revealed Resident #47 was sitting in the dining room in a wheelchair. A Hoyer sling with faded straps was underneath him. The straps were all a gray color, and the black main strap is faded to a charcoal color. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation and interview on 11/06/24 at 09:10 am revealed Resident #31 was sitting in the common area in a wheelchair. A Hoyer sling with faded straps was underneath her. The straps were all a gray color, and the black main strap was faded to a charcoal color. Physical Therapy Assistant C said the staff have received training to pull slings from use if they have rips, tears, or ravels. He said that the nursing staff was responsible for removing the slings, but all staff should be trained and be actively involved in keeping all resident safe. He said the risk to the resident would be a fall and injury if the sling failed during transfer. During an interview on 11/05/24 at 10:07 AM the DON said the staff had been in-serviced on Hoyer lift safety that included taking damaged slings out of service. She said the risk to the resident of the slings failed was an injury from a fall. During an observation and interview on 11/06/24 at 9:09 AM revealed a Hoyer sling with a torn attachment loop was in the clean area of the laundry area on the cabinet. The Laundry Staff said she would throw the sling away with the broken strap. She said she did not bleach the Hoyer slings that came to her in routine laundry, she washed them with the colored clothes of the residents. She said that she was washing the Hoyer slings that came to her in isolation bags with bleach, she did not separate the slings from the bleachable items and then she air dries them. She said that she shows any worn, torn, or [NAME] slings the Housekeeping Supervisor and she decides if they need to be thrown away. She said worn, torn and faded slings could cause the Hoyer sling to tear or break causing a possible injury to the resident. During an interview on 11/06/24 10:04 AM the Housekeeping Supervisor said she had not considered the slings that were faded to be unsafe. She said the facility would have to come up with a plan for disinfecting the slings without using bleach. The housekeeping supervisor was not aware the slings were being bleached. She said all staff would need in-servicing on what conditions require the straps to be removed. She said using bleach during the wash cycle would deteriorate the slings. She said worn, torn and faded slings could cause the Hoyer sling to tear or break causing a possible injury to the resident. During an interview on 11/06/24 at 10:37 AM the Administrator said that bleached, worn torn or [NAME] Hoyer slings should be removed from service. She said the staff would be in-serviced and the facility would address not bleaching the slings during laundry service. She said the staff will be in serviced on when to take the slings out of service. She said worn, torn and faded slings could cause the Hoyer sling to tear or break causing a possible injury to the resident . Record review of manufacture guidelines Full Body Slings - Instructions for use accessed at www.medline.com on 11/06/24 reflected .Always inspect slings prior to each use. Signs of rips, tears, or frays indicate sling wear which is unsafe and could result in injury. Signs of color fading, bleached areas, or permanent wrinkles on the straps indicate improper laundering which is unsafe and could result in injury. Any slings with signs of wear or improper laundering should be immediately removed from use . and .Do not remove sling labels. If sling labels are removed or no longer legible, sling must be immediately removed from use . Record review of manufacture guidelines Invacare Patient Sling Reference Guide accessed at www.invacare.com on 11/06/24 reflected .Inspect sling before each use for wear, tears, and loose stitching. Bleached, torn, cut, frayed or broken slings are unsafe and could result in injury. Discard immediately . (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of an undated facility policy titled Hoyer Slings, indicated . IT IS THE POLICY OF THE FACILITY THAT EACH RESIDENT IN NEED OF HOYER TRANSFER SHALL HAVE TWO ASSIGNED SLINGS. PROCEDURE: I. Residents requiring Hoyer transfer will be provided two Hoyer slings in their proper size. 2. C.N.A or anyone performing a transfer shall inspect the sling prior to each use per the manufacture guidelines. 3. Central Supply shall inspect the slings monthly. 4. If the sling becomes torn, ripped, stretched, or altered per the manufacture guideline, the facility shall dispose and replace it immediately.

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. 43994 Based on observation and interview, the facility failed to ensure nurse staffing data was posted daily and readily accessible to residents and visitors with all required information for 1 of 3 days reviewed (11/4/2024) nurse staffing posting. The facility failed to post the daily staffing information in a prominent place on 11/4/2024. This failure could place residents, families, and visitors at risk of not being informed of the census and number of staff working each day to provide care on all shifts. Findings: During an observation on 11/4/2024 at 9:15 AM, revealed there was no daily staffing posting in or around the front entrance or at the nurse's station. During an observation and interview on 11/5/2024 at 7:55 AM, revealed the daily staffing posting dated 11/4/2024 was located on hall A on a wall,, unable to see the posting if coming in the front entrance and not in a place where residents and visitors could see it. The Treatment Nurse said she was responsible for placing the posting on the wall but did not gather the information for staff numbers. She said the posting where it had always been posted and was not in any other location. The daily posting had all required information with census numbers and staffing hours for nurses and nurse aides. During an observation on 11/6/2024 at 8:12 AM, revealed the daily staff posting dated 11/5/2024 was located at the front entrance. During an interview on 11/6/2024 at 9:15 AM, the Treatment Nurse said she was responsible for assisting with staffing. She said she was responsible for completing the daily and monthly schedule and putting up the daily posting. She said she put out the posting in the morning after she arrived at work. She said she was told to put the posting on A hall on the wall by management. She said she was not aware that the posting needed to be in a visible place for all residents and visitors to see. She said they changed the location yesterday for the posting to be placed at the front of the facility. During an interview on 11/6/2024 at 2:25 PM, the Administrator said the Treatment Nurse was responsible for putting up the daily staffing census posting daily, and it had to be put up within 2 hours. She said the posting should be in plain sight.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43994 Based on observations, interviews, and record review the facility failed to establish and 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 1 of 6 residents (Resident #184) and 2 of 4 staff (CNA F and CNA G) reviewed for infection control. CNA F and CNA G did not sanitize or wash their hands between glove changes when incontinent care was provided on 11/5/2024 to Resident #184. These failures could place residents at risk of exposure to infectious diseases due to improper infection control practices. Findings included: Record review of an Admission Record for Resident #184 dated 11/5/2024 indicated he admitted to the facility on [DATE] and was [AGE] years old with diagnoses of UTI (infection in the urinary tract), Alzheimer's disease and urogenital candidiasis (yeast infection in or around the genitals). Record review of an Admission MDS Assessment for Resident #184 dated 9/7/2024 indicated he had moderate impairment in thinking with a BIMS score of 6. He required substantial/maximal assistance with personal hygiene. He did not have an indwelling catheter but was always incontinent of urine and frequently incontinent of bowel. Record review of active physician's orders for Resident #184 dated 11/5/2024 indicated an order for catheter care every shift that started on 10/23/2024. Record review of a care plan for Resident #184 dated 10/24/2024 indicated he had an infection of the urine with interventions to maintain standard precautions when providing resident care. He had bowel/bladder incontinence related to disease process dated 9/11/2024 with interventions for incontinent: check as required for incontinence, wash, rinse, and dry perineum. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 11/05/2024 at 11:04 AM, in the room of Resident #184, revealed CNA F and CNA G were present to perform catheter and incontinent care. Both washed their hands in the bathroom, donned (put on) gowns and gloves. Supplies were in a plastic bag and two pans of water were on the over bed table, one with soap and the other without. CNA F pulled down Resident #184's pants. His urinary catheter was anchored to his left thigh, and he was rolled onto his side and a towel was placed underneath his buttocks. His brief was opened and pulled down between his thighs. CNA F removed a washcloth from the soapy water and cleaned down this right and left inner thighs, and placed the towel in a plastic bag. A small bowel movement was noted in the brief. CNA F removed her gloves and placed them in the trash, she did not sanitize or wash her hands, and placed clean gloves on. CNA F removed wipes from the plastic bag x4 and cleaned his rectum from front to back and removed the brief and placed it in the trash. CNA F doffed (took off) her gown and gloves and said she was going to get the nurse because the dressing to Resident #184's sacrum (bone that holds the pelvis and spine together) was loose and needed to be replaced. Resident #184 was covered back up and CNA F exited the room. CNA F returned to the room and washed her hands, donned a gown and gloves, and removed a soapy towel from the basin and cleaned the shaft of the penis from the tip to the base and pulled his skin back and placed the towel in the plastic bag. CNA F removed her gloves and placed them in the trash and applied clean gloves to both hands without sanitizing them. CNA F removed another towel from the soapy water and cleaned the tip of the penis and placed the towel in a plastic bag. CNA F removed her gloves and placed them in the trash and applied clean gloves to both hands without washing or sanitizing them. CNA G removed a towel from the soapy water and cleaned down the catheter tubing and then removed her gloves and placed them in the trash which fell to the floor. CNA G took another a soapy towel and cleaned both inner thighs and placed the towel in a plastic bag. Resident #184 asked CNA G to dry him and she removed a dry towel from the plastic bag and patted him dry with the towel. CNA F removed her gloves and placed them in the trash and the gloves fell to the floor because it was overflowing and placed clean gloves on her hands without sanitizing them. CNA F and CNA G both removed the towel that was underneath Resident #184's buttocks and placed a clean brief and secured it. Both removed their gloves and gowns and placed them in the trash and then they washed their hands. During an interview on 11/5/2024 at 11:36 AM, CNA G said she had been employed at the facility for a year. She said during the care provided to Resident #184, she should have had extra gloves in the room, should have sanitized between glove changes, should have folded the towel when she cleaned, would have circled around the base of the penis to the body then cleaned the area. She said if a male resident was uncircumcised then she would have pulled the skin back to clean and then pulled the skin back over after. She said there was a risk of cross contamination and infections if they did not follow the proper procedures. She said the gloves should not be on the floor and should have been in the trash. She said she was not sure when the last time she had skills check off by staff. Record review of a Skills Checklist-Catheter Care, indwelling for CNA F dated 8/30/2024 indicated she was successful with catheter care and perineal care, conducted by ADON H. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/5/2024 at 12:54 PM, CNA F said she had been employed at the facility for 2 months and worked both shifts. She said during the care provided to Resident #184, she would have one pan for the washcloths, would have cleaned more thoroughly, should have sanitized between glove changes, and would have pulled skin back in place because he had excess skin on his penis. She said she should have washed from the base up, would have gotten another towel and cleaned the tubing in one single stroke. She said she should have cleaned the thighs and peri area before starting the Foley catheter care. She said there was risk for residents to get UTIs, yeast infections and sepsis (infection in the blood stream) if left untreated. She said she was unsure if she had skills check off with any staff. Record review of a Skills Checklist-Catheter Care, indwelling for CNA F dated 8/31/2024 indicated she was successful with catheter care and perineal care. During an interview on 11/6/2024 at 9:34 AM, ADON A said the Treatment Nurse was responsible for conducting skills check offs with staff. She said she did conduct in-services with staff at times. She said she was made aware of the care provided to Resident #184 yesterday 11/5/2024. She said hand hygiene should be performed before care, between glove changes and after care. She said gloves should be placed in the trash and not on the floor. She said during incontinent care, staff should use 1 wipe per side and they should have cleaned the bowel movement first and then performed Foley care. She said there was a risk for UTIs, sepsis, and skin breakdown if care was not done properly. During a joint interview on 11/6/2024 at 9:44 AM, ADON H and the Treatment Nurse both said skills check offs were conducted with staff on hire, annually, and prn. They said part of the skills check offs were hand hygiene and peri care with return demonstration. They said hand hygiene should be done before care, after care, with each glove change and gloves should be placed in the trash and not on the floor. They said they planned to recheck both staff off on skills and conduct an in-service with all staff. Both said if a male resident was not circumcised, staff should pull the skin back, clean and place the skin back after. Both said there was a risk for skin breakdowns, UTIs, and wounds if staff did not follow proper procedures when performing incontinent care and urinary catheter care. During an interview on 11/6/2024 at 2:00 PM, the DON said she was responsible for all staff training on infection control. She said training should be done on hire, annually and prn in between times. She said hand hygiene should be performed before care, when gloves were removed and after gloves were removed. She said gloves should never be placed on the floor. She said they conducted training all the time at the facility. She said incontinent care should start at the front of the body before going to the back. She said there was a risk of infections if they did not perform hand hygiene. She said they would plan to do more training with staff. During an interview on 11/6/2024 at 2:25 PM, the Administrator said Management Nurses were responsible for training staff at least annually and prn. She said hand hygiene should be performed before care, during and after care and between glove changes. She said gloves should never be placed on the floor. She said they planned to do an in-service with staff and more education. She said there was a risk for infections. Record review of a facility policy titled catheter policy/procedure revised 1/2024 indicated, .It is the policy of this facility that each resident with an indwelling urinary catheter will receive catheter care daily. To promote hygiene, comfort and decrease risk of infection for catheterized residents . (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of a facility policy titled Hand Hygiene revised 12/2023 indicated, .It is the policy of this facility to provide the necessary supplies, education, and oversight to ensure healthcare workers perform hand hygiene. Procedure: 2. Use an alcohol-based hand rub containing at least 62% alcohol; or, alternatively, soap and water for the following situations: j. After contact with blood or bodily fluids; m. After removing gloves .