

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675978	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/15/2025
NAME OF PROVIDER OR SUPPLIER Arbor Grace Wellness Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1241 W Marshall Howard Blvd Littlefield, TX 79339	

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>47159</p> <p>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 3 of 37 residents (Resident #1, Resident #2, and Resident #3) reviewed for infection control.</p> <p>The facility failed to ensure proper hand hygiene techniques were practiced while feeding dependent residents (Residents #1, #2 and #3) during the luncheon service.</p> <p>This failure could place residents at risk of the spread of communicable diseases and infections and a diminished quality of life.</p> <p>Findings included:</p> <p>An observation of the luncheon service on 01/15/2025 at 11:55AM revealed CNA A, CNA B and LVN C feeding residents who required full assistance while eating. CNA A got up from the table where she was feeding Resident #1 to move her wheelchair closer to the table. She sat back down and before continuing to feed Resident #1, ran her hands through her hair to move her hair off her shoulders.</p> <p>CNA A resumed feeding Resident #1 without sanitizing her hands. LVN C sanitized his hands upon entering the dining room, walked to an empty chair at one of the dining room tables, lifted the chair and moved it to the table where dependent residents were being fed and began feeding Resident #2, without re-sanitizing his hands. CNA B was feeding Resident #3 when Resident #4 approached CNA B and asked her to refill his drink. CNA B took the glass from the hand of Resident #4, filled it with the drink the resident had requested, returned the glass to the hand of Resident #4 and then pushed his wheelchair to a dining room table so he could eat. CNA B resumed feeding Resident #3 without sanitizing her hands.</p> <p>An interview with LVN C on 01/15/2025 at 3:23PM revealed he had realized as he began to feed Resident #2, he had not re-sanitized his hands after handling the dining room chair. He stated a negative outcome of not practicing proper hand hygiene between the two tasks was the spread of infections.</p> <p>An interview with CNA A on 01/15/2025 at 3:26PM revealed she realized as she began to feed Resident #1, she had not sanitized her hands after touching the wheelchair of Resident #1 and then touching her own hair, before feeding resident #1. She stated the negative outcome of not practicing proper hand hygiene after moving Resident #1's wheelchair and touching her own hair was contamination.</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>An interview with CNA B on 01/15/2025 at 3:29PM revealed she had realized she had broken hand hygiene by handling the glass of Resident #4, pushing his wheelchair and returning to feed Resident #3 without sanitizing her hands. She stated the negative outcome of not practicing proper hand hygiene between the two tasks was the spread of infections or diseases.</p> <p>An interview with the DON and the ADMN on 01/15/2025 at 4:45PM revealed they had completed in-service education on Hand Hygiene on 11/11/2024 and Universal Precautions on 12/10/2024. The DON stated there was no reason CNA A, CNA B, and LVN C would not know the steps to proper hand hygiene with regard to transmission of infections/disease, as all three had attended both in-services and demonstrated competency.</p> <p>Record Review of facility policy and procedures for Hand Washing/Hand Hygiene dated August 2015 revealed the following:</p> <p>7. Use an alcohol-based hand rub containing at least 62% alcohol; or, alternatively, soap (anti-microbial or non-antimicrobial) and water for the following situations.</p> <p>b. Before and after direct contact with residents;</p> <p>l. After contact with objects (e.g., medical equipment) in the immediate vicinity of the resident;</p> <p>o. Before and after handling food;</p> <p>q. Before and after assisting a resident with meals.</p>