

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675981	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/09/2025
NAME OF PROVIDER OR SUPPLIER Caraday of Mineola		STREET ADDRESS, CITY, STATE, ZIP CODE 716 Mimosa Street Mineola, TX 75773	

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 - Few</p>	<p>Provide and implement an infection prevention and control program.</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 - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, 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 4 resident (Residents #9) reviewed for infection control. RN A failed to put on a gown prior to administering medications through a jejunostomy tube (also called aJ-Tube, enteral tube, or feeding tube). This failure could place residents at risk of exposure and/or possible transmission of communicable diseases and infections. Findings include: A record review of a face sheet dated 07/08/2025 indicated Resident #9 was a [AGE] year-old female who was admitted to the facility on [DATE]. She had diagnoses which included feeding difficulties, artificial opening of gastrointestinal tract status (a jejunostomy which is a tube inserted through the abdomen into the small intestine to provide nutrition and medications), oropharyngeal dysphagia (difficulty in swallowing), and cerebral infarction (a stroke). A record review of Resident #9's admission MDS assessment dated [DATE] noted Resident #9 had a BIMS of 3 which indicated her cognition was severely impaired. The MDS assessment indicated Resident #9 had a feeding tube. A record review of the physician's orders dated 07/08/2025 indicated Resident #9 had a J-Tube for administration of medications and nutrition. A record review of Resident #9's care plan dated 05/21/2025 indicated EBP were to be used when providing care involving the J-Tube. During an observation on 07/08/2025 at 09:08 AM, RN A prepared Resident #9's morning medications for administration through her feeding tube. RN A put on gloves and entered Resident #9's room. Resident #9 had a sign on the doorway entrance into her room which indicated Enhanced Barrier Precautions were required. The sign also said that all providers and staff must wear gloves and a gown for high-contact activities which included feeding tube care or use. There was a 3-drawer plastic container outside the doorway which contained PPE that included gloves and gowns. RN A did not put on a gown. RN A told Resident #9 that she had her medications. RN A checked tube placement and administered the medications through the feeding tube. After completion of the task, RN A removed her gloves, disposed of them, and washed her hands. RN A then returned to her cart and said she was finished. During an interview on 07/08/2025 at 09:12 AM, RN A said she should have put on a gown prior to administering Resident #9's medications because Resident #9 had a feeding tube which required EBP. RN A said EBP was important for preventing the spread of infection. RN A said she forgot to put on a gown because she was nervous. During an interview with the DON on 07/08/2025 at 10:45 AM, she said she expected the nurses to adhere to Enhanced Barrier Precautions when providing direct care to residents with feeding tubes. She said EBP required the wearing of gloves and gowns when providing direct care to residents with indwelling medical devices. She said the purpose was to reduce the risk of spreading infections and diseases. During an interview with the MDS Coordinator on 07/08/2025 at 03:12 PM, she said she was a registered nurse and the Infection Preventionist for the facility. She said nurses were required to wear gloves and a gown when administering medications through a feeding tube to reduce the spread of infections and diseases. A record review of the facility's policy titled Enhanced Barrier Precautions and dated 08/2022 indicated the following: 1. Enhanced barrier Precautions (EBPs) are used as an infection prevention and control intervention to reduce the spread of multi-drug resistant organisms (MDROs) to residents. 2. EBPs employ targeted gown and gloves use during high contact resident care activities when contact precautions do not otherwise apply. a. Gloves and gown are applied prior to performing the high contact resident care activity (as opposed to before entering the room). 3. Examples of high-contact resident care activities requiring the use of gown and gloves for EBPs include: . g. device care or use (central line, urinary catheter, feeding tube, .).</p>		