STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676011	A. Building B. Wing	06/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Magnolia Place Health Care	1620 Magnolia St. Liberty, TX 77575

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)
F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure residents had the right to be informed in advance, by the physician or other practitioner or professional, of the risks and benefits of proposed care, of treatment and treatment alternatives or treatment options and to choose the alternative or option he or she preferred for 2 of 5 residents (Residents #6 and #64) reviewed for psychoactive medications. 1. The facility failed to ensure Resident #6 had a completed psychotropic consent from the resident or family for Seroquel (antipsychotic medication) before administering to Resident #6 on 09/09/24. 2. The facility failed to ensure Resident #64 had a completed psychotropic consent from the resident or family for Seroquel (antipsychotic medication) and Cymbalta (antidepressant) before administering to Resident #66 on 01/03/25. These failures could place residents at risk for receiving unnecessary antipsychotic medications without informed consent. Findings included: 1. Record review of Physician Orders for June 2025 indicated Resident #6 was an [AGE] year-old female who was admitted on [DATE]. Her diagnoses included major depressive disorder (mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life); bipolar disorder (mental disorder associated with episodes of mood swings ranging from depressive lows to manic highs); and adjustment insomnia (sleep disorder where people have difficulty sleeping). She had orders dated 09/09/2024 to receive Seroquel (antipsychotic) daily for major depressive disorder, bipolar disorder, and adjustment insomnia; and Cymbalta (antidepressant) daily for major depressive disorder. Record review of an MDS dated [DATE] indicated Resident #6 had moderately impaired cognition, she was taking an antipsychotic, and she was taking an antidepressant. Record review of a care plan dated 09/09/24 indicated Resident #6 used high risk drugs and was at risk for side effects with antidepressant and anti-psychotic/anti-mania was marked. Record review of the HHSC form 3713 Consent for Antipsychotic or Neuroleptic Medication Treatment for Resident #6's Seroquel dated 09/09/24 indicated the following: (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Section I The following must be completed by the person prescribing the medication, that person's designee, or the medical director. I have been treating this individual since:[blank] I believe the individual has the following psychiatric condition and/or maladaptive behavior: (ICD Code) [blank] In my clinical opinion: The probable clinically significant side effects and risks of the proposed treatment with antipsychotic or neuroleptic medication(s) are indicated: [antipsychotic was not marked] The above information and statements are to the best of my knowledge truthful and complete. [The person prescribing the medication, that person's designee, or the medical director printed name and signature with date are left blank] Section II The following must be completed by the resident and if appropriate the person authorized to by law, to consent on behalf of the resident. I, [blank] (resident) or [blank] (resident representative) on behalf of [blank] (resident) acknowledge by signing this form, I agree to the following .[The blanks were not filled in] . Record review of the HHSC form 3713 Consent for Antipsychotic or Neuroleptic Medication Treatment for Resident #6's Cymbalta dated 09/09/24 indicated the following: Section I The following must be completed by the person prescribing the medication, that person's designee, or the medical director. I have been treating this individual since:[blank] I believe the individual has the following psychiatric condition and/or maladaptive behavior: (ICD Code) [blank] In my clinical opinion: The probable clinically significant side effects and risks of the proposed treatment with antipsychotic or neuroleptic medication(s) are indicated: [antianxiety was also marked] The above information and statements are to the best of my knowledge truthful and complete. [The person prescribing the medication, that person's designee, or the medical director's printed name and signature with date are left blank] Section II The following must be completed by the resident and if appropriate the person authorized to by law, to consent on behalf of the resident. (continued on next page)

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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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	I, [blank] (resident) or [blank] (resident representative) on behalf of [blank] (resident) acknowledge by signing this form, I agree to the following .[The blanks were not filled in] . 2. Record review of Physician Orders for June 2025 indicated Resident #64 was an [AGE] year-old female who was admitted on [DATE]. Her diagnoses included major depressive disorder (mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life). She had an order dated 01/03/25 to receive Seroquel (antipsychotic) daily for major depressive disorder. Record review of an MDS dated [DATE] indicated Resident #64 had severely impaired cognition and she was taking an antipsychotic. Record review of a care plan dated 04/04/25 indicated Resident #64 used high risk drugs and was at risk for side effects with anti-anxiety/anxiolytic and anti-psychotic/anti-mania marked. Record review of the HHSC form 3713 Consent for Antipsychotic or Neuroleptic Medication Treatment for Resident #64's Seroquel dated 01/03/25 indicated the following: Section II The following must be completed by the resident and if appropriate the person authorized to by law, to consent on behalf of the resident. I, [blank] (resident) or [blank] (resident representative) on behalf of [blank] (resident) acknowledge by signing this form, I agree to the following .[The blanks were not filled in] . During an interview on 06/04/25 at 04:00 p.m., the DON said she was not aware Resident #6 and #64's consent forms were not completed for Cymbalta and Seroquel. She said the psychiatric services would fill out the consent forms for the psychotropic medications. She said the nurse could also fill out the form and have the resident or their RP sign it. She said she and the ADONs would randomly review the resident charts. During an interview on 06/04/25 at 04:10 p.m., the Administrator said he expected the policies and protocols to be followed for psychotropic medication consents, medications, and orders. Record review of Use of Psychotropic Medication(s) policy, dated 02/01/25 indicated: Policy: Residents are not given psychotropic drugs unless the medication is necessary to treat a specific condition, as diagnosed and documented in the clinical chart, and the medication is beneficial to the resident, as demonstrated by monitoring and documentation of the resident's response to the medication(s). Policy Explanation and Compliance Guidelines: 7. Prior to initiating or increasing psychotropic medication, the resident, family, and/or resident representative must be informed of the benefits, risks, and alternatives for the medication, including any black box warnings for antipsychotic medications, in advance of such initiation or increase. (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	8. The resident has the right to accept or decline the initiation or increase of a psychotropic medication. 9. The facility will document that the resident or resident representative was informed in advance of the risks and benefits of the proposed care, the treatment alternatives or other options and the preferred option to accept or decline in a format the facility deems to use (e.g., written consent form, narrative note, etc.)

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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 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure individuals identified with MI, DD or ID were evaluated for services for 2 of 5 residents (Residents #6 and #19) reviewed for PASRR. The facility failed to ensure the accuracy of the PASRR Level 1 (P1) screen for Resident #6 and Resident #19. This failure could place residents who had a mental illness at risk of not receiving individualized specialized services to meet their needs. 1. Record review of the June 2025 Physician Order indicated Resident #6 was an [AGE] year-old female who was admitted on [DATE]. Her diagnoses included major depressive disorder (mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life); bipolar disorder (mental disorder associated with episodes of mood swings ranging from depressive lows to manic highs); and adjustment insomnia (sleep disorder where people have difficulty sleeping). She had orders, dated 09/09/2024, to receive Seroquel (antipsychotic) daily for major depressive disorder, bipolar disorder, and adjustment insomnia; and Cymbalta (antidepressant) daily for major depressive disorder. Record review of a care plan, dated 09/09/24, indicated Resident #6 used high risk drugs and was at risk for side effects with antidepressant and anti-psychotic/anti-mania marked. Record review of a PASRR Level 1 dated 09/09/24 indicated Resident #6 had a primary of diagnosis of dementia. The MI was not marked. Record review of the EMR for Resident #6 from 09/09/24 through 06/03/25 indicated there was no HHSC form 1012 filled out and there was no physician/NP note indicating the primary diagnosis was dementia. Record review of an MDS, dated [DATE], indicated Resident #6 had moderately impaired cognition. She was taking an antipsychotic, and she was taking an antidepressant. During an interview on 06/03/25 at 04:25 p.m., MDS Nurse M said she pulled the diagnosis from the medical record for Resident #6 upon admission and put on the PASRR Level 1 that it was the primary diagnosis. She said there was no form 1012 or documentation by the physician that the resident's primary diagnosis was dementia. She said she did not verify with the physician the primary diagnosis was dementia therefore the PASRR Level 1 was not correct and needed to be redone and resubmitted. During an interview on 06/04/25 at 04:00 p.m. the DON said she was made aware of the issue with Resident #6's PASRR and MDS Nurse M was working on it. She said she expected the PASRR to be filled out correctly. She said residents could not receive needed services if not coded correctly. During an interview on 06/04/25 at 04:10 p.m. the Administrator said he expected the policies and protocols to be followed for PASRR. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Record review of the Resident #19's face sheet, dated 06/04/25, indicated Resident #19 admitted to the facility on [DATE]. Resident #19 was [AGE] years old female with and had diagnoses of which included schizoaffective disorder (a mental health condition with schizophrenia [disconnect from reality] and mood disorder), stroke (damage to the brain due to lack of blood flow), and major depressive disorder (mental illness with sadness and loss of interest). Record review of the Resident #19's admission MDS assessment, dated 05/06/25, indicated Resident #19's was not currently considered by the state level II PASRR process to have serious mental illness and/or intellectual disability or a related condition. Record review of the Resident #19's care plan dated 04/30/25, indicated she received anti-psychotic medications. Record review of the Resident #19's P1 dated 04/30/25, indicated she was admitted at the facility for less than 30 days. Record review of the Resident #19's care plan dated 05/02/25, indicated she wished to remain here at to the facility for long term placement. During an interview on 06/03/25 at 10:00 a.m., the MDS nurse L said Resident #19's P1 was completed and when it was transferred to the LIDDA . She said there was a mark to indicate the resident was here at the facility for only 30 days. She said Resident #19 was at the facility for long term placement. The MDS nurse L said she was responsible for Resident #19's P1 and unsure why the form was marked wrong. She said this error could have delayed services. Record review of a the facility's Resident Assessment - Coordination with PASARR Program policy, dated 01/01/24, indicated: Policy: This facility coordinates assessments with the preadmission screening and resident review (P ASARR) program under Medicaid to ensure that individuals with a mental disorder, intellectual disability, or a related condition receives care and services in the most integrated setting appropriate to their needs. Policy Explanation and Compliance Guidelines: 1. All applicants to this facility will be screened for serious mental disorders or intellectual disabilities and related conditions in accordance with the State's Medicaid rules for screening. a. PASARR Level I - initial pre-screening that is completed prior to admission i. Negative Level I Screen - permits admission to proceed and ends the PASARR process unless a possible serious mental disorder or intellectual disability arises later. ii. Positive Level I Screen - necessitates a P ASARR Level II evaluation prior to admission. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	b. PASARR Level II - a comprehensive evaluation by the appropriate state-designated authority (cannot be completed by the facility) that determines whether the individual has MD, ID, or related condition, determines the appropriate setting for the individual, and recommends any specialized services and/or rehabilitative services the individual needs

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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 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure each resident's drug regimen was free from unnecessary medications (is a medication used: without adequate indication for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued) for 1 of 5 residents (Resident #6) reviewed for unnecessary medications. * The facility failed to ensure Resident #6 had an appropriate diagnosis on entered orders for her Seroquel (antipsychotic). This failure could place residents at risk for unintended, harmful events attributed to the use of a medication without the appropriate indication. Findings included: Record review of Physician Orders for June 2025 indicated Resident #6 was an [AGE] year-old female admitted on [DATE]. Her diagnoses included major depressive disorder (mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life); bipolar disorder (mental disorder associated with episodes of mood swings ranging from depressive lows to manic highs); and adjustment insomnia (sleep disorder where people have difficulty sleeping). She had orders dated 09/09/2024 to receive Seroquel (antipsychotic) daily for major depressive disorder, bipolar disorder, and adjustment insomnia; and Cymbalta (antidepressant) daily for major depressive disorder. Record review of an MDS dated [DATE] indicated Resident #6 had moderately impaired cognition, she was taking an antipsychotic, and she was taking an antidepressant. Record review of a care plan dated 09/09/24 indicated Resident #6 used high risk drugs and was at risk for side effects with antidepressant and anti-psychotic/anti-mania marked. During an interview on 06/04/25 at 04:00 p.m. the DON said she was not aware Resident #6 had multiple diagnoses for her Seroquel. She said a resident could receive a medication for the wrong indication. She said the nurse was to verify with the physician what diagnosis was indicated for the medication. She said she and the ADONs would randomly review the resident charts. During an interview on 06/04/25 at 04:10 p.m. the Administrator said he expected the policies and protocols to be followed for psychotropic medication use. Record review of Use of Psychotropic Medication(s) policy dated 02/01/25 indicated: Policy: Residents are not given psychotropic drugs unless the medication is necessary to treat a specific condition, as diagnosed and documented in the clinical chart, and the medication is beneficial to the resident, as demonstrated by monitoring and documentation of the resident's response to the medication(s)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interview and record review the facility failed to ensure, in accordance with State and Federal laws, all drugs were stored in a locked compartments under proper temperature controls, and only permitted authorized personnel to have access to the keys for 1 of 20 resident (Resident #29) reviewed for storage and labeling of medications. The facility failed to ensure Resident #29 did not have over the counter medications, Luden's cough drops, Neosporin and Equate hydrocortisone cream at the bedside. This failure could place residents at risk for misuse of medication, overdose, drug diversions, adverse reactions of medications, and not receiving the therapeutic benefit of medications. The findings include: Record review of Resident #29's face-sheet revealed a [AGE] year-old male who was admitted to the facility on [DATE]. His diagnosis included chronic hepatic failure(liver failure), cirrhosis of liver(hardening of liver) and essential hypertension, Record review of Resident #29's consolidated report of current Physician orders, dated 06/2025, indicated no scheduled or PRN order for Luden's cough drops, Neosporin, Equate hydrocortisone cream, self-administer medications or to leave at bedside. Record review of Resident #29's electronic record indicated there was no Care Plan addressing may keep medications at bedside and no care plan to self-administer medications. Further review of the electronic record, reflected Resident #29 did not have a Self-Administration Medication Assessment initiated or completed. Record review of Resident #29's MDS, dated [DATE], indicated Resident #29 had intact cognition with a BIMS of 15 out of 15. During an observation on 06/02/25 at 9:45 a.m., revealed Resident #29 was not in his room and the door was opened. On his bedside table was an opened and used (25 count drops) bag of Luden's wild cherry flavored cough drops, Neosporin ointment 1 ounce tube, was opened and used, and Equate hydrocortisone cream max strength 2 ounce tube, was opened and used. During an observation and interview on 06/02/25 at 1:00 p.m., Resident #29 said the medication on his table was none of the state surveyors business where he got them. When asked where does he put the medications he and how often does he use it? Resident #29 said on his skin. Resident #29 said he did not report it to the nurses that he had the medication stored in his room because he was a grown man. On his bedside table was an opened and used (25 count drops) bag of Luden's wild cherry flavored cough drops, Neosporin ointment 1 ounce tube, was opened and used and Equate hydrocortisone cream max strength 2-ounce tube, was opened and used. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 06/03/25 at 11:00 a.m., Resident #29 was not in his room and the door was opened. On his bedside table was the same bag of Luden's wild cherry flavored cough drops, Neosporin ointment 1 ounce tube and Equate hydrocortisone cream max strength 2-ounce tube. During an observation on 06/04/25 at 9:45 a.m., Resident #29 was not in his room and the door was opened. On his bedside table was an opened and used (25 count drops) bag of Luden's wild cherry flavored cough drops, Neosporin ointment 1 ounce tube, was opened and used and Equate hydrocortisone cream max strength 2 ounce tube, was opened and used. During an interview on 06/04/25 at 2:00 p.m., LVN-N said no resident should have medications at their bedside. She said she did not know of any residents having medications in their rooms. She said a physician's order must be on file for the resident to receive the medication as well as to self-administer medications. She said a resident could take inappropriate amounts of the medication or another resident could wonder in the room and get the medication and take it. She said residents could have an allergic reaction or become ill from taking unprescribed medication Interview on 06/04/25 at 2:30 p.m., the RP for Resident #29 revealed she had no concerns with the Medications her family member was taking. The RP said she was the person responsible for bringing in the medications Luden's wild cherry flavored cough drops, Neosporin ointment 1 ounce tube and Equate hydrocortisone cream max strength 2-ounce tube and she had done so approximately 3-4 weeks ago. The RP said she had not notified the nurses about the medications because she was not aware she had to tell them since the medications were over-the-counter medications. The RP also said no one from the facility contacted her about the medications, or that they could not be left out unattended at the bedside. Interview on 06/04/25 at 4:00 p.m. the DON said she was just made aware of the mediations Luden's wild cherry flavored cough drops, Neosporin ointment and Equate hydrocortisone cream at Resident #29's bedside but could not remember who told her. The DON said her expectation was for nursing staff to follow facility policy and procedure and not leave medications at the bedside. The DON said Resident #29 would need a doctor's order and medication self-administration assessment completed before he would be able to keep medications at the bedside and administer them himself. The DON revealed she would have to look in the computer to see if Resident #29 had an order or med assessment. The DON said leaving medications at the bedside put residents at risk of not taking properly or giving it to someone else to take, but she (DON) felt Resident #45 was cognitively intact enough to take the medication correctly and would need to have a MD order or Self-Med Assessment first. The DON stated residents in the facility must have a doctor's order to receive medications and no resident could keep medication in their rooms and were not allowed to self-medicate. She stated there must be a physician's order to leave the medication at the bedside and an order for the resident to self-medicate. Record review of the facility's policy, Resident Self-Administration of Medication, dated March 2, 2024, indicated, in part: (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Policy: It is the policy of this facility to support each resident's right to self-administer medication. A resident may only self-administer medications after the facility's interdisciplinary team has determined which medications may be self-administered safely .5. All nurses and aides are required to report to the charge nurse on duty any medication found at the bedside not authorized for bedside storage. Unauthorized medications are given to the charge nurse for return to the family or responsible party. Families or responsible parties are reminded of policy and procedures regarding resident self-administration when necessary .9. The care plan must reflect resident self-administration and storage arrangements

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Administer the facility in a manner that enables it to use its resources effectively and efficiently. Based on observation, interview, and record review, the facility failed to be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of all residents reviewed. 1. The Administrator failed to ensure he, the DON, and the IP received training on Enhanced Barrier Precautions. 2. The Administrator failed to implement Enhanced Barrier Precautions for residents with chronic wounds or indwelling medical devices during high-contact resident care activities regardless of their multidrug-resistant organism status. This failure could cause residents not to receive appropriate care resulting in an increase in infections. Findings included: During observations on 06/02/25 during initial tour from 09:15 a.m. through 11:03 a.m. there were no resident rooms with any EBP signage on the doors or PPE set up outside or inside the resident rooms. During general observations on 06/02/25 from 11:30 a.m. through 04:00 p.m. there were no resident rooms with any EBP signage on the doors or PPE set up outside or inside the resident rooms. During general observations on 06/03/25 from 08:30 a.m. through 05:00 p.m. there were no resident rooms with any EBP signage on the doors or PPE set up outside or inside the resident rooms. During an interview on 06/03/25 at 5:00 p.m., the ADON/IP said she was responsible for the infection control program. She said she was the infection preventionist and received the CMS training in 2022 and reviewed the CMS and CDC web sites. She said she had not been updated or completed any joint trainings or provider trainings. She said she was not aware of any changes or updates within the last two years. She said she trained the staff. The ADON/IP said she had no back up to double check the infection control program. When asked what enhanced barrier precautions was, she said EBP did not sound familiar to her, and she was not trained on EBP. She said the DON and Administrator notified her of infection control updates. She said no residents in the facility were currently on enhanced barrier precautions. During an interview on 06/03/25 at 5:07 p.m., the DON, when asked what enhanced barrier precautions was, she said the new CDC recommendations to use face mask more than just with regular isolation. She said she was not aware of the specifics but knew it was the new update. She said she was not trained on EBP. The DON said she had no luck signing up for in person trainings, joint trainings, or classes, they were always full. She said the Administrator received provider letters. She said she was unable to say her expectations related to EBP. The DON said she was aware new regulation changes were on the horizon. She said the facility had 3 Residents with g-tubes and 2 residents with foley catheters and they were not currently on EBP. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676011	A. Building B. Wing	06/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Magnolia Place Health Care	1620 Magnolia St. Liberty, TX 77575

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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 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 06/03/25 at 5:18 p.m., the Administrator said he was aware briefly of EBP but did not realize there was a provider letter that put EBP into effect. He said he did not receive all the provider letters so he was unsure of the details, but he would pull up provider letters online he thought it was a recommendation not a requirement according to the CDC. During general observations on 06/04/25 from 06:30 a.m. through 12:00 p.m. there were no resident rooms with any EBP signage on the doors or PPE set up outside or inside the resident rooms. Record review of CMS memorandum ref: QSO-24-08-NH dated March 20, 2024 and titled, Enhanced Barrier Precautions in Nursing Homes, indicated, . CMS is issuing new guidance for State Survey Agencies and long term care (LTC) facilities on the use of enhanced barrier precautions (EBP) to align with nationally accepted standards. o EBP recommendations now include use of EBP for residents with chronic wounds or indwelling medical devices during high-contact resident care activities regardless of their multidrug-resistant organism status . Enhanced Barrier Precautions (EBP) refer to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and glove use during high contact resident care activities.

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview 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 6 of 6 residents (Residents #9, #11, #51, #53, #58 and #167) reviewed for infection control. 1. The facility failed to ensure Resident #9 who had an indwelling suprapubic catheter (a tube surgically inserted through the lower abdomen into the bladder to drain urine) and an unstageable pressure ulcer/injury to the left heel (a wound caused by pressure from a surface) had Enhanced Barrier Precautions signage and PPE set up before entering his room and failed to ensure staff wore PPE during high contact resident care activities. 2. The facility failed to ensure CNA A and CNA B followed enhanced barrier precautions while providing incontinent care to Resident #11, who had a gastrostomy tube (G-tube) (a small flexible tube surgically inserted though the abdomen into the stomach to deliver nutrition to the resident) on 06/03/2025. 3. The facility failed to ensure signage was posted outside of Residents #9, #11, #51, #53, #58 and #167's rooms to notify staff of enhanced barrier precautions. 4. The facility failed to ensure PPE was readily accessible for staff to provide high-contact activities for Residents #9, #11, #51, #53, #58 and #167, residents who identified with wounds or indwelling medical devices. 5. The facility failed to ensure LVN G utilized enhanced barrier precautions with wearing a gown while administering medications through Resident #51's g-tube. Resident #51 had a history of non-targeted CDC MDRO, MRSA and ESBL in his urine. 6. The facility failed to ensure CNA C and CNA D utilized enhanced barrier precautions with wearing a gown while transferring Resident #51. 7. The facility failed to ensure Resident #167, who had a gastrostomy tube (G-tube) (a small flexible tube surgically inserted though the abdomen into the stomach to deliver nutrition to the resident), had Enhanced Barrier Precautions signage and PPE set up before entering his room and failed to ensure staff wore PPE during high contact resident care activities. These failures could place residents at risk for cross contamination and the spread of infection. Findings included: 1. Record review of a face sheet dated 06/03/25 indicated Resident #9 was a [AGE] year-old male admitted on [DATE]. His diagnoses included paraplegia (injury to the spinal cord or brain that stops signals from reaching the lower body) and retention of urine (the bladder does not empty completely or at all). (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676011	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Magnolia Place Health Care	1620 Magnolia St. Liberty, TX 77575

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation and interview on 06/02/25 at 10:35 a.m. Resident #9 was up in his wheelchair in him room. A catheter bag to drain was noted. The resident said he had a suprapubic catheter. There was no EBP signage or PPE set up noted before entering the room. Record review of Physician Orders for June 2025 indicated Resident #9 had an order dated 01/01/25 for suprapubic catheter change, 20Fr/30ml, 1st of every month and as needed for catheter care. Record review of an MDS dated [DATE] indicated Resident #9 had moderately impaired cognition with a BIMS of 12 out of 15, had an indwelling urinary catheter, had 1 or more pressure ulcer/injuries, and had 1 unstageable pressure injuries presenting as deep tissue injury present at admission. Record review of a care plan dated 04/04/25 indicated Resident #9 had a care plan initiated on 03/22/23 for an indwelling suprapubic catheter. There was no indication of EBP to be used. Record review of a Weekly Wound/Skin Condition Measure & Evaluation form dated 05/30/25 indicated Resident #9 had an unstageable pressure ulcer to the left heel. During an observation and interview on 06/03/25 at 09:55 a.m. Resident #9 had no EBP signage on the door and no set up for PPE. He said staff wore gloves but did not wear gowns when they provided care to him even with the catheter care and the wound care. During an observation on 06/04/25 at 08:35 a.m. Resident #9 had no EBP signage on the door and no set up for PPE. 2. Record review of Resident #11's face sheet, dated 06/04/25, indicated a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #11 had diagnoses which included dysphagia (difficulty swallowing) and stroke (damage to the brain from interruption of blood supply). Record review of Resident #11's care plan, initiated 01/21/25, indicated he had a g-tube feeding with interventions of local care to g-tube as ordered and monitor for signs and symptoms of infection and give feeding as ordered. Resident #11 was incontinent bowel and bladder. Record review of Resident #11's quarterly MDS assessment, dated 02/21/25, indicated a BIMS score of 15, which indicated intact cognition. Resident #11 was dependent (helper does all effort) for bathing, dressing, toileting, and hygiene and frequently incontinent of bladder and always incontinent of bowel. Resident #11 had diagnoses of stroke and dysphagia and received nutrition by a feeding tube. Record review of Resident #11's Order Summary Report, dated 06/02/25, indicated clean g-tube site with wound cleanser, apply split sponge and secure daily and enteral feed (nutrition through a tube in the stomach) two times a day of Jevity 1.2 at 65 ml/hr by a feeding Pump for 22 hours by g-tube. The physician orders did not indicate the use of enhanced barrier precautions. During an interview and observation on 06/03/25 at 2:00 p.m., Resident #11 was lying in bed with a g-tube feeding attached. He said when the staff provided incontinent care or care to his gastrostomy tube, they washed their hands and wore gloves but did not wear gowns over their clothes. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation and interview of incontinent care on 06/03/25 at 03:05 p.m., CNA A provided incontinent care to Resident #11with assistance of CNA B. Resident #11 was in his bed. CNA A provided the incontinent care while CNA B assisted by holding Resident #11's shoulder and hip. CNA A and CNA B donned gloves, but they did not put on a gown. There was no EBP sign on the door or in the room. Resident #11 was observed with an intact g-tube. When asked did they forget anything or would do anything different CNA A and CNA B said no. During an interview on 6/3/25 at 4:10 p.m., CNA B stated EBP was putting a towel across the table and setting everything up for incontinent care. She said the difference between EBP and transmission-based precautions was standard precautions were washing your hands and wearing gloves for incontinent care. She said she was unsure what high contact resident care activities would need EBP. CNA B said she had been trained on EBP but did not remember when. During an interview on 6/3/25 at 4:28 p.m., CNA A stated EBP was putting barrier cream on the resident. She said the nurses told the CNA's when needed. CNA A said she was unsure of the difference between EBP and TBP. She said high contact resident activities included changing the residents. She said she wore gloves and washed her hands before and during incontinent care. She said she was unsure if she was trained on EBP. 3. Record review of Resident #51's face sheet, dated 06/03/25, indicated a [AGE] year-old male who was admitted to the facility on [DATE]. His diagnoses included gastrostomy tube and extended spectrum beta lactamase resistance (ESBL)(bacteria resistant to antibiotics). Record review of Physician Orders for June 2025 indicated Resident #51 had an order, dated 11/17/25, check feeding tube site every shift. The physician orders did not indicate the use of enhanced barrier precautions. Record review of Resident #51's quarterly MDS, dated [DATE], indicated Resident #51 was moderately impaired cognitively with a BIMS of 9 out of 15. Resident #51 had a feeding tube and received 51% or more of his calories through the feeding tube. Record review of Resident #51's care plan, dated 12/04/24, indicated Resident #51 had MRSA - colonization interventions to notify doctor of significant abnormalities. Care plan, dated 11/18/24, indicated Resident #51 had a gastrostomy tube feeding with interventions of care to gastrostomy tube as ordered and monitor for signs and symptoms of infection and give feeding as ordered. During an observation on 06/02/25 at 9:00 a.m. revealed Resident #51 was in his bed with a gastrostomy tube connected to a feeding pump with Jevity 1.2 which infused at 73 milliliters an hour. There was no EBP signage inside or outside of the resident's room which indicated the type of PPE required and no PPE set up noted before entering the room. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 06/03/25 at 8:50 a.m. revealed Resident #51 had no EBP signage on the door and no set up for PPE. LVN G prepared Resident #51's morning meds for administration thru his g-tube and did not wash her hands but donned gloves before the start of care. The WC Nurse took her medications into the resident's room and placed it on his bedside table. She turned off his feeding pump, repositioned the resident to expose his abdomen and disconnected the feeding tubing from the residents abdominal g-tube tubing. During medication administration LVN G did not have on a PPE gown and her uniform touched the resident's bed and his left side while she leaned to administer the medications. LVN G removed her gloves and went to her medication cart to obtain a syringe and did not perform hand hygiene. LVN G donned a fresh set of gloves, flushed Resident #51 g-tube with 30cc of water and her uniform was touching the resident's bed and his left side while she leaned to administer the water. During an observation on 06/03/25 at 1:00 p.m. revealed Resident #51 had no EBP signage on the door and no set up for PPE. CNA C and CNA D assisted Resident #51 during transfer care from the bed to the wheelchair. CNA C and CNA D did not wash their hands but donned gloves before the start of care. During the transfer care, CNA C and CNA D did not have on a PPE gown and their uniform touched the resident's bed and his body (one CNA on each side). In an interview on 06/03/25 at 10:30 a.m., Resident #51 said the staff did not wear gowns during his personal care of changing his brief, administering medications or during his showers. In an interview on 06/04/25 at 1:20 p.m., CNA C said EBP was putting barrier cream (a topical product to protect the skin's natural barrier) on the resident. CNA C said no residents on her halls were on EBP. CNA C said high contact resident care activities included incontinent care or feeding residents. She was unsure of the difference between EBP and TBP. CNA C said she received infection control training during orientation, which included PPE, when to wear it and what kind of isolation needed certain PPE, but had not received EBP training until 06/04/25. In an interview on 06/03/25 at 1:30 p.m., CNA D said EBP was putting barrier cream on the resident. CNA D said she was unsure of the difference between EBP and TBP. She said high contact resident activities included changing resident's dirty brief. CNA D said she wore gloves and washed her hands before and during incontinent care. She said she had not been trained on EBP prior to 06/04/25. In an interview on 06/03/25 at 1:55 p.m., LVN G said she was responsible for teaching the CNA class and helping out wherever she was needed. LVN G said she did not know until today when she was in-serviced by the DON what EBP was. LVN G stated she should have worn a gown when she administered g-tube medications to Resident #51, because that was considered a direct contact. She said not wearing a gown increased the risk of spreading infection. LVN G said she should have washed her hand during glove change. LVN G explained she received infection control training on glove changes during orientation. She said the resident could acquire an infection when she did not follow good infection control practices which included washing hands before commencing care. 4. Record review of Resident #53's face sheet, dated 06/03/25, indicated an [AGE] year-old female who was admitted to the facility on [DATE]. Her diagnoses included chronic heart failure and hypertension. (continued on next page)

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Magnolia Place Health Care	1620 Magnolia St. Liberty, TX 77575

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Physician Orders for June 2025 indicated Resident #53 had an order, dated 05/30/25, to provide foley catheter for urinary retention, care every shift, and change monthly and as needed. The physician orders did not indicate the use of enhanced barrier precautions. Record review of an admission MDS, dated [DATE], indicated Resident #53 was cognitively intact with a BIMS of 14 out of 15. The MDS did not document a foley catheter. Record review of Resident #53's care plan, dated 12/04/24, indicated Resident #53 had interventions to follow therapeutic regime for elimination of urinary tract infections. During an observation on 06/02/25 at 9:30 a.m. revealed Resident #53 was in her bed. A urinary foley catheter was noted with 200 mililiters of yellow urine in the drain bag. There was no EBP signage or PPE set up noted before entering the room. During an observation on 06/03/25 at 8:40 a.m. revealed Resident #53 was in her bed. A urinary foley catheter was noted with 100 mililiters of yellow urine in the drain bag. There was no EBP signage or PPE set up noted before entering the room. During an observation on 06/04/25 at 9:00 a.m. revealed Resident #53 was in her bed. A urinary foley catheter was noted with 200 mililiters of yellow urine in the drain bag. There was no EBP signage or PPE set up noted before entering the room. 5. Record review of Resident #58's face sheet, dated 06/03/25, indicated a [AGE] year-old female who was admitted to the facility on [DATE]. Her diagnosis included cutaneous abscess of right lower limb. Record review of Physician Orders for June 2025 indicated Resident #58 had an order, dated 06/02/25, for right and left heel cleanse with wound cleanser apply medi honey and wrap with kerlix daily. Record review of Resident #58's quarterly MDS, dated [DATE], indicated Resident #58 was severely cognitively impaired with a BIMS of 7 out of 15. Resident #58 had two unhealed stage 3 pressure ulcers. Record review of Resident #58's care plan, dated 10/02/24, indicated Resident #58 had a skin integrity issue with interventions of care to monitor for signs and symptoms of infection. During an observation on 06/02/25 at 9:30 a.m. revealed Resident #58 was in her bed. There was no EBP signage or PPE set up noted before entering the room. During an observation on 06/03/25 at 8:40 a.m. revealed Resident #58 had no EBP signage on the door and no set up for PPE. During an observation on 06/04/25 at 9:00 a.m. revealed Resident #58 had no EBP signage on the door and no set up for PPE. 6. Record review of a face sheet dated 06/03/25 indicated Resident #167 was an [AGE] year-old female who was admitted on [DATE]. Her diagnoses included gastrostomy tube (a small flexible tube surgically inserted though the abdomen into the stomach to deliver nutrition to the resident). (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 06/02/25 at 02:35 p.m. Resident #167 was in her bed. A feeding pump was noted connected to a gastrostomy tube which was going into the resident's abdomen. There was no EBP signage or PPE set up noted before entering the room. Record review of Physician Orders for June 2025 indicated Resident #167 had an order dated 02/24/25 check feeding tube site every shift. The physician orders did not indicate the use of enhanced barrier precautions. Record review of an MDS dated [DATE] indicated Resident #167 was cognitively intact with a BIMS of 13 out of 15, had a feeding tube, and received 51% or more of her calories through the feeding tube. Record review of a care plan dated 04/04/25 indicated Resident #167 had a gastrostomy tube feeding with interventions of local care to gastrostomy tube as ordered and monitor for signs and symptoms of infection and give feeding as ordered. There was no indication of EBP to be used. During an observation on 06/03/25 at 09:55 a.m. Resident #167 had no EBP signage on the door and no set up for PPE. During an observation on 06/04/25 at 08:36 a.m. Resident #167 had no EBP signage on the door and no set up for PPE. During an interview on 06/03/25 at 5:00 p.m., the ADON/IP said she was responsible for the infection control program. She said she was the infection preventionist. She said she was not aware of any changes or updates within the last two years. She said the DON and Administrator notified her of infection control updates. She said no residents in the facility were currently on enhanced barrier precautions. During an interview on 06/03/25 at 5:07 p.m., the DON said enhanced barrier precautions were the new CDC recommendations to use a face mask more than just with regular isolation. She said she was not aware of the specifics but knew it was the new update. She said the Administrator received the provider letters. She said she was unable to say her expectations related to EBP. The DON said she was aware new regulation changes were on the horizon. She said the facility had 3 Residents with g-tubes and 2 residents with foley catheters and they were not currently on EBP. During an interview on 06/03/25 at 5:18 p.m., the Administrator said he was aware briefly of EBP but did not realize there was a provider letter that put EBP into effect. He said he did not receive all the provider letters so he was unsure of the details, but he would pull up the provider letters online, he thought it was a recommendation not a requirement according to the CDC. During an interview on 06/04/25 at 3:50 p.m., ADON/IP said she was responsible for the Infection control program that now included EBP with the DON as back up. She said the risk of a resident that should be on EBP not receiving EBP precautions was increased risk of infection. She said she was trained on EBP on 06/03/25. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 06/04/25 at 3:53 p.m., the DON said she expected the staff to follow EBP precautions on all residents identified needing EBP. She said there is no resident risk for the staff not following EBP because all residents were treated with universal precautions and if a resident had a risk or active infection they would be on special precautions as needed. During an interview on 06/04/25 at 3:53 p.m., the Administrator said he was ultimately responsible for concerns in the facility. He said the ADON/IP was responsible for the infection control program including EBP and the DON was the back up. He said he expected staff to follow EBP precautions on all residents identified needing EBP. He said there is no resident risk for the staff not following EBP because all residents were treated with universal precautions and if a resident had a risk or active infection they would be on special precautions as needed. Record review of the facility's policy titled, Enhanced Barrier Precautions, effective 06/04/2025, indicated, It is the policy of this facility to implement enhance barrier precautions for the prevention of transmission of multidrug-resistant organisms. EBP refer to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and gloves use during high contact resident care activities.b. An order for enhanced barrier precautions will be obtained for residents with any of the following: i. Wounds (e.g., chronic wounds such as pressure ulcers, diabetic foot ulcers, . or indwelling medical devices (e.g., central lines, urinary catheters, feeding tubes, . even if the resident is not known to be infected or colonized with a MDRO.)

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F 0945 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Include as part of its infection prevention and control program, mandatory training that includes written standards, policies, and procedures for the program. Based on observation, interview and record review the facility failed to ensure as part of its infection prevention and control program mandatory training included the written standards, policies, and procedures for the program for 11 of 12 employees, new and existing staff, (Administrator, DON, ADON/IP, LVN E, LVN H, CNA A, CNA B, CNA F, CNA I, CNA J, and CNA K) reviewed for training. 1. The facility failed to ensure the Administrator, DON, ADON/IP were trained on EBP (an infection control strategy that uses gloves and gowns during high- contact resident care to reduce spread of MDRO) (MDRO-bacteria that have become resistant to certain antibiotics) 2. The facility failed to ensure LVN E and LVN H were trained on EBP. 3. The facility failed to ensure CNA A, CNA B, CNA F, CNA I, CNA J and CNA K were trained on EBP. These failures could place residents at risk of illness due to lack of staff training. Findings include: Record review of a facility's in-service on 06/04/25, titled, Enhanced Barrier Precautions, indicated, It is the policy of this facility to implement enhance barrier precautions for the prevention of transmission of multidrug-resistant organisms indicated all nurses and CNAs were educated after surveyor intervention. During an observation and interview of incontinent care on 06/03/25 at 03:05 p.m., CNA A provided incontinent care to Resident #11 with assistance of CNA B. Resident #11 was in his bed. CNA A provided the incontinent care while CNA B assisted by holding Resident #11's shoulder and hip. CNA A and CNA B donned gloves, but they did not put on a gown. There was no EBP sign on the door or in the room. Resident #11 observed with an intact g-tube (small flexible tube surgically inserted through the abdomen and stomach to deliver nutrition to the stomach). When asked did they forget anything or would do anything different CNA A and CNA B said no. During an interview on 6/3/25 at 4:10 p.m., CNA B when asked what EBP was, she said putting a towel across the table and setting everything up for incontinent care when asked the difference between EBP and TBP she said standard precautions was washing your hands and wearing gloves for incontinent care. She said she was unsure what high contact resident care activities would need EBP. CNA B said she had been trained on EBP but did not remember when. During an interview on 6/3/25 at 4:20 p.m., CNA K said she was unsure what EBP was, she said she had been trained on EBP in class earlier this year but unsure when. She said high contact resident care activities included changing and dressing residents. CNA K said the PPE worn depended on the type of infection or isolation the resident was in. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676011	A. Building B. Wing	06/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Magnolia Place Health Care	1620 Magnolia St. Liberty, TX 77575

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F 0945 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During the interview on 6/3/25 at 4:25 p.m., LVN E said she was responsible for halls 100, 200, and 300. She stated she was unsure what EBP was but she knew it included gloves. She said TBP included airborne, contact, droplet precautions but she had not heard anything about EBP. LVN E said for residents on isolation, staff did not remove anything out of a resident's room until it's covered and bagged properly and used hand hygiene properly. LVN E said she was unsure if she was trained on EBP. She said there were no residents on her halls on EBP and if a resident had some kind of infection or a reason to be on isolation precautions they were put in a private room. During an interview on 6/3/25 at 4:28 p.m., CNA A when asked what EBP was, she said putting barrier cream (a topical product to protect the skin's natural barrier) on the resident. She said the nurses tell the CNA's when needed. CNA A said she was unsure of the difference between EBP and TBP. She said high contact resident activities included changing the residents. She said she wore gloves and wash her hands before and during incontinent care. She said she was unsure if she was trained on EBP. During an interview on 6/3/25 at 4:33 p.m., LVN H said she was responsible for halls 400, 500 and 600. She said she was unsure what EBP was. She said the difference between EBP and TBP included use of PPE depending on the type of isolation. She said none of the residents on her halls were on EBP. During an interview on 6/3/25 at 4:40 PM, CNA F said barrier meant the green pad she put down on the table to separate supplies and cream that was put on the resident for skin issues. She said she was unsure of the difference between EBP and TBP. CNA F said she was trained on EBP. She said isolation included putting on a gown, mask and gloves and it must be disposed of properly. CNA F said a few residents on hall 300 received barrier cream when asked if any residents were on EBP. During an interview on 6/3/25 at 4:47PM, CNA I said EBP was putting barrier cream on the resident. She was unsure of the difference between EBP and TBP. She said she received infection control training which included PPE, when to wear it and what kind of isolation needed certain PPE. CNA I said no residents on her halls were on EBP. CNA I said high contact resident care activities included incontinent care. During an interview on 06/03/25 at 4:55 p.m., CNA J said EBP was a way to control infection, staff wore a gown and gloves. She said the difference between TBP was isolation, the resident could not go around in the facility or leave the room and staff must wear complete PPE to enter the resident room. She said for EBP the resident did not have to stay in their room, but staff wore a gown and gloves for direct patient care. CNA J said high contact resident care activities included changing or dressing the resident. She said the charge nurse would notify the CNA's of EBP and TBP, and there would be a sign on the door and PPE on the outside of the door and PPE to use for resident care. CNA J said no residents on her hall received EBP at this time. During an interview on 06/03/25 at 5:00 p.m., the ADON/IP said she was responsible for the infection control program. She said she had not been updated or completed any joint trainings or provider trainings. She said she was not aware of any changes or updates within the last two years. She said EBP did not sound familiar to her and she was not trained on EBP. She said she did not go to any provider or joint trainings. She said she looked on the Texas Health and Human Services website and CDC for changes. She said the DON and Administrator notified her of updates. The ADON/IP said she was responsible for training staff on infection control concerns. She said no residents in the facility were on EBP. (continued on next page)

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F 0945 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 06/03/25 at 5:07 p.m., the DON, said EBP was the new CDC recommendations to use face a mask more than just with regular isolation. She was not aware of the specifics but knew it was the new update in infection control. She said she had not been trained on EBP. The DON said she had no luck signing up for the in-person trainings, joint trainings, or classes, they were always full. She said she stayed up to date through emails and provider letters, but it was a lot to sort through. The DON said the Administrator also received provider letters and notified her of them. She said she was unable to say her expectations related to the infection control program and EBP. She said herself and the ADON/ IP worked together to complete the infection control program. The DON said the new regulations changes were on the horizon, but she did not take the class. She said the facility had 3 Residents with g-tubes and two residents with Foley catheters (a thin tube placed in the bladder to drain urine when normal urination id not possible) and they were not currently on EBP. During an interview on 06/04/25 at 3:50 p.m., ADON/ IP after surveyor intervention said she was now educated on EBP. She said she was responsible for the Infection control program now including EBP with DON as back up. She said the risk of a resident that should be on EBP not being on EBP was increased risk of infection. She said she was trained on EBP as of 06/03/25. During an interview on 06/04/25 at 3:53 p.m., the DON after surveyor intervention said she was now educated on EBP on 06/03/25. She said she had reached out to their training company for computer training to add EBP training and added it to orientation. She said the current nurses and CNAs were trained on 06/04/25. She said the ADON/IP was trained on EBP and was responsible for training staff and she was the back up. She said she expected her staff to be educated on EBP on hire and as needed and to follow EBP precautions on all residents identified needing EBP. She said there is no resident risk for staff not following EBP because all residents were treated with universal precautions and if a resident had a risk or active infection they would be on special precautions as needed. During an interview on 06/04/25 at 3:53 p.m., the Administrator after surveyor intervention said he was ultimately responsible for concerns in the facility including infection control education. He said the ADON/IP was responsible for infection control program including EBP and the DON was the back up. He said he expected all staff to be educated on EBP on hire and as needed and to follow EBP precautions on all residents identified needing EBP. He said there is no resident risk for the staff not following EBP because all residents were treated with universal precautions and if a resident had a risk or active infection they would be on special precautions as needed. Record review of the facility's policy titled, Enhanced Barrier Precautions, effective 06/04/2025, indicated, It is the policy of this facility to implement enhance barrier precautions for the prevention of transmission of multidrug-resistant organisms. EBP refer to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and gloves use during high contact resident care activities.b. An order for enhanced barrier precautions will be obtained for residents with any of the following: i. Wounds (e.g., chronic wounds such as pressure ulcers, diabetic foot ulcers, . or indwelling medical devices (e.g., central lines, urinary catheters, feeding tubes, . even if the resident is not known to be infected or colonized with a MDRO.)