STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676028	A. Building B. Wing	09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Southern Specialty Rehab & Nursing	4320 W 19th St Lubbock, TX 79407

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 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** 43150 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 to help prevent the development and transmission of communicable diseases and infections for 3 of 3 Residents observed for infection control for practices (Resident #1, Resident #2, and Resident #3) in that: 1. CNA A failed to use proper hand washing techniques before and after assisting with resident during wound care for Resident #1. CNA A washed her hands for 6 seconds with soap and friction before rinsing. 2. CNA A failed to use proper hand washing techniques before and after assisting with resident during wound care for Resident #2. CNA A washed her hands for 4 seconds with soap and friction before rinsing. 3. CNA B failed to use proper hand washing techniques before and after assisting with resident during wound care for Resident #3. CNA B put soap in hands, rubbing hands together under water and not allowing to lather. These failures could place residents at risk for infection through cross contamination of pathogens. The findings included: Resident #1: Record Review of Resident #1's face sheet revealed a [AGE] year-old male, admitted on [DATE] with a primary diagnosis of: urinary tract infection, anemia, paraplegia (paralysis of the legs and lower body), gastrointestinal hemorrhage (gastrointestinal bleeding), chronic viral hepatitis C (an infection caused by a virus that attacks the liver and leads to inflammation), hyperlipidemia (a condition in which there are high levels of fat particles in the blood), acid reflux, weakness, muscle wasting and atrophy (decrease in size and wasting of muscle tissue), thrombocytopenia (low platelet level), type 2 diabetes, dementia (a group of thinking and social symptoms that interferes with daily functioning), schizophrenia (a disorder that affects a person's ability to think, feel, and behave clearly), metabolic encephalopathy (a series of neurological disorders not caused by primary structure abnormalities), high blood pressure. (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

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #1's Annual MDS (Minimum Data Set) dated 08/29/2024, revealed Resident #1 had a BIMS Score of 06, meaning Resident #1 could not recall information. Record Review of Resident #1's Physician Orders dated 09/20/2024 revealed: Right Plantar foot: cleanse, pat dry, apply silver alginate and idosorb, skin prep peri wound, cover with gauze island bordered dressing once daily and PRN, one time a day related to pressure ulcer of other site, unstageable. Record Review of Resident #1 Care Plan dated 05/08/2024 revealed Resident #1 had an unstageable that had progressed to stage 4 on right plantar foot with interventions of administer medications as ordered, monitor/document for side effects and effectiveness, administer treatments as ordered, replace loose or missing dressings PRN, access/record/monitor wound healing at least weekly, measure length, width, and depth where possible, access and document status of wound perimeter, wound bed, and healing progress, report declines to the MD, avoid positioning the resident on the location of the pressure ulcer. During an observation on 09/26/2024 at 10:26 am CNA A failed to wash her hands prior to putting gloves on and proceeded with removing Resident #1's boot and sock on the right foot. CNA A held right foot up while LVN C performed wound care. After the completion of wound care CNA A had placed the socks back on Resident #1's foot. CNA A removed gloves and discarded in the trash. CNA A proceeded to wash hands after LVN C coached her to do so. CNA A turned on water in Resident #1's restroom. CNA A wet her hands and applied soap. CNA A applied soap/friction for 6 seconds and then rinsed her hands. CNA A used three clean paper towels to dry her hands and discarded in the trash. CNA A used one clean paper towel to turn off the faucet. Resident #2: Record Review of Resident #2 face sheet revealed a [AGE] year-old female, admitted on [DATE] with a primary diagnosis of schizophrenia (a disorder that affects a person's ability to think, feel, and behave clearly), seizures (a burst of uncontrolled electrical activity between brain cells that cause temporary abnormalities in muscle tone), quadriplegia (paralysis of all 4 limbs), polyneuropathy (is damage or disease affecting peripheral nerves in roughly the same areas on both sides of the body), acute respiratory failure (results from inadequate gas exchange by the respiratory system), heart failure, osteoarthritis (type of arthritis that occurs when flexible tissue at the ends of bones wears down), difficulty swallowing, polydipsia (excess thirst), urinary tract infection. Record review of Resident #2's Annual MDS (Minimum Data Set) dated 07/05/2024, revealed Resident #1 had a BIMS Score of 00, meaning Resident #2 had severe cognitive impairment. MDS indicated that Resident #2 had a pressure ulcer/injury, a scar over bony prominence, or a non-removable dressing/device. Under risk of pressure ulcers/injuries indicated that resident was at risk of developing a pressure ulcer. Under unhealed pressure ulcers/injuries indicated that Resident #2 had one or more unhealed pressure ulcers. Under current number of unhealed pressure ulcers/injuries at each stage indicated Resident #2 had 3 stage 3 pressure ulcers. (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 Resident #2 Care Plan dated 05/16/2024 revealed: Resident #2 had a stage 3 pressure ulcer to the sacrum and stage 3 pressure wound to the right upper back with interventions of: administer supplements per medical provider or dietician, administer treatments as ordered and monitor for effectiveness, replace loose or missing dressing PRN, access/record/monitor wound healing at least weekly, measure, length, width, and depth where possible, access and document status of wound perimeter, wound bed and healing progress, report declines to the MD, avoid positioning the resident on the location of the pressure ulcer, do not massage over bony prominences and use mild cleansers for peri/care/washing, educate the resident/family/caregivers as to causes of skin breakdown, including transfer/positioning requirements importance of taking care during ambulating/mobility, good nutrition and frequent repositioning, ensure heels are floated with the use of pillows, follow facility policies/protocols for the prevention/treatment of skin breakdown, incontinent care after each episode and apply moisture barrier, inform the resident/family/caregivers of any new area of skin breakdown, monitor nutritional status, serve diet as ordered, monitor intake and record, notify nurse immediately of any new areas of skin breakdown, notify nurse immediately of any new areas of skin breakdown, open areas, redness, blisters, discoloration noted during bath or daily care, report loose or missing dressings to the nurse. Wounds to be managed by [NAME] wound physicians, treat per provider orders and notify for worsening or non-healing wounds. Date Initiated: 02/15/2024 During an observation on 09/26/2024 at 10:59 am CNA A failed to wash her hands prior to putting gloves on and proceeded with removing Resident #2's boot and sock on the left foot. After the completion of wound care CNA A had placed the socks back on Resident #2's foot. CNA A removed gloves and discarded in the trash. CNA A turned on water in Resident #1's restroom. CNA A wet her hands and applied soap. CNA A applied soap/friction for 4 seconds and then rinsed her hands. CNA A used three clean paper towels to dry her hands and discarded in the trash. CNA A used one clean paper towel to turn off the faucet. Resident #3: Record Review of Resident #3's face sheet revealed a [AGE] year-old female, admitted on [DATE] with a primary diagnosis of: schizoaffective disorder (a mental health condition including schizophrenia and mood disorder), type 2 diabetes, morbid obesity, anxiety, quadriplegia (paralysis of all 4 limbs), high blood pressure, acute respiratory failure, contracture of muscle (occurs when your muscles, tendons, joints, or other tissues tighten or shorten causing a deformity), difficulty swallowing, muscle weakness, tracheostomy site. Record review of Resident #3's Annual MDS (Minimum Data Set) dated 08/18/2024, revealed Resident #3 had a BIMS Score of 12, meaning Resident #3 had mild cognitive impairment. MDS indicated that Resident #3 had a risk of a pressure ulcer/injury, a scar over bony prominence, or a non-removable dressing/device. Under unhealed pressure ulcers/injuries indicated that Resident #3 had one or more pressure ulcers/injuries. Under skin conditions indicated that Resident #3 had one stage 4 pressure ulcer and one stage 4 pressure ulcer that was upon admission. Record Review of Resident #3's Physician Orders, dated 08/09/2024, revealed Resident #3 had a stage 4 pressure ulcer to coccyx, cleanse, pat dry, apply collagen sheet and silver alginate, skin prep peri wound, cover with silicone bordered dressing and secure once daily PRN. (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 Resident #3 Care Plan dated 12/29/2023 revealed: Resident #3 had a pressure ulcer and the potential for additional pressure ulcer development with impaired mobility. Resident #3 had a stage 4 pressure ulcer to the coccyx with interventions of: Needs assistance to turn/reposition at least every 2 hours, requires a cushion to their wheel or Geri chair, requires the use of an air mattress, treat pain as per orde3rs to treatment/turning to ensure the resident's comfort, use lifting device, draw sheet, to reduce friction, wounds are to be managed by wound physicians, treat per provider orders and notify for worsening or non-healing wounds. During ana observation on 09/26/2024 at 11:20 am . CNA B turned on faucet and wet her hands. CNA B put soap in her hands and used soap/friction for three seconds and immediately rinsed her hands. CNA B grabbed two clean paper towels to dry hands and used the same paper towel used to dry hands to turn off the faucet. CNA B put on clean gloves and proceeded in aiding with turning of Resident #3 for LVN C to provide wound care. CNA B aided in turning Resident #3 twice and replaced wedge underneath Resident #3. CNA B covered Resident #3, removed gloves, and discarded in the trash. CNA B went into Resident #3 restroom to wash hands. CNA B turned on faucet and wet hands. CNA B put soap in hands and used soap/friction immediately under the water and not allowing soap to lather. CNA B completely rinsed hands. CNA B used two paper towels to dry hands and used the same paper towel to dry hands to turn off faucet. During an interview with CNA B on 09/26/2024 at 12:11 pm. CNA B stated she was trained in hand washing by competency checks and in-services monthly. CNA B stated hand washing should occur for 20 seconds, rinse, and then dry. CNA B stated the negative potential outcome of not washing hands properly would be to transfer germs and infections to others. During an interview with CNA A on 09/26/2024 at 1:01 pm. CNA A stated she read the policy for hand washing. CNA A stated the policy for hand washing stated to wet the hands with water, put soap on hands, wash hands for 20 seconds, rinse hands, and use clean paper towel to dry hands. CNA A stated she did not follow the policy for washing hands but did not know why she did not. CNA A stated she was not thinking about it. CNA A stated the policy had guidelines to stop the spread of infection. CNA A stated she worked in the facility since July and had not completed a competency check. CNA A stated she had been trained in hand washing by in-services, every two weeks. During an interview with the DON on 09/26/2024 at 1:10 pm. the DON stated hand washing was something that had been gone over multiple times and staff should know the process of washing hands. The DON stated accurate handwashing must be practiced for all residents, but especially those who are susceptible to infections such as trach/vent and wound residents. The DON stated the expectations for an effective infection control practices would be to follow the policy and the ultimate goal was to prevent the spread of infections. The DON stated hand washing competencies are done monthly as well as in-services. The DON stated the negative potential outcome for not using proper hand washing techniques would be the spread of infection and long term spread of infection could lead to death. During an interview with the Administrator on 09/26/2024 at 1:30 pm revealed the expectations of proper hand washing was to follow the policy and use proper infection control practices. The Administrator stated the staff had been trained in hand washing multiple times. The Administrator stated training for hand washing was by in-services and competency checks monthly. The Administrator stated the negative potential outcome of not using proper hand washing techniques would be the spread of infection. (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 the facility skills competency for CNA B titled; Hand Hygiene Checkoff dated 07/09/2024 revealed the following expectations were met: Hand washing with soap and water: 1. Wet hands with water using temperature that is comfortable. 2. Lather your hands by rubbing them together with the soap. Lather the backs of your hands, between your fingers, and under your nails. 3. Scrub your hands for at least 20 seconds. 4. Rinse your well under clean, running water. 5. Dry your hands using a clean towel or air dry them. Turn faucet off using a dry paper towel to touch the handle protecting clean hands from the contaminated handle. Record review of the facility skills competency for CNA A titled; Hand Hygiene Checkoff dated07/11/2024 revealed the following expectations were met: Hand washing with soap and water: 1. Wet hands with water using temperature that is comfortable. 2. Lather your hands by rubbing them together with the soap. Lather the backs of your hands, between your fingers, and under your nails. 3. Scrub your hands for at least 20 seconds. 4. Rinse your well under clean, running water. 5. Dry your hands using a clean towel or air dry them. Turn faucet off using a dry paper towel to touch the handle protecting clean hands from the contaminated handle. Record review of the facility in-services titled; Hand hygiene dated 03/18/2024 revealed 91 staff members signed and attended, No evidence of CNA A or CNA B attending this in-service. Record review of the facility in-services titled; Hand hygiene dated 03/18/2024 revealed 91 staff members signed and attended, CNA B attended this in-service. Record review of the facility in-service training report titled; Infection Control dated 08/10/2024 with 24 staff members attended and signed, CNA A attended this in-service. Record review of the facility policy titled; Fundamentals of Infection Control Precautions date revised 03/2024 revealed: A variety of infection control measures are used for decreasing the risk of transmission of microorganisms in the facility. These measures make up the fundamentals of infection control precautions. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1. Hand hygiene: Hand hygiene continues to be the primary means of preventing the transmission of infection. The following is a list of some situations that require hand hygiene. .before and after direct resident contact (for which hand hygiene is indicated by acceptable professional practice). Before and after assisting a resident with personal care. Upon and after coming into contact with a resident's intact skin (when taking a pulse or blood pressure and lifting a resident). After removing gloves or aprons. Recommending techniques for washing hands with soap and water include: Wetting hands first with clean, running water, applying the amount of product recommended by the manufacturer to hands, and rubbing hands together vigorously for at least 20 seconds covering all surfaces of the hands and fingers; then rinsing hands with water and drying thoroughly with a new disposable towel; and turning off the faucet on the hand sink with the disposable paper towel. Gloving: Wearing gloves does not replace the need for hand washing because gloves may have small inapparent defects or be torn during use, and hands can become contaminated during removal of gloves. Failure to change gloves between resident contacts is an infection control hazard. Record review of the facility policy titled; Infection Control Plan date revised 03/2024 revealed: The facility will require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.