

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676100	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/06/2025
NAME OF PROVIDER OR SUPPLIER San Angelo Nursing and Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 5455 Knickerbocker Rd San Angelo, TX 76904	

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 0685</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Some</p>	<p>Assist a resident in gaining access to vision and hearing services.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26221</p> <p>Based on observation, interview and record review, the facility failed to assist the residents in making appointments to ensure residents receive proper treatment and assistive devices to maintain hearing abilities for one of two residents (Resident #45) reviewed for hearing devices.</p> <p>The facility failed to make an appointment for an audiologist for Resident #45 after the Responsible Party requested one on 8/20/24.</p> <p>This failure could place residents at risk of decreased communication ability, quality of life, and/or social isolation.</p> <p>The findings included:</p> <p>Review of Resident #45's Admission Record, dated 2/29/25, revealed she was a [AGE] year-old female admitted to the facility on [DATE] with diagnosis including hearing loss.</p> <p>Review of Resident #45's Quarterly MDS Assessment, dated 11/29/24, revealed:</p> <p>She had a BIMS score of 5 of 15 (indicating severe cognitive impairment);</p> <p>She had minimal difficulty hearing (Difficulty in some environments e.g. when person speaks softly or setting is noisy); and</p> <p>She wore hearing aids.</p> <p>Review of Resident #45's Care Plan, dated 6/13/24, revealed she had a communication problem related to hearing deficit. The identified goal was the resident will be able to make basic needs known on a daily basis through the review date. Interventions included: Repeat as necessary; Request clarification from resident to ensure understanding; face when speaking; make eye contact; use alternative communication tools as needed. Refer to audiology for hearing consult as ordered.</p> <p>Review of Resident #45's Order Summary Report, dated 2/19/25, revealed an order dated 5/24/24 for audiological care as needed.</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 0685</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the Social Services Note, dated 8/20/24, revealed Resident #45's Responsible Party asked if the Social Worker could set Resident #45 up with an appointment with and audiologist for hearing aids.</p> <p>Interview and observation with Resident #45 on 2/18/25 at 10:13 AM revealed Resident #45 in her room reading a book, there was no television or radio on. Resident #45 stated surveyor would have to speak up because she could not hear anything. Even with speaking up Resident #45 had difficulty understanding surveyor. Surveyor wrote interview on notebook paper and Resident #45 answered verbally. Resident #45 stated staff frequently came into her room and did whatever they were going to do without taking the time to explain what they were doing. Resident #45 said the staff never tried communicating with her through a notebook or a dry erase board. Observation of the room revealed no dry erase and no notebooks near where Resident #45 sat. Resident #45 stated staff don't care to tell me anything, they just come and do what they're going to do. Resident #45 said she felt like a hindrance because no one would explain to her what was going on. Resident #45 stated, that's just harmful to treat someone that way and ignore you. Resident #45 stated she felt her happiness no longer mattered because no one took the time to talk to her. Resident #45 started crying and said the conversation with surveyor would make her feel better for a month. Resident #45 stated she felt like she was not treated like a human and was not important to anyone in the building.</p> <p>Interview on 2/19/25 at 6:25 PM CNA G stated she was aware of Resident #45's needs. CNA G described Resident #45 as very hard of hearing. CNA G said speaking very loudly generally worked for communicating with Resident #45 but the staff had to repeat things a couple of times but it would eventually communicate what was needed. CNA G said she never asked which was Resident #45's good ear or bad ear. CNA G said she had nothing to add about Resident #45's hearing ability.</p> <p>Interview on 2/19/25 at 6:44 PM LVN H stated he worked with Resident #45. LVN H said Resident #45 was hard of hearing. LVN H said Resident #45's right ear was her bad ear. LVN H said to communicate with Resident #45 he would get closer and enunciate and speak louder to her. LVN H said the facility never tried any communication tools with her, but they did use one with a different resident. LVN H said he did not know what kind of hearing loss Resident #45 had. LVN H stated Resident #45 was alert and oriented to person, place and time and had nothing else to add about her abilities.</p> <p>Interview on 2/20/25 at 9:19 AM CNA I stated he almost always worked on Resident #45's hall so he was familiar with Resident #45. CNA I said was extremely hard of hearing. CNA I stated to manage Resident #45's hearing they would normally speak louder and get right next to her so Resident #45 could read his lips. CNA I said Resident #45's good side was the left side. CNA I stated he used writing to communicate with a different resident but not with Resident #45. He stated he did not know if would be easier for them (CNA I and Resident #45) because it did not take long to communicate basic stuff. CNA I said he had nothing to add about Resident #45's hearing ability.</p> <p>Interview on 2/20/25 at 9:32 a.m. LVN J said he worked with Resident #45. LVN J said Resident #45 was hard of hearing but he was able to communicate with her. LVN J stated he never had to use communication tools with Resident #45 because if he got at eye level with her, she did not have a problem understanding. LVN J said he had nothing to add about Resident #45's hearing ability.</p> <p>(continued on next page)</p>

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<p>F 0685</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Some</p>	<p>Interview on 2/20/25 at 9:57 AM the Social Worker stated Resident #45 stayed in her room, her cognition was moderately impaired. The Social Worker stated she assessed Resident #45's cognition by completing the MDS Brief Mental Status interview. The Social Worker stated on 8/24/24 Resident #45's Responsible Party wanted the hearing appointment. The Social Worker stated she just hadn't reached out to the audiologist and then she just kind of forgot about it. The Social Worker said to communicate with Resident #45 a person had to get close to Resident #45 on her right side. The Social Worker said she had not tried any other communication tools with Resident #45 because Resident #45 had no problems answering questions once Resident #45 heard what the communicator was trying to communicate. The Social Worker stated she did not know if other communication tools would make communicating with Resident #45 easier because Resident #45's hearing was not assessed. The Social Worker said she usually found out if a resident had changes in hearing if the nurses on the floor told her.</p> <p>Interview on 2/20/25 at 12:03 PM the DON stated her expectation for staff when communicating with the hard of hearing was to get at eye level, speak in a clear voice, and ask one question at a time. The DON stated if the information was complex she would try to break the information down. The DON said Resident #45 would ask her (the DON) for clarification if she (Resident #45) did not understand. The DON was informed of the results of the investigation, and said she did not know if anyone had asked Resident #45 about her hearing and she did not know if Resident #45 was assessed for hearing aids. The Corporate RN, who was with the DON, said the MDS Nurse was required to assess when there was an MDS Assessment due. The Corporate RN stated the Social Worker should have acted quicker.</p> <p>Interview on 2/20/25 at 1:04 p.m. the MDS Coordinator state Resident #45's hearing aides were on Resident #45's nightstand table, were dirty and the batteries needed to be replaced. The MDS Coordinator stated Resident #45 stated the hearing aides were cleaned in the hospital. The MDS Coordinator stated Resident #45's Responsible Party wanted Resident #45 assessed for something stronger.</p> <p>Interview on 2/20/25 at 2:50 p.m. Resident #45's Responsible Party stated the facility supposedly got Resident #45 an appointment later in the month for an audiologist. Resident #45's Responsible Party stated they wanted the audiologist appointment to lessen Resident #45's depression so hopefully Resident #45 would leave her room and join activities more.</p> <p>Interview on 2/20/25 at 6:00 PM The Activity Director and Human Resources Director both said they probably would not leave their room or attend activities if they could not hear what was going on.</p> <p>Observation on 2/20/25 at 6:34 p.m. the Activity Director and Corporate RN, asked Resident #45 if new hearing aids would make a difference in Resident #45 attending activities. Resident #45 looked at surveyor and said, oh no, it's too late for me now. Resident #45 said she missed her old living arrangements where she could have one-on-one conversations with other old ladies.</p> <p>Review of the facility's undated Policy on Social Services revealed:</p> <p>The facility provides medically related social services. The social service program is designed to assist each resident to attain or maintain the highest practicable physical, mental, and psychosocial well-being. This includes assisting residents in maintaining or improving their abilities to manage their everyday physical, mental, and psychosocial needs.</p> <p>Review of the facility's undated Policy on Accommodation of Needs and Services Provided in the facility revealed:</p> <p>(continued on next page)</p>		

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F 0685 Level of Harm - Actual harm Residents Affected - Some	The facility provides residents with services in the facility with reasonable accommodation of individual needs and preferences. If the need arises, the resident will be assisted with arrangements to receive the services outside of the facility.

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<p>F 0745</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Some</p>	<p>Provide medically-related social services to help each resident achieve the highest possible quality of life.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26221</p> <p>Based on observation, interview and record review, the facility failed to assist the residents in making appointments to ensure residents receive proper treatment and assistive devices to maintain hearing abilities for one of two residents (Resident #45) reviewed for hearing devices.</p> <p>The facility failed to make an appointment for an audiologist for Resident #45 after the Responsible Party requested one on 8/20/24.</p> <p>This failure could place residents at risk of decreased communication ability, quality of life, and/or social isolation.</p> <p>The findings included:</p> <p>Review of Resident #45's Admission Record, dated 2/29/25, revealed she was a [AGE] year-old female admitted to the facility on [DATE] with diagnosis including hearing loss.</p> <p>Review of Resident #45's Quarterly MDS Assessment, dated 11/29/24, revealed:</p> <p>She had a BIMS score of 5 of 15 (indicating severe cognitive impairment);</p> <p>She had minimal difficulty hearing (Difficulty in some environments e.g. when person speaks softly or setting is noisy); and</p> <p>She wore hearing aids.</p> <p>Review of Resident #45's Care Plan, dated 6/13/24, revealed she had a communication problem related to hearing deficit. The identified goal was the resident will be able to make basic needs known on a daily basis through the review date. Interventions included: Repeat as necessary; Request clarification from resident to ensure understanding; face when speaking; make eye contact; use alternative communication tools as needed. Refer to audiology for hearing consult as ordered.</p> <p>Review of Resident #45's Order Summary Report, dated 2/19/25, revealed an order dated 5/24/24 for audiological care as needed.</p> <p>Review of the Social Services Note, dated 8/20/24, revealed Resident #45's Responsible Party asked if the Social Worker could set Resident #45 up with an appointment with and audiologist for hearing aids.</p> <p>(continued on next page)</p>		

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<p>F 0745</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Some</p>	<p>Interview and observation with Resident #45 on 2/18/25 at 10:13 AM revealed Resident #45 in her room reading a book, there was no television or radio on. Resident #45 stated surveyor would have to speak up because she could not hear anything. Even with speaking up Resident #45 had difficulty understanding surveyor. Surveyor wrote interview on notebook paper and Resident #45 answered verbally. Resident #45 stated staff frequently came into her room and did whatever they were going to do without taking the time to explain what they were doing. Resident #45 said the staff never tried communicating with her through a notebook or a dry erase board. Observation of the room revealed no dry erase and no notebooks near where Resident #45 sat. Resident #45 stated staff don't care to tell me anything, they just come and do what they're going to do. Resident #45 said she felt like a hindrance because no one would explain to her what was going on. Resident #45 stated, that's just harmful to treat someone that way and ignore you. Resident #45 stated she felt her happiness no longer mattered because no one took the time to talk to her. Resident #45 started crying and said the conversation with surveyor would make her feel better for a month. Resident #45 stated she felt like she was not treated like a human and was not important to anyone in the building.</p> <p>Interview on 2/20/25 at 9:57 AM the Social Worker stated Resident #45 stayed in her room, her cognition was moderately impaired. The Social Worker stated she assessed Resident #45's cognition by completing the MDS Brief Mental Status interview. The Social Worker stated on 8/24/24 Resident #45's Responsible Party wanted the hearing appointment. The Social Worker stated she just hadn't reached out to the audiologist and then she just kind of forgot about it. The Social Worker said to communicate with Resident #45 a person had to get close to Resident #45 on her right side. The Social Worker said she had not tried any other communication tools with Resident #45 because Resident #45 had no problems answering questions once Resident #45 heard what the communicator was trying to communicate. The Social Worker stated she did not know if other communication tools would make communicating with Resident #45 easier because Resident #45's hearing was not assessed. The Social Worker said she usually found out if a resident had changes in hearing if the nurses on the floor told her.</p> <p>Interview on 2/20/25 at 2:50 p.m. Resident #45's Responsible Party stated the facility supposedly got Resident #45 an appointment later in the month for an audiologist. Resident #45's Responsible Party stated they wanted the audiologist appointment to lessen Resident #45's depression so hopefully Resident #45 would leave her room and join activities more.</p> <p>Review of the facility's undated Policy on Social Services revealed:</p> <p>The facility provides medically related social services. The social service program is designed to assist each resident to attain or maintain the highest practicable physical, mental, and psychosocial well-being. This includes assisting residents in maintaining or improving their abilities to manage their everyday physical, mental, and psychosocial needs.</p> <p>Review of the facility's undated Policy on Accommodation of Needs and Services Provided in the facility revealed:</p> <p>The facility provides residents with services in the facility with reasonable accommodation of individual needs and preferences. If the need arises, the resident will be assisted with arrangements to receive the services outside of the facility.</p>		

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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>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26221 30057</p> <p>Based on observation, interview, and record review, the facility failed to 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 (Residents #14 and #28 and #288) of 4 residents reviewed for infection control in that:</p> <p>CNA F failed to wash her hands and change her gloves after they became contaminated during incontinent care while assisting Resident #14.</p> <p>CNA D used double gloves when she performed incontinent care for Resident #28.</p> <p>RN K failed to wash her hands and change her gloves after they became contaminated during wound care performed on Resident #288.</p> <p>These failures could place resident's risk for cross contamination and the spread of infection.</p> <p>Finding include:</p> <p>RESIDENT 14</p> <p>Record review of Resident #14's admission record dated 02/20/25 indicated he was admitted to the facility on [DATE] with diagnoses of dementia. He was [AGE] years of age.</p> <p>Record review of Resident #14's care plan dated 11/17/24 indicated in part: Problem: The resident has bowel/bladder incontinence related to dementia, limited mobility. Goal: The resident will not have any complications r/t bowel incontinence. Interventions: Incontinent: Check every two hours and as required for incontinence. Wash, rinse and dry perineum. Change clothing PRN after incontinence episodes.</p> <p>Record review of Resident #14's MDS dated [DATE] indicated in part: BIMS = 04 indicating resident had severe impairment. Urinary continence and bowel continence = Always incontinent.</p> <p>(continued on next page)</p>

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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>During an observation on 02/18/25 at 02:40 PM CNA A and CNA F transferred Resident #14 from his wheelchair to his bed with the use of a mechanical lift. Resident #14 was in a wheelchair and sitting on top of the lift sling. Both CNAs sanitized their hands and put on some gloves then connected the sling to the machine. After they transferred the resident to the bed they undid the resident's pants and brief. Resident #14 was noted to be wet with urine as it had leaked onto his pants. CNA A took some wet wipes and wiped the resident's penis and scrotum area and then changed her gloves. Both CNAs then turned Resident #14 on his right side and CNA F took some wet wipes and wiped the resident's rectal area. While CNA F wiped Resident #14's rectal area and her gloved hand come in contact with the resident's buttocks and rectal area. While wearing the same gloves she used to wipe the resident's rectal area, CNA F took a new brief and fastened it to the resident and also assisted with changing Resident #14's pants and putting a clean pair of pants on.</p> <p>During an interview on 02/18/25 at 02:55 PM CNA F said she should have changed her gloves and sanitized her hands before she applied the new brief and assisted Resident #14 with his pants. CNA F said there was a possibility of cross contamination and could lead to the spread of infections if her gloves were not changed.</p> <p>RESIDENT 28</p> <p>Record review of Resident #28's admission record dated 02/20/25 indicated he was admitted to the facility on [DATE] with diagnoses of high blood pressure and type 2 diabetes. He was [AGE] years of age.</p> <p>Record review of Resident #28's care plan dated 01/12/25 indicated in part: Problem: The resident has (specify urge, stress, functional, mixed) bladder incontinence related to Impaired mobility. Goal: The resident will remain free</p> <p>from skin breakdown due to incontinence and brief use. Interventions: Brief use: The resident uses disposable briefs. Change frequently and prn. Incontinent: Check Frequently and as required for incontinence. Wash, rinse and dry perineum. Change clothing PRN after incontinence episodes.</p> <p>Record review of Resident #28's MDS dated [DATE] indicated in part: BIMS = 15 indicating resident was cognitively intact. Urinary continence and bowel continence = Always incontinent.</p> <p>During an observation on 02/19/25 at 10:55 AM CNA C and CNA D performed incontinent care for Resident #28. Both CNA's entered the room and put on some PPE due to the resident being on EBP precautions. CNA D was seen putting 2 pair of gloves on. The aides assisted Resident #28 to his bed then removed his shorts and brief. The brief was noted to be wet with urine. CNA D wiped the resident's penis and in between his legs with some wet wipes. Both CNAs then turned the resident on his right side then CNA D took some wipes and wiped the resident's rectal area. Resident #28 had a bowel movement so CNA D wiped the resident's rectal area several times and some of the feces got on the CNA's gloves. CNA D then took the first pair of gloves off and placed a new pair of gloves over the second pair. CNA D then took some barrier cream and applied it to the resident's groin area. CNA D then removed the first pair of gloves and while wearing the second pair she and the other CNA fastened a new brief on the resident, put his shorts on then they removed their gloves.</p> <p>(continued on next page)</p>		

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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>During an interview on 02/19/25 at 05:07 PM CNA D said she was not sure if they were allowed to double glove during resident care. CNA D said she had learned to double glove while she worked at a previous facility. CNA D said if it was not considered safe to use double gloves during resident care then that could lead to cross contamination and the spread of infections.</p> <p>During an interview on 02/20/25 at 03:00 PM the DON said staff were expected to change their gloves when going from dirty to clean or if they came in contact with any bodily fluids. The DON said double gloving was not acceptable as that could lead to cross contamination. The DON said double gloving or not changing their gloves at the appropriate time could lead to the spread of infections and it was not good practice. The DON said the failure probably occurred because of a lack of training. The DON said they would be conducting training on the proper use of glove use and when to change them.</p> <p>RESIDENT #288</p> <p>Review of Resident #288's Admission Record, dated 2/19/25, revealed she was a [AGE] year-old female admitted to the facility on [DATE] with diagnosis including heart failure and chronic pain.</p> <p>Review of Resident #288's clinical records revealed the MDS had not been completed yet.</p> <p>Review of Resident #288's Care Plan, Initiated 2/10/25, revealed: Resident is on Enhanced Barrier Precautions related to increased risk of Multi-Drug Resistant Organisms acquisition - resident has a wound Deep Tissue Injury to sacrum, left heel, right great toe, right posterior leg. Venous ulcer to right dorsal foot. Goal: reduce transmission of multi drug-resistant organisms and will have no complications through review date. Interventions included: Ensure the staff have access to alcohol-based hand rub.</p> <p>Resident #288's Order Summary Report, dated 2/19/25, revealed orders dated 2/10/25 for Left Heel Deep Tissue Injury Cleanse with Wound Cleanser, apply Triple Antibiotic Ointment and cover with foam dressing, changed twice weekly and as needed one time a day every Tuesday and Friday for wound care.</p> <p>Observation on 2/19/25 at 3:53 PM revealed RN K slid a bordered bandage into her pocket on her pants. RN K stated she was just doing a little pressure wound on Resident #288. RN K put on a gown, put on gloves and entered the room. RN K had a stack of 4cm x 4cm gauze, 2 packet of triple antibiotic ointment and wound cleanser spray already set up on the bedside table with no barrier The wound care supplies were set up at the end of Resident # 288's bedside table, unevenly mixed with Resident #288's water. There was no barrier and no disinfecting wipes seen. RN K removed the old dressing. RN K described Resident #288's stage I pressure wound as probably 1 mm with 1/2 cm by 1 cm oval wound bed. With the same gloves, RN K took some gauze from the stack of 4 cm x cm gauze, sprayed it with the wound cleanser spray and cleanser spray; she wiped the wound and placed the dirty gauze onto Resident #288's bed. With the same contaminated gloves, RN K took another stack of 4cm x cm gauze, sprayed it with gauze, cleaned the wound and threw it in the resident's trash can. With the same dirty gloves RN K placed some triple antibiotic ointment onto her finger, smeared it onto Resident # 288's wound. Then with the same dirty gloves RN K pulled the bordered dressing out of her pocket and placed it onto Resident #288's heel. With the same contaminated gloves, RN K placed a sock over Resident # 288's heel, pulled off the sock from the other foot, did an edema check, changed the sock and then changed her gloves. RN K hooked the bottle of wound cleanser on her pants without sanitizing them.</p> <p>(continued on next page)</p>		

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(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>Interview on 2/19/25 5:01 p.m. RN K stated this was her 1st year of nursing. She stated the wound care could have gone better. RN K said she forgot to set up the bag at the end of the bed for the used wound care supplies and she did not wash her hands because Resident #288 was on Enhanced Barrier Precautions. RN K stated personally she did not like the border dressing used on Resident #288's foot because she had to fold it to make it fit. RN K said she liked to wash her hands at the end of the wound care but felt taking out the trash at the end defeated the purpose RN K said if she put the dirty gauze on the bed she contaminated the bed. RN K stated she was taught to avoid cross contamination as much as possible in nursing school and if cross contamination did happen to disinfect the area as much as possible. RN K stated in the real world it would not be any different. RN K stated she did clean the bedside table with a Sani-cloth wipe prior to setting up wound care supplies, but admitted she put the bandage in her pocket. RN K said there was no barrier between the bedside table and the wound care supplies. RN K said her gloves were dirty through the wound care and she probably should have applied the triple antibiotic ointment with an applicator. RN K said the only training she received when hired was the nurse she shadowed but the Assistant Director of Nursing was very good about answering any questions she had about wound care, but it was more about order clarification.</p> <p>Interview on 2/20/25 at 12:29 p.m. the DON with the Corporate RN present stated her expectation for wound care was the nurse to gather her supplies, put the supplies on wax paper, and have extra gloves. The DON stated she expected the staff to wash their hands, place a trash bag at the foot of the bed, put on gloves, take off the old dressing, take off the old dressing, using alcohol gel, put on clean gloves, clean the wound inner wound to outer wound, change those gloves using alcohol in between, put on the clean dressing, take off the gloves, place excess material into the trash, make sure the resident was comfortable, place a clean glove on, dispose of the trash, and wash hands.</p> <p>Record review of the facility's policy titled Infection prevention program policy and dated 08/21/2024 indicated in part: Purpose: To describe the structure , function and processes in place to prevent healthcare associated infections in patients, visitors and staff and to establish policy, guidelines and responsibilities for [name] Nursing and rehab infection prevention program. Policy: The goal of the infection prevention program and its activities is to improve clinical outcomes and have a multidisciplinary approach within a coordinated and structured program. The infection prevention program (IPP) is established to: Provide a mechanism for the surveillance, prevention and control of infection and to ensure the facility compliance with the requirements of the centers for Medicaid and Medicare. Department of Health and local, state and federal agencies as they relate to infection prevention. Review and provide recommendations in the matters concerning isolation, sanitation and asepsis policies and procedures. Develop, review, revise and approve infection prevention standards and policies and infection prevention procedures.</p> <p>Record review of the facility's policy titled Glove use dated 2012 indicated in part: Purpose: to provide guidelines for the use of gloves for resident and employee protection. When gloves are indicated, disposable single-use gloves (preferably latex free) should be worn. Used gloves should be discarded into the nearest waste receptacle inside the room. Perform hand hygiene after removing gloves. Disposable (single-use) gloves must be replaced as soon as practical when contaminated, torn, punctured, they exhibit signs of deterioration or when their ability to function as a barrier is compromised. When to use gloves - gloves should be used- when touching excretions, secretions, blood, body fluids, mucous membranes or no-intact skin; when the employee's hands have any cuts, scrapes, wounds, chapped skin, dermatitis. Etc, when it is likely that hands will come in contact with blood, body fluids or other potentially infectious material.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676100	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/06/2025
NAME OF PROVIDER OR SUPPLIER San Angelo Nursing and Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 5455 Knickerbocker Rd San Angelo, TX 76904	
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0908</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Keep all essential equipment working safely.</p> <p>30057</p> <p>Based on observation and interview the facility failed to maintain all mechanical, electrical, and patient care equipment in safe operating condition for 1 of 1 kitchen reviewed for physical environment.</p> <p>The facility failed to ensure one of six stove top burners ignited automatically.</p> <p>This failure could place residents at risk of foodborne illnesses and potential for injury to residents and staff.</p> <p>Findings included:</p> <p>During an observation and interview on 02/18/25 at 10:02 AM, the stove in the kitchen was inspected. One of the six burners was noted to not turn on when the knob was turned to the on position by [NAME] E. [NAME] E said the burner had not worked for a while and was not sure what was wrong with it or if it was clogged. The DM attempted to try and light it up manually, but it would not light up. During the time the DM turned the knob you could hear and smell the gas coming out of the pilot, but it would not light the burner. The burner appeared to have a buildup of grease on some sort of gunk on it. The DM said they would try to wash the burner to see if it unclogged it. The DM said he had not reported to the Maintenance department that the burner was not working.</p> <p>During an observation and interview on 02/20/25 at 01:15 PM, the stove top was inspected again with the DM and the burner was still noted to have the built up of grease and gunk on it. The burner knob was tuned on and the burner did not light up. There was a sound of gas passing through to the burner but it would not light up. The DM again said he would try to remove the burner and clean it or call the service repair person. The DM said he had been working at the facility for about 2 years and the burner had been non-functional since then.</p> <p>During an interview on 02/20/25 at 01:22 PM, the Administrator was made aware of the burner in the stove top not working. The Administrator said he had been at the facility for the last 2 months and was not aware of the burner not working. The Administrator said he would look into it and look for a policy regarding essential equipment.</p> <p>During an interview on 02/20/25 at 02:28 PM, the DM said they had washed the burner and that it was working a little better but that the service person was still coming later to completely repair the rest of the parts. The DM stated outcome of the other burner was not working, was a possibility of an explosion or someone getting hurt.</p>		