

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  676172	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  08/07/2024
NAME OF PROVIDER OR SUPPLIER  Groveton Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 1020 W 1st St Groveton, TX 75845	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46273</b></p> <p>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 1 of 5 residents reviewed for infection control. (Resident #5)</p> <p>The facility failed to ensure CNA A did not leave a trash bag containing a used brief on the floor of Resident #5's room on 8/5/24.</p> <p>The facility failed to implement enhanced barrier precautions for Resident #5 on 8/6/24.</p> <p>These failures could put residents at risk of infections and decreased quality of life.</p> <p>Findings include:</p> <p>Record review of a facility face sheet dated 8/6/24 for Resident #5 indicated that she was a [AGE] year-old female admitted to the facility on [DATE] and subsequently readmitted on [DATE] with diagnoses including: Extended Spectrum Beta Lactamase (ESBL) Resistance and urinary tract infection.</p> <p>Record review of a Quarterly MDS assessment dated [DATE] for Resident #5 indicated that she had a BIMS score of 3, which indicated that she had severe cognitive impairment. She was always incontinent of bowel and bladder. She required moderate to total assistance with toileting and personal hygiene. Section I (Active Diagnoses) indicated that she had a multi-Drug resistant organism (MDRO).</p> <p>Record review of an Order Report Summary dated 8/6/24 for Resident #5 indicated that she did not have an order for enhanced barrier precautions.</p> <p>Record review of a comprehensive care plan dated 4/30/24 for Resident #5 indicated that she had a focus of Resident is on enhanced barrier precautions Interventions included .Gloves and gown should be donned if any of the following activities are to occur: linen change, resident hygiene, transfer, dressing, toileting/incontinent care, bed mobility, wound care, enteral feeding care, catheter care, trach care, bathing, or other high-contact activity ad .Posting at the resident room entrance indicating the resident is on enhanced barrier precautions Comprehensive care plan also indicated that she had a focus f .The resident has Urinary Tract Infection, placed on Macrobid 100mg daily for prophylactic colonized ESBL with interventions includig . Continue enhanced barrier precautions dated 6/15/24.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of hospital records for Resident #5 from admitted [DATE] red .Microbiology: UA revealed quite significant pyuria with urine cultures growing out an ESBL producing E. coli. ad .Assessment and Plan of Treatment: UTI with an ESBL producing gram-negative rod</p> <p>Record review of Resident #5's electronic medical record dashboard on 8/6/24 indicated that she had enhanced barrier precautions.</p> <p>Record review of an undated list of residents on enhanced barrier precautions provided by the DON indicated that Resident #5 was not on the list.</p> <p>During an observation on 8/5/24 at 9:23 a.m., a clear plastic trash bag was noted on the floor in Resident #5's room. It contained what appeared to be a used brief. Residents room did not have signage indicating that she was on enhanced barrier precautions.</p> <p>During an interview on 8/5/24 at 9:26 a.m., LVN B said the trash bag should not have been left in Resident #5's room on the floor. She said residents could be at risk of infection if proper infection control measures were not followed.</p> <p>During an interview on 08/06/24 at 02:15 p.m., CNA A said she had taken care of Resident #5 yesterday morning. She said she had changed her and went to get the barrel and got distracted. She said she had left the trash bag in there and she was upset about it. She said she'd been trained on infection control. She said she would do better in the future. She said she was unaware that resident was to be on EBP until today. She said Resident #5 did not have the sign or PPE there until earlier today. She said it was not there during incontinent care this morning. She said residents could be at risk of developing infections if proper infection control measures were not followed.</p> <p>During an observation on 08/06/24 at 10:05 a.m., CNA A and CNA C were both present in Resident #5's room to provide incontinent care. Both washed their hands in the bathroom and applied gloves. Had supplies set up on an overbed table in the room. CNA C pulled the covers down and opened the resident's brief and placed it between her legs. CNA A rolled the resident onto her right side and CNA C removed the brief and placed it in the trash. CNA C removed her gloves and placed them in the trash and washed her hands. CNA C placed gloves on both hands, placed a towel underneath the resident's buttocks. CNA A placed a towel over the resident to cover her. Both CNAs removed their gloves and placed them in the trash, sanitized their hands and applied gloves. CNA C removed a wipe from the plastic bag and wiped across the lower abdomen and placed the wipe in the trash. CNA C removed another wipe and wiped down the middle of the vagina from front to back and placed the wipe in the trash. CNA C removed another wipe from the plastic bag and wiped both inner thighs and placed the wipe in the trash. CNA C removed her gloves and placed them in the trash, washed her hands and applied gloves. CNA A rolled the resident onto her right side and CNA C removed a wipe from the plastic bag and wiped the resident's rectal area from front to back. CNA C removed the towel that was underneath the resident's buttocks and removed her gloves. CNA C sanitized her hands and put on gloves. CNA C placed a brief and secured it in place. Both repositioned the resident in bed, removed their gloves and washed their hands.</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 - Few</p>	<p>During an interview on 8/6/24 at 3:40 p.m., CNA C said they had an in-service some months ago by the Administrator on EBP. She said they were told which residents were on EBP and they also had notes on the resident doors along with PPE in drawers outside of their rooms in the hallways. She said when a resident was on EBP that meant the staff had to wear a gown and gloves while providing incontinent care. She said the residents that were on EBP included Resident #5.</p> <p>During an interview on 8/6/24 at 3:45 p.m., LVN B said the residents that were on EBP included Resident #5, who was placed on EBP earlier that day. She said anyone with a history of ESBL colonization, anyone with wounds, foley catheters, have MRSA or any opening to the body that could cause infection would be placed on EBP.</p> <p>During a joint interview on 08/07/24 at 11:47 a.m., the DON said that going forward they would review all hospital records when residents come back from hospital and take appropriate actions with MDROs. DON and Administrator said they would be providing education to all the staff, and they would be doing a PIP and QAPI. DON said they would be reviewing CMS guidelines to ensure they follow the appropriate infection control practices. DON said residents could be at risk of an outbreak of proper procedures were not followed.</p> <p>Record review of a CNA Proficiency Audit for CNA A dated 4/16/24 indicated she had been trained on infection control awareness, including universal precautions, with perineal care.</p> <p>Record review of a facility policy titled Enhanced Barrier Precautions undated read:</p> <ol style="list-style-type: none"> <li>1.EBP are indicated for residents with any of the following: Colonization with a CDC-targeted MDRO when Contact Precautions do not otherwise apply (see MDRO list on page 3) .;</li> <li>2.Resident status: Colonized with a CDC-targeted MDRO without a chronic wound, indwelling medical device or secretions that are unable to be covered or contained. Use EBP: Yes .;</li> <li>3.Donning PPE for Residents on EBP Based on activity provided / assistance while in resident room: providing hygiene .Don gloves and gown: yes .;</li> <li>4. (from page 3, referenced above) .List of colonized MDRO to utilize EBP: .ESBL-producing Enterobacterales .;</li> <li>5.Communication to staff: The facility will utilize postings outside the room and Point Click Care to communicate to staff if a resident requires EBP .</li> </ol> <p>Record review of a facility policy titled Perineal Care Female dated 2003, with a revision date of December 8, 2009, read .Closing steps .discard disposables per facility policy .</p> <p>Record review of CMS Memo titled Center for Clinical Standards and Quality/Quality, Safety &amp; Oversight Group Ref: QSO-24-08-NH read .The recommendations now include the use of EBP during high-contact care activities for residents with chronic wounds or indwelling medical devices, regardless of their MDRO status, in addition to residents who have an infection or colonization with a CDC-targeted or other epidemiologically important MDRO when contact precautions do not apply .</p>		