STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676175	A. Building B. Wing	09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Permian Residential Care Center	1601 NE Mustang Andrews, TX 79714

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 43344 Based on observation, interview, and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety in 1 of 1 dining rooms reviewed for dietary services. LVN A failed to properly serve a beverage to Resident #39 during the noon meal service. LVN B failed to properly serve beverages to Resident #3 and Resident #61 during the noon meal service. LVN C failed to properly serve a beverage to Resident #8 during the noon meal service. These failures could place residents at risk for food contamination and foodborne illness. The findings included: Observations were made on 09/25/24 during noon dining services and revealed the following: At 11:50 AM, LVN A picked up a glass of ice water from the serving area and took it to Resident #39 who was seated at the dining table. LVN A did not wear gloves or use hand sanitizer prior to serving the glass of water. LVN A's hand placement was over the top of the glass and her fingers touched the top of the glass where the resident would drink from. Resident #39 drank from the glass after it was placed in front of her. At 11:53 AM, LVN B picked up a glass of ice water from the serving area and took it to Resident #3 who was seated at the dining table. LVN B's hand placement was over the top of the glass and her fingers touched the top of the glass where the resident would drink from. Resident #3 drank from the glass after it was placed in front of her. At 12:15 PM, LVN B picked up a glass of ice water and took it to Resident #61 who was seated at the dining table. While serving Resident #61, LVN B did not wear gloves or use hand sanitizer prior to serving beverages. LVN B's hand placement was over the top of the glass and her fingers touched the top of the glass where the resident would drink from. Resident #61 drank from the glass after it was placed in front of him. (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: 676175	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/26/2024
NAME OF PROVIDER OR SUPPLIER: Permian Residential Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 1601 NE Mustang Andrews, TX 79714	

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	At 12:09 PM, LVN C picked up a glass of ice water from the serving area and took it to Resident #8 who was seated at the dining table. LVN C did not wear gloves or use hand sanitizer prior to serving beverages. LVN C's hand placement was over the top of the glass and her fingers touched the top of the glass where the resident would drink from. Resident #8 drank from the glass after it was placed in front of him. In an interview on 09/25/24 at 4:21 PM with LVN C, she stated she was usually in the dining room during mealtime and helped pass beverages and trays. She stated she did handle Resident #8's glass improperly and that the glass should only be carried from the side. She stated she had not been trained specifically on food service, but she had been trained on cross-contamination by nursing administration. She stated a potential negative outcome of failure to properly serve food and beverages was the transfer of germs. In an interview on 09/25/24 at 4:27 PM with LVN B, she stated she was usually in the dining room during mealtime and helped pass beverages and trays. She stated she did handle Resident #3 and Resident #61's glasses improperly and that the glass should only be carried from the side. She stated she had been trained on proper passing of food and drinks during mealtimes. She stated she was trained approximately quarterly by nursing administration on avoiding cross-contamination. She stated a potential negative outcome of failure to properly serve food and beverages was the transferring of germs to residents. In an interview on 09/25/24 at 4:48 PM with LVN A, she stated she was usually in the dining room during mealtime and helped pass beverages and trays. She stated she did handle Resident #39's glass improperly and that the glass should only be carried from the bottom. She stated she had been trained on proper handling of drinking glasses through infection control training conducted quarterly by nursing administration. She stated a potential negative outcome of failure to properly serve food and beverages was infection, cross-contamination and getting someone sick. In an interview on 09/26/24 at 10:22 AM with the ADM, she stated the facility policy for serving foods and beverages was to follow proper infection control practices. She stated placing a bare hand over the glass while serving a beverage was incorrect hand placement and it should be carried from the side of the glass. The ADM stated staff had been trained on proper infection control practices during dining times through annual in servicing and proficiency checks. She stated anything that a staff member touched should not come in contact with the resident's mouth and hand sanitizing should be observed between residents. She stated a potential negative outcome of failure to properly serve food and beverages was the spread of infection. In an interview on 09/26/24 at 10:45 AM with the DON, she stated the proper delivery of beverages to a resident was to carry the glass from the side, not over the top. She stated staff had been trained on proper infection control practices to utilize during dining times through hand hygiene training and infection control competency checks. She stated nursing administration was responsible to conduct staff training annually and as needed. The DON stated her expectation of staff for proper food and beverage service during mealtimes was to observe hand hygiene and infection control practices. She stated a potential negative outcome of failure to properly serve food and beverages was the spread of infection. Record review of facility-provided policy titled, Dining Services Standards, revised 12/2020 revealed: (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Purpose Residents are provided a positive meal experience. Policy The facility staff will ensure the residents are provided with a positive meal experience Procedure 3. All staff involved with meal service is trained on the general server competencies, including safe food handling practices 4. Proper handwashing and glove usage are utilized when serving food to patients/residents. No bare hand contact is made with ready to eat food. 5. Dining service standards apply to all areas where patients/residents are served meals and are divided into dining room service and in-room service.

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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** 49279 Based on observations, interviews, and record review, the facility failed to maintain an infection control program designed to provide a safe, comfortable, and sanitary environment to help prevent the development and transmission of diseases for 2 of 17 residents (Residents #41 and #44) reviewed for infection control. 1. The facility failed to display transmission-based precaution signs for Resident #44 who was Covid positive on 9/25/24. 2. Housekeeper D failed to utilize personal protective equipment (PPE) when entering Resident #44's room who was Covid positive on 9/25/24. 3. LVN A staff failed to utilize hand hygiene practices during medication administration on 9/25/2024 for Resident #41. These failures could place residents at risk for infection and cross contamination. The finding included: Resident #44 Record review of undated face sheet revealed Resident #44 was an [AGE] year-old female admitted to the facility on [DATE]. Resident #44 had a medical history of extraarticular fracture of lower end of right radius (bone fractures to the long bone of the arm), anemia (low iron in the blood), hypotension (low blood pressure), retention of urine and heart failure. Resident #44 had a diagnosis of Covid-19 (an acute disease in humans caused by a coronaviru) on 9/17/2024. Record review of Resident #44's care plan dated 9/17/2024 revealed, The resident has a Respiratory Infection Covid 19. Interventions for respiratory infection included, Emphasize good hand washing techniques to all direct care staff. Encourage fluid intake. Resident remains on contact and droplet isolation d/t COVID + status per CDC guidelines. Care plan revealed Resident #44 had a foley catheter and was placed on enhanced barrier precautions dated 7/19/2024. Resident #44 care plan reflected an intervention stating, ENHANCED BARRIER PRECAUTIONS: PPE required for high resident contact care activities. Record review of Resident #44's admission MDS dated [DATE], Section C- Cognitive Patterns revealed she had a BIMS score of 14, which indicated Resident #44 was cognitively intact. Record review of Resident #44's physician orders revealed an order dated 9/17/2024, resident in contact/droplet contact isolation r/t COVID + status per CDC guidelines. Physician order dated 7/19/2024 revealed an order for enhanced barrier precautions. Record review of Resident #44's progress notes dated 9/17/2024 revealed, Resident Complains of sore throat, runny nose, malaise. Test was positive for Covid. Precautions initiated. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation of Resident #44's bedroom door on 9/25/2024 at 11:04 AM revealed there was an enhanced barrier precaution sign taped to the door. The sign reflected information on what to do prior to entering the room, Everyone must: Clean their hands, including before entering and when leaving the room. Providers and staff must also: wear gloves and a gown for the following high contact resident care activities. Dressing, bathing/showering, transferring, changing linen, providing hygiene, changing briefs, or assisting with toileting device care or use, wound care. A red sign with the word hot was noticed taped to the door below the EBP sign. Gowns, gloves, and N95 mask were available outside of Resident #44's room. No face shields were noted. No contact precautions or droplet precautions signs were noted on the door. During an observation of Resident #44's room on 9/25/2024 at 1:48pm, Housekeeper D was observed exiting Resident #44's room with an N95 mask in place. Housekeeper D, returned into the room with the N95 mask and no other PPE, to grab her cleaning supplies. Resident #41 Record review of undated face sheet revealed Resident #41 was a [AGE] year-old male, admitted to the facility on [DATE]. Resident #41 had a medical history of heart failure, chronic pain, hypertension (high blood pressure), and contractures (hardening or tightening of the muscles or tendons) of the right forearm and right lower leg. Record review of annual MDS dated [DATE] revealed Resident #41 had a BIMS score of 11 which indicated Resident #41 had moderate cognitive impairment. Record review of Resident #41's physician orders revealed an order for Voltaren External Gel 1% to be applied to the right ankle. During an observation on 9/25/2024 at 8:32 AM, LVN A grabbed Resident #41's Voltaren Gel medication and a pair of clean gloves. LVN A entered Resident #41's room, donned the clean gloves, removed residents' protective pad from the right leg, removed his sock, and applied the cream to the right foot. LVN A put Resident #41's sock back on, readjusted his pants leg, and the soft pad. LVN A doffed dirty gloves and exited resident #41's room with trash bag. LVN A walked down the hall to the biohazard room to discard trash bag and returned to the medication cart. LVN A failed to utilize hand hygiene prior to entering the room, before donning gloves, after doffing gloves, when exiting room and after discarding trash in the biohazard room. During an interview with LVN A on 9/25/2024 at 4:48pm, she stated she had been trained on handwashing. She stated the DON and ADON were responsible for handwashing training. LVN A stated the potential negative outcome from failure to properly sanitize hands could be spreading illness and germs. She stated she should have washed her hands after applying the medication. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with Housekeeper D on 9/26/2024 at 9:26 AM, she stated she had been trained on infection control but did not remember when. She stated the DON had showed her how to use the CAPR system (air-purifying respirator) on 9/26/2024 but prior to that she had not been trained to use it. She stated the housekeeping supervisor was responsible for her training on infection control. She stated the housekeeping supervisor would let the housekeeping staff know if there was a resident who was on transmission-based precautions. Housekeeper D stated she had donned the gown, gloves and an N95 mask prior to entering Resident #44's room and before she exited, she removed the gown and gloves but not the N95 mask. She stated she forgot to grab one of her cleaning supplies and reentered the room with only the N95 mask. She stated she did see the red signs on the door that said hot, and it indicates to staff that the resident was covid positive. She stated she did not wear the face shield when she went in, and no one had told her that she needed a face shield. She stated it was not until 9/25/24 that she was told she had to wear the CAPR system. She stated she followed the sign on the door on what all to wear, and if there had been a sign stating to wear a face shield, she would have followed those steps. She stated the potential negative outcomes of not utilizing the proper PPE could be spreading the infection to another resident or another person in the facility. She stated she had not had any training on PPE prior to 9/25/24. She stated she had training upon hire, approximately 3 years ago, but nothing since. She stated the DON had taught her about the CAPR system today (9/26/2024) and was told that would be the only system to use for face shield and then the gown and gloves. She stated she did see the red hot sign and how to dress on the EBP signs. She stated she followed what was posted on the door for PPE usage. During an interview with the Housekeeping Supervisor on 9/26/2024 at 9:26 AM, she stated her staff only go by what they know, and they had not had anyone training them on infection control. She stated they are given a piece of paper that shows them what they must do but they are not trained on how to do it. She stated the papers for example will state to take off the gloves, but they do not know if there was a proper way to take the gloves off. She stated she had spoken to the infection preventionist at the hospital for guidance on 9/26/24. She stated her goal is to have her staff trained correctly. She stated they had not been trained on how to don and doff PPE. She stated there is not one person designated to calling her and notifying her if a resident was on TBP and she will get calls from different people, but it was not always the DON. She stated she did not know what the red signs with the word hot meant. She stated they had been told the signs on the doors would show what they needed to wear or what PPE they needed. She stated the potential negative outcome could be the housekeepers spreading whatever that resident had and spreading it to the facility. The Housekeeping Supervisor stated prior to 9/26/2024, her staff had not been trained on the CAPR system. She stated back in 2019, they had been trained on the CAPR system at the hospital but have not had any training since. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the DON on 9/26/2024 at 10:21 AM, she stated she is the infection preventionist. She stated she and the ADON do most of the handwashing training and treatment nurses can help as needed. She stated staff are trained to wash their hands after removing their gloves but sometimes they get nervous when they are being observed. She stated staff are expected to wash their hands or use hand sanitizer between residents' medication administration and between residents. She stated the potential negative outcome of not utilizing proper hand hygiene could be infections. The DON stated for residents who are covid positive, staff are trained to use the CAPR system, gowns, and gloves and if the CAPR system is not available the N95 mask and a face shield. She stated the housekeeping staff are trained to use PPE for TBP upon hire and annually for the hospital. She stated she did not train housekeeping staff this last time that there was a covid positive on 9/17/2024 and the potential negative outcome could be spreading the infection. The DON stated the facility had a mock survey conducted, unsure of date, and there had been a suggestion to take the TBP signs off the door because the signs needed to be clear for visitors to talk to the nurse and the signs could be a violation of HIPPA. She stated they could not find any documentation regarding that recommendation. The DON stated when there is a new covid positive resident, all departments are notified such as the kitchen, laundry, and housekeeping. She stated sometimes she will call, or she will have the business administrator make those notification. She stated the potential negative outcomes of not having the proper signage on the door could be people not understanding or spreading infection unintentionally. She stated the hot sign indicates when a resident is covid positive. She stated compliance was monitored by having the nurse managers go up and down the halls frequently and correct anything that is not being done correctly immediately and retrain as needed. She stated training was done with the staff's yearly competency . The DON stated handwashing monitoring and training was done the same, yearly with competencies and as needed. During an interview with the ADM on 9/26/2024 at 10:46 AM, she stated the DON was responsible for handwashing training . She stated staff are trained annually and upon hire and as needed. She stated staff are expected to wash their hands between medication administration and after removing gloves with either soap and water or alcohol-based hand sanitizer. She stated the potential negative outcomes of not utilizing proper hand hygiene could be spreading infection. The ADM stated staff are trained to use gown gloves and the CAPR system for Covid Positive residents. She stated if the CAPR system was not available, they would use the N05 mask and face shield. She stated housekeeping is trained by the staff development coordinator at the hospital and the infection preventionist at the hospital. She stated the potential negative outcome of not utilizing the proper PPE could be spreading infection. The ADM stated they had an organization (TMF iCare), that did a mock survey and they recommended to do zones for Covid. She stated they had been told that isolations signs could be a HIPPA violation. The ADM stated they tried to go back and find something in writing, but they had not been able to find it. She stated this had been within the last year. She stated they would be going back to the visual signs for what PPE to use for those rooms. She stated the potential negative outcomes of not having the proper signage on the door could be spreading infection. The ADM stated audits for PPE and handwashing are done by shift and staff are observed going into and exiting out of those rooms. She stated training on handwashing and PPE was done annually and upon hire. Record review of facility policy titled Handwashing/Hand Hygiene last revised August 2015 revealed: Policy Statement This facility considers hand hygiene the primary means to prevent the spread of infections. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	.7. Use an alcohol-based hand rub containing at least 62% alcohol; or, alternatively, soap (antimicrobial or non-antimicrobial) and water for the following situations: . b. Before and after direct contact with residents; c. Before preparing or handling medications; . .m. After removing gloves; n. Before and after entering isolation precaution settings. Record review of facility undated policy titled Covid + Resident revealed: .Nurse to ensure signage on door, ISO cart within area. Record review of facility policy titled Resident Isolation - Categories of Transmission-Based Precautions last revised 6/2020 revealed: I. Transmission-based precautions are used whenever measures more stringent than standard. precautions are needed to prevent or control the spread of infection . III. Contact Precautions . G. Notice i. The Facility alerts staff to the type of precaution a resident requires. ii. The Facility also ensures that the resident's care plan indicates the type of precautions implemented for the resident. iii. The Facility may utilize a sign requesting visitors to check in at the nursing station before entering a resident's room . IV. Droplet Precautions i. The Facility alerts staff to the type of precaution a resident requires. ii. The Facility also ensures that the resident's care plan indicates the type of precautions implemented for the resident. iii. The Facility may utilize a sign requesting visitors to check in at the nursing station before entering a resident's room. Record review of facility policy titled Administering Medications last revised December 2012 revealed, (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	22. Staff shall follow established facility infection control procedures (e.g., handwashing, antiseptic technique, gloves, isolation precautions, etc.) for the administration of medications, as applicable. 49305