

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676177	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/26/2024
NAME OF PROVIDER OR SUPPLIER Garrison Nursing Home & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 333 North Fm 95 Garrison, TX 75946	

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 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46436</p> <p>Based on observation, interview, and record review, the facility failed to ensure a resident who was incontinent of bladder received appropriate treatment and services to prevent urinary tract infections for 1 of 4 residents (Resident #27) reviewed for quality of care.</p> <p>1. The facility failed to ensure Resident #27's indwelling catheter (drains urine from your bladder into a bag outside your body) had a securement device to anchor catheter.</p> <p>This failure could place residents at risk for urinary tract infections and catheter related injuries.</p> <p>Findings:</p> <p>Record review of a facility face sheet dated 6/25/2024 indicated Resident # 27 was a [AGE] years old female and admitted on [DATE] with diagnosis of heart disease and urinary retention.</p> <p>Record review of a comprehensive care plan dated 3/22/24 indicated Resident #27 was at risk for complications related to Foley catheter and to provide catheter care every shift.</p> <p>Record review of a Quarterly MDS assessment dated [DATE] indicated Resident #27 had a BIMS score of 08 indicating moderately impaired cognition, and she required an indwelling catheter.</p> <p>During an observation and interview on 6/25/24 at 9:45 am, Resident # 27 was observed with an indwelling catheter with no securement device for the catheter. Resident # 27 said there was a pulling feeling in her private area at times.</p> <p>During an interview on 6/25/24 at 9:55 am, CNA B said that when care was provided to a resident with a catheter, she made sure the catheter was not pulled but did not check for a securement device. She said the nurses were responsible for placing the securement device. She said a catheter that was not secure could come out or cause pain.</p> <p>During an interview on 6/25/24 at 1:11 pm, LVN A said she had been at the facility for 4 years. She said that residents with an indwelling catheter should be checked every shift and a securement device should be in place to prevent discomfort and dislodgment. She said she had received competency training on indwelling catheters and care.</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 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 6/26/24 at 10:43 am, the DON said the charge nurses were responsible for checking residents with catheters each shift and each resident with a catheter should have a securement device. She said she was responsible for all nursing oversight and training and nurses had been trained on catheter assessment and ensuring a securement device was in place. She said if a catheter was not secure it could cause abrasions and become dislodged.</p> <p>During an interview on 6/26/24 at 10:46 am, the Administrator said that nursing management was responsible for overseeing that each resident with a catheter had a securement device. She said that an unsecured catheter could cause, pain, infections, and affect the skin. She said she expected the policy to be followed and that all residents with a catheter, had a securement device.</p> <p>Record review of competency check dated 01/26/2024 for catheter care for LVN A indicated LVN A was trained on catheter care and securing catheter according to policy.</p> <p>Record review of facility policy titled Evidenced Based Best Practices: Indwelling Bladder Catheters dated 01/2024 indicated, .the catheter tubing should be secured to prevent accidental displacement .</p>		

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<p>F 0732</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Many</p>	<p>40124</p> <p>Post nurse staffing information every day.</p> <p>Based on observation, interview, and record review, the facility failed to ensure nurse staffing data was posted and readily accessible to residents and visitors with all required information for nurse staffing information for 5 of 5 days (6/21/24, 6/22/24, 6/23/24, 6/24/24 and 6/25/24).</p> <p>The facility failed to ensure the daily staffing information was accurate and posted daily for 6/21/24, 6/22/24, 6/23/24, 6/24/24 and 6/25/24.</p> <p>This failure could place residents, families, and visitors at risk of not being informed of the census and number of staff working each day to provide care on all shifts.</p> <p>Findings:</p> <p>During an observation on 6/25/2024 at 9:00 am, there was a daily staffing posting for the facility on the 200-hallway bulletin board (not in a central location, easily visible to all residents and visitors) dated 6/21/2024. The staffing form was blank for reporting the daily census. The form was not easily legible to all residents and visitors due to misprinting of the copied form.</p> <p>During an interview on 06/25/24 at 9:41 am, the Assistant Regional Nurse said the facility should post the nurse staffing information for each discipline daily with the facility census. She said she could see if the posting was not posted and visible for residents and visitors, they could think there were not enough staff present to provide care. She said the restorative aide was responsible for the daily staff posting. The Assistant Regional Nurse said she would correct the posting and place the posting on a wall at the entrance so all residents and visitors could view it.</p> <p>During an interview on 06/25/24 at 10:00 am, the DON said the restorative aide was responsible for posting the staffing information and she should have been ensuring that it was posted. She said they would also start a binder to store the information for 18 months per the regulation. She said by not having the information posted residents and visitors might not think there was sufficient staff present to provide care.</p> <p>During an interview on 06/25/24 at 10:20 am, the Administrator said the restorative aide was responsible for posting the nurse staffing information. She said she was not sure when the last time the nurse staffing information was posted but would correct the problem and place the sign per the regulations that day. She said there was no policy for nurse staffing information.</p> <p>Record Review of a staffing policy undated titled Staffing read: .Our facility provides sufficient numbers of staff with the skills and competency necessary to provide care and services for all residents in accordance with resident care plans and the facility assessment .</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** 46436</p> <p>49017</p> <p>Based on observations, interviews, and record reviews 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 3 of 6 residents (Resident #11, #12, and #43) reviewed for infection control.</p> <p>The facility failed to ensure CNA C sanitized or washed her hands between glove changes,</p> <p>CNA D changed gloves while providing incontinent care to Resident #11 and Resident #43 on 6/24/2024.</p> <p>The facility failed to ensure the COTA (certified occupational therapy assistant) followed enhanced barrier precautions when she provided care to Resident #12 on 6/24/2024.</p> <p>These failures could place residents at risk for cross contamination and infection.</p> <p>Findings included:</p> <p>1. Record review of a face sheet dated 6/25/2024 for Resident #43 indicated she admitted to the facility on [DATE] and was [AGE] years old with diagnosis of dysphagia (a swallowing disorder that may be due to various neurological, structural, and cognitive deficits), chronic respiratory failure (when the airways that carry air to your lungs become narrow and damaged), cognitive communication deficit (are problems with communication that have an underlying cause in a cognitive deficit), and hemiplegia and hemiparesis following cerebral infarction (total or nearly complete paralysis on one side of the body).</p> <p>Record review of a Quarterly MDS assessment dated [DATE] for Resident #43 indicated she had moderate impairment in thinking with a BIMS score of 9. She was always incontinent of bladder and always incontinent of bowel.</p> <p>Record review of a care plan revised 3/22/2024 for Resident #43 indicated an ADL self-care performance deficit. She required the extensive assist of direct care staff member for ADL completion for toilet use.</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 6/21/2024 at 10:10 AM, CNA C and CNA D were in the room of Resident #43 to provide incontinent care. Both washed their hands and put on gloves. Supplies were in a plastic bag on the over bed table. CNA C assisted with positioning and holding the resident. CNA C and CNA D opened the brief and pulled it down between Resident #43's thighs. CNA D removed a wipe from the plastic bag and wiped the resident's right inner thigh and folded it over and wiped the left inner thigh and placed the wipe in the trash. CNA D removed a wipe from the plastic bag and wiped up the middle of the vagina from front to back. CNA C rolled Resident #43 onto her left side. CNA D removed wipes from the plastic bag and wiped Resident #43's perineal area from front (vagina) to back (buttocks) and placed wipe in the trash. CNA D rolled the soiled brief under Resident 43's buttocks and rolled Resident 43 to her right side. CNA C removed soiled brief and placed it in the trash. CNA C removed her gloves and placed in the trash and put clean gloves on without sanitizing hands. CNA C placed clean brief under Resident 43 and rolled Resident 43 to her left side. CNA D positioned clean brief under Resident 43. Resident #43 was rolled onto her back and the brief was secured by CNA C and CNA D and the resident was repositioned in the bed. CNA C removed her gloves and exited the room. CNA D removed her gloves and washed her hands. CNA D did not change her gloves while providing incontinent care and repositioning Resident #43.</p> <p>During an interview on 6/21/2024 at 10:20 AM, CNA C said she had been employed at the facility for less than 1 year and worked on the 6 am-2 pm shift. She said with the incontinent care provided to Resident #43 earlier, she should have washed her hands between glove changes. She said that she did not have hand sanitizer with her while providing care to Resident 43. She said that the facility did provide hand sanitizer for the staff. She said that the facility does in services on hand hygiene and infection control. She said residents could be at risk of infections if staff did not wash or sanitize their hands between gloves changes.</p> <p>During an interview on 6/21/2024 at 10:25 AM, CNA D said that she had been employed with the facility for [AGE] years and worked the 6-2 shift. She said that she should have changed gloves and sanitized her hands while providing incontinent care to Resident #43. She said that the facility provided training on hand hygiene and infection control. She said that the residents were at risk for infection if hand hygiene is not practiced.</p> <p>2. Record review of a face sheet dated 6/25/2024 for Resident #11 indicated she was admitted to the facility on [DATE] and was [AGE] years old with the diagnosis of hypertension (high blood pressure), polyosteoarthritis (a degenerative joint condition that causes pain, stiffness, and inflammation), and dementia (a loss of cognitive functioning that interferes with daily life).</p> <p>Record review of a comprehensive MDS dated [DATE] for Resident #11 indicated she had severe impairment in thinking with a BIMS score of 3. She was always incontinent of bladder and incontinent of bowel.</p> <p>Record review of a care plan revised 4/18/2024 indicated that she required extensive to total assistance with ADL care related to dementia and failure to thrive and that Resident #11 was incontinent of bladder and bowel.</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 6/21/2024 at 2:15 PM, CNA D was in the room of Resident #11 to provide incontinent care. CNA D washed her hands and put on gloves. Supplies were in a plastic bag on the over bed table. CNA D opened the brief and pulled it down between Resident #11's thighs. CNA D removed a wipe from the plastic bag and wiped the resident's right inner thigh and folded it over and wiped the left inner thigh and placed the wipe in the trash. CNA D removed a wipe from the plastic bag and wiped down the middle of the vagina from front to back. CNA D rolled Resident #11 onto her left side. CNA D removed wipes from the plastic bag and wiped Resident #11's perineal area from front (vagina) to back (buttocks) The soiled brief was removed from Resident #11. CNA D removed a brief from the plastic bag and placed it underneath the resident's buttocks. Resident #11 was rolled onto her back and the brief was secured and the resident was transferred to wheelchair with assist of another CNA. CNA D removed her gloves and sanitized her hands before exiting the room. CNA D did not change gloves or sanitize her hands while providing incontinent care to Resident #11.</p> <p>3. Record review of a facility face sheet dated 6/25/24 indicated Resident #12 was [AGE] years old and admitted on [DATE] with diagnosis of disruption of surgical wound.</p> <p>Record review of an admission MDS assessment dated [DATE] indicated a BIMS score of 00 indicating severely impaired cognition and t required maximum assistance with all ADL care.</p> <p>Record review of an acute care plan dated 5/31/24 indicated Resident #12 had a wound and required EBP.</p> <p>Record review of consolidated orders dated 6/25/24 indicated Resident #12 had no order for EBP (enhanced barrier precautions).</p> <p>During an observation on 6/24/24 at 9:47 am, Resident #12 was observed with signs posted on door for Enhanced Barrier Precautions and PPE outside the room.</p> <p>During an observation on 06/24/24 at 2:06 PM, the COTA (certified occupational therapy assistant) was observed transferring Resident # 12 without wearing PPE. The COTA applied gloves and then placed a gait belt around Resident #12's waist. She positioned her next to the bed, locked the wheelchair, and transferred Resident #12 to a sitting position on the side of the bed. COTA then placed her arm around Resident #12's back and legs and turned her into a lowered position in the bed. The COTA removed Resident #12's bra and placed a heel boot on her left foot. The COTA then positioned Resident #12's blanket, call light and remote to the bed. The COTA then adjusted the table next to the bed. She removed her gloves and washed her hands before leaving the room.</p> <p>During an interview on 06/24/24 at 2:16 pm, the COTA said she worked at the facility as needed and had been a COTA for [AGE] years. She said she was trained by facility staff on EBP and should have put on a gown and gloves before performing care and just got nervous and forgot. She said by not following the EBP, cross contamination could have occurred.</p> <p>During an interview on 06/24/24 at 2:50 pm, the ADON said if a resident required EBP, then signs were posted and PPE were placed outside the room. The ADON stated staff were educated on the precautions, and the infection prevention nurse was notified. She said the infection prevention nurse completed an acute care plan. She said if EBP was not followed, it could introduce residents to infections.</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 06/24/24 at 2:58 pm, the infection prevention (IP) nurse said she has been the IP nurse since February 2024 and when EBP was determined for a resident, the resident and family were educated, signs were posted on the doors and PPE was placed outside the room. She said she then provided education to the staff and completed an acute care plan for the EBP reason. She said that staff that did not follow EBP could place residents at risk of infections.</p> <p>During an interview on 6/26/2024 at 9:50 AM, the DON said she had been employed at the facility for [AGE] years and has been the DON for almost 1 year. She said EBP was for any resident that had a history of MDRO's (multi drug resistant organisms), current chronic wounds, feeding tubes, and foley catheters. She said EBP would stay in place for residents that had MDRO's indefinitely. She said staff were supposed to wear a gown and gloves when they are providing care that would include contact with the resident, when linens were changed, bathing, incontinent care, and wound care. She said staff were aware of the residents that had EBP in place because they placed protocols on the resident's door. She said the infection preventionist monitored that staff were following EBP protocols. She said there was a risk of spreading MDRO's to other residents if staff did not follow EBP. She said hand hygiene should be performed before care, between care, before and after glove changes and after care was provided. She said glove changes occurred during incontinent care when gloves were visibly soiled and after disposing soiled briefs and prior to placing clean brief on resident. She said would be performing hand hygiene and infection control in services for all staff as well as one on one hand hygiene check offs with direct care staff. She said residents could be a risk of infections if staff did not wash or sanitize their hands.</p> <p>During an interview on 6/26/2024 at 10:15 AM, the Administrator said EBP was for residents that had MDRO's, chronic wounds, and implanted devices to prevent spreading of bacteria. She said staff should don (put on) and doff (take off) gown and gloves to prevent cross contamination for residents who were on EBP. She said staff should wash or sanitize their hands anytime gloves were changed, and staff should be changing gloves during incontinent care. She said there was a risk of contamination and infections if staff did not wash their</p> <p>hands after glove changes or change their gloves when appropriate.</p> <p>Record review of a CNA Proficiency Skills Check dated 4/25/2024 for CNA C indicated she was satisfactory in perineal care for a female along with infection control on hand washing.</p> <p>Record review of a CNA Proficiency Skills Check dated 12/21/2023 for CNA D indicated she was satisfactory in perineal care for a female along with infection control on hand washing.</p> <p>Record review of course certification dated 3/30/24 indicated the COTA was trained on EBP.</p> <p>Record review of a facility policy titled Handwashing/ Hand Hygiene revised August 2015 indicated, .Use of an alcohol-based hand rub containing at least 62% alcohol; or, alternatively, soap (antimicrobial or non-antimicrobial) and water for the following situations . j. after contact with blood or bodily fluids .m. after removing gloves. 8. Hand hygiene is the final step after removing and disposing of personal protective equipment. The policy also indicated, Perform hand hygiene before applying non-sterile gloves and after removing gloves.</p> <p>Record review of CMS QSO-24-08-NH titled Enhanced Barrier Precautions in Nursing Homes dated March 20, 2024 indicated, .EBP is indicated for residents with chronic wounds, surgical wounds</p>		