

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  676279	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  07/19/2024
NAME OF PROVIDER OR SUPPLIER  Crown Point Health Suites		STREET ADDRESS, CITY, STATE, ZIP CODE  6640 lola Avenue Lubbock, TX 79424	

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 - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 49305</p> <p>Based on observation, interview 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 communicable diseases for 3 of 3 (Residents #1, #2, #3) and 4 of 5 staff (CNA A, CNA B, CNA D, CNA E ) reviewed for infection control.</p> <ol style="list-style-type: none"> <li>1. CNA A failed to change gloves and sanitize hands during and after providing incontinent care for Resident #1. CNA A failed to wear proper PPE when providing care for Resident #1 who was on Enhanced Barrier Precautions.</li> <li>2. CNA B failed to wear proper PPE when providing care for Resident #1 who was on Enhanced Barrier Precautions.</li> <li>3. CNA D failed to sanitize hands between glove changes during incontinent care for Resident # 2.</li> <li>4. CNA E failed to change gloves and sanitize hands during incontinent care for Resident #3.</li> </ol> <p>These failures could place residents at risk for spread of infection and cross contamination.</p> <p>Findings included:</p> <p>Resident #1</p> <p>Record review of the face sheet for Resident #1 revealed a [AGE] year-old male admitted to the facility on [DATE] with the following diagnoses: quadriplegia (paralysis of all four limbs), gastrostomy (surgical opening into the stomach for introduction of food), colostomy (opening in large intestine through abdominal wall), anxiety, aphasia (loss of ability to understand or express speech), traumatic brain injury (brain dysfunction caused by an outside force).</p> <p>Review of Resident #1's annual MDS , dated 06/25/24 revealed Resident #1 had no BIMS score and cognitive skills were listed as severely impaired. MDS revealed Resident # 1 had a feeding tube, an ostomy (artificial opening created in the body during an operation) and was incontinent of urine.</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 - Some</p>	<p>Record review of Resident #1's Comprehensive Care Plan dated 07/19/24 revealed resident had quadriplegia and required assistance with all ADL 's including ostomy and incontinent care and feeding tube care. The care plan revealed Resident #1 required Enhanced Barrier Precautions due to indwelling medical device and listed interventions to include the following: clean hands before entering and when leaving room, use appropriate PPE for enhanced barrier precautions, per facility policy and guidance (gloves and gown, face protection as needed for risk of splash or spray), use Enhanced Barrier Precautions per facility policy during instances of high contact</p> <p>care, such as: dressing, bathing/showering, transferring, changing linens,</p> <p>providing hygiene, changing briefs/assisting with toileting, device care or use, wound care.</p> <p>Observation on 07/19/24 at 11:14 AM of incontinent care on Resident #1 with CNA A and CNA B. CNA's were observed using hand sanitizer prior to care. Resident #1 had an ostomy and feeding tube and was on Enhanced Barrier Precautions, per signage on outside of room. CNA A and CNA B failed to put on required PPE (gown) prior to performing care. Resident was informed of care that was to be performed. Supplies were gathered prior to entering room. CNA A and CNA B each donned gloves. Resident was placed in supine (on back) position and brief was removed by CNA A, who then performed male incontinent care. Resident was then turned to right side with the assistance of CNA B and incontinent care was performed to buttocks area by CNA A. A new brief was placed by CNA A. There was no observation of glove change by CNA A between clean and dirty aspects of care. Resident was rolled to left side and brief was pulled under then resident was again placed in supine (on back) position and brief was secured in place by CNA A. The sheet and blanket were replaced by CNA A and CNA B and the resident's head rest pillow was repositioned by CNA A with the assist of CNA B. After positioning resident, CNA A was then observed to wipe the resident's mouth with a wipe and lower the bed. CNA B was observed using hand sanitizer prior to leaving the resident's room. CNA A did not sanitize hands upon leaving the room and was observed to walk down the hallway to speak to the nurse.</p> <p>During an interview with CNA A on 07/19/24 at 11:26 AM, she stated she did not change gloves during incontinent care because she got nervous. She stated she was recently trained on hand hygiene in her CNA class at the end of June. She stated she should have changed her gloves and sanitized her hands after performing the dirty portion of incontinent care and before touching anything clean in the room. She stated the potential negative outcome for failure to perform hand hygiene during incontinent care is spreading illness. CNA A stated she did not put on a gown prior to performing direct care for Resident #1. She stated the sign on the door indicated that Resident #1 was on Enhanced Barrier Precautions, which she stated meant that staff should sanitize their hands before going in and should wear a gown if doing care, such as changing a resident's brief. She stated she did not put on a gown prior to doing care because she forgot Resident #1 had an ostomy, and she was nervous about being observed by the Surveyor. She stated she did know the difference regarding when to use PPE for a resident who is on Enhanced Barrier Precautions and that it would not be necessary if she were just entering the room to check on the resident but not perform direct care. She stated a potential negative outcome to not putting on proper PPE before direct care of a resident on Enhanced Barrier Precautions would be cross-contamination.</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 with CNA B, 07/19/24 at 11:29 AM she stated CNA A should have changed her gloves and sanitized her hands after performing incontinent care and before touching the resident's clean brief and sheets. She stated she has been trained on infection control through in-services at the facility approximately twice per month. She stated the potential negative outcome of failing to perform hand hygiene during incontinent care is spreading bacteria. CNA B stated she did not put on a gown prior to incontinent care on Resident #1 because she was not aware that she was going to be assisting with incontinent care. She stated she realized she should have put a gown on after the incontinent care had begun. She stated the sign on the door means the resident has something such as a foley catheter or feeding tube which puts them at higher risk of infection and that PPE, including a gown, is required before doing direct care. She stated she knew the difference in when she should put a gown on and when she did not need to. She stated she would not need to put on a gown if she were just taking water to a resident, for example. She stated she has been trained at the facility regarding Enhanced Barrier Precautions approximately 2 months ago through in servicing. She stated the potential negative outcome of not observing Enhanced Barrier Precautions is spreading germs to a resident which could cause an infection.</p> <p>Resident #2</p> <p>Record review of face sheet for Resident #2 revealed a [AGE] year-old female admitted to the facility on [DATE] with the following diagnoses: acute respiratory failure with hypoxia (lack of oxygen), tracheostomy (surgically created hole in the windpipe that provides an alternate airway for breathing), chronic obstructive pulmonary disease (constriction of airways causing difficulty breathing), asthma (respiratory condition which causes spasms in the airways and difficulty breathing), quadriplegia (paralysis of all four limbs), Parkinson's Disease (disorder of the central nervous system that affects movement), dysphagia (swallowing difficulties).</p> <p>Review of Resident #2's MDS, dated [DATE] revealed Resident #2 had no BIMS score and cognitive skills were listed as severely impaired. MDS revealed Resident #2 had a tracheostomy, a feeding tube, was always incontinent of bowel and bladder.</p> <p>Record review of Resident #2's Comprehensive Care Plan, dated 06/09/23, revealed Resident #2 had quadriplegia and required assistance with all activities of daily living, including tracheostomy care, incontinent care and feeding tube care. The care plan revealed Resident #2 required Enhanced Barrier Precautions due to indwelling medical device and listed interventions to include the following: clean hands before entering and when leaving room, use appropriate PPE for enhanced barrier precautions, per facility policy and guidance (gloves and gown, face protection as needed for risk of splash or spray), use Enhanced Barrier Precautions per facility policy during instances of high contact care, such as: dressing, bathing/showering, transferring, changing linens,</p> <p>providing hygiene, changing briefs/assisting with toileting, device care or use, wound</p> <p>care.</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>Observation on 07/19/24 at 1:26 PM of incontinent care for Resident #2 with CNA C and CNA D . Resident #2's room had an Enhanced Barrier Precautions sign outside the door. Resident #2 was observed sitting in wheel chair room waiting to be transferred back to bed. Resident gave permission for Surveyor to observe care. Observed each CNA wash their hands in the resident's restroom and don PPE (gloves and gowns) prior to using mechanical lift to transfer resident to bed for incontinent care. Resident #2 was transferred to bed using mechanical lift and rolled to each side in bed to remove the mechanical lift sling. Resident was placed in supine (on back) position and both CNA C and CNA D performed female incontinent care using incontinent wipes then the resident was rolled to right side for incontinent care to buttocks area. CNA C removed soiled brief and placed it in the trash then removed gloves and used hand sanitizer before donning new gloves. CNA C then applied a clean brief while CNA D assisted Resident #2 to remain on right side. Resident was then rolled to left side. CNA D then performed incontinent care to buttocks area and pulled clean brief from under resident. CNA D then removed dirty gloves and donned new gloves and continued to assist to fasten brief. CNA D failed to sanitize her hands between glove changes. Observed CNA C and CNA D used the draw sheet to pull Resident #2 up in bed. Following incontinent care, CNA C and CNA D were observed washing their hands in the resident's bathroom.</p> <p>During an interview with CNA D on 07/19/24 at 1:40 PM, she stated the reason she did not sanitize her hands between glove changes is because, I just don't like to because it makes my gloves sticky. She stated she should have sanitized her hands after removing her dirty gloves and before putting on clean gloves. She stated she has been trained on proper hand hygiene through in-services at the facility approximately once every month. She stated a potential negative outcome for failure to sanitize hands during incontinent care is spreading germs.</p> <p>Resident #3</p> <p>Record review of face sheet for Resident #3, dated 07/15/2024, revealed a [AGE] year-old female admitted to the facility on [DATE] with the following diagnoses: fracture of radius (break in bone of lower arm), fracture of ulna (break in bone of lower arm), traumatic subdural hemorrhage (bleeding between the brain and its outer covering), heart failure (condition in which the heart doesn't pump blood as well as it should), chronic kidney disease (long-standing disease of the kidneys).</p> <p>Review of Resident #3's MDS, dated [DATE] did not show BIMS score or activities of daily living information, as resident is a new admission (entry MDS).</p> <p>Record review of Resident #3's Comprehensive Care Plan, dated 07/16/24 revealed Resident #3 requires assistance with all activities of daily living due to recent fall with injury.</p> <p>Observation on 07/19/24 at 1:49 PM of incontinent care for Resident #3 with CNA E . Surveyor obtained permission from family member and from Resident #3 to observe care. Observed CNA E wash hands with soap and water prior to performing care. CNA E performed female incontinent care using wipes then rolled resident to right side. CNA E then performed incontinent care to buttocks area and applied barrier cream and applied new brief. CNA E rolled resident back to supine (on back) position and fastened brief then replaced sheet and blanket over the resident. CNA E did not change gloves between clean and dirty aspects of incontinent care.</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 with CNA E on 07/19/24 at 1:57 PM, she stated she did not change her gloves between clean and dirty aspects of incontinent care. She stated she should have changed her gloves before applying the clean brief, but she forgot. She stated she has been trained by the facility on proper hand hygiene and training occurs every couple of weeks. She stated a potential negative outcome of failure to sanitize hands during incontinent care is spreading bacteria to herself or other residents.</p> <p>During interview with the Administrator on 07/19/24 at 2:21 PM , she stated nursing administration is responsible for training staff on proper hand hygiene and Enhanced Barrier Precautions. She stated her expectation of staff regarding hand hygiene and Enhanced Barrier Precautions is that they are meeting all criteria effectively. The Administrator stated a potential negative outcome of failure to properly sanitize hands and observe enhanced precautions would be a failed infection control process and spread of infection.</p> <p>During an interview with the DON on 07/19/24 at 2:21 PM , she stated she and the ADON 's are responsible for training staff on proper hand hygiene and Enhanced Barrier Precautions. She stated staff are trained through annual competencies and in-services every 1-3 months and as needed. She stated her expectation of staff regarding hand hygiene and Enhanced Barrier Precautions is that they are performed and observed in every room and as needed during resident care. The DON stated a potential negative outcome of failure to properly sanitize hands and observe Enhanced Barrier Precautions would be the spread of infection.</p> <p>Record review of the facility's policy titled Handwashing/Hand Hygiene, (revised October 2023) revealed:</p> <p>Policy Statement:</p> <p>This facility considers hand hygiene the primary means to prevent the spread of healthcare-associated infections.</p> <p>Policy Interpretation and Implementation</p> <p>Administrative Practices to Promote Hand Hygiene</p> <p>2. All personnel are expected to adhere to hand hygiene policies and practices to help prevent the spread of infections to other personnel, residents, and visitors.</p> <p>Indications for Hand Hygiene</p> <p>1. Hand hygiene is indicated :</p> <p>a. immediately before touching a resident;</p> <p>c. after contact with blood, body fluids, or contaminated surfaces;</p> <p>d. after touching a resident;</p> <p>e. after touching the resident's environment;</p> <p>(continued on next page)</p>		

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