STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676301	A. Building B. Wing	11/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumn Winds Living & Rehabilitation	3301 Fm 3009 Schertz, TX 78154

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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33866 Based on observation, interview, and record review, the facility failed to ensure residents have a right to personal privacy for 1 of 8 residents (Resident #8) reviewed for privacy, in that: CNA B and CNA C failed to provide privacy while providing peri-care to Resident #8 by not closing Resident #8's privacy curtain. This failure could place residents at-risk of loss of dignity due to lack of privacy. The findings include: Record review of Resident #8's face sheet, dated 11/08/2024, reflected an admitted [DATE] with diagnoses which included: Rheumatoid lung disease (lung condition associated with rheumatoid arthritis which can cause scarring, inflammation and nodules in the lung); Noninfective gastroenteritis (stomach virus) and colitis (inflammation in colon); Rheumatoid arthritis of right knee (type of arthritis where immune system attacks the tissue lining the joints); Type 2 diabetes mellitus (chronic condition of high level of sugar in blood), Major depressive Disorder (mental disorder characterized by at least two weeks of pervasive low mood, low self-esteem, and loss of interest or pleasure; Urinary tract infection (bladder infection). Record review of Resident #8's Quarterly MDS assessment, dated 09/30/2024, reflected the resident had a BIMS score of 12, indicating she was moderately cognitively impaired. Resident required partial to extensive assistance with her ADL's. Record review of Resident #8's care plan, dated 09/26/2024, reflected a problem of urinary incontinence with interventions that included: provide incontinent care as needed post each incontinent episode and preventive skin care as per orders. Observation on 11/07/2024 at 1:43 p.m. with RN A also present, reflected CNA B and CNA C did not completely close the privacy curtains while they provided peri-care for Resident #8, with only the area behind the foot of the bed covered by privacy curtains, but both sides left open to view. The resident's roommate was in the room and the resident's buttocks and groin area were exposed. (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: 676301	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/08/2024
NAME OF PROVIDER OR SUPPLIER Autumn Winds Living & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 3301 Fm 3009 Schertz, TX 78154	

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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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with CNA C on 11/07/2024 at 1:46 p.m., CNA C verbally confirmed the privacy curtains were not completely closed while she provided care for Resident #8, and stated she did not see that her roommate was also in the room. CNA C stated she should have closed the curtain all the way to provide privacy to Resident #8. She stated she has received training in resident rights. During an interview with RN A on 11/07/2024 at 1:50 p.m. RN A stated she had also observed the privacy curtain not being closed completely, and stated that she intervened immediately to close the privacy curtain all the way. RN A stated that it was important for privacy to be provided during peri care and confirmed Resident #8's privacy curtains should have been closed completely while peri-care was being performed. During an interview with the DON on 11/08/2024 at 12:26 p.m., the DON stated privacy curtains should always be closed to provide privacy during peri-care, and that all facility staff had received training on resident rights. Record review of facility policy titled Dignity revised February 2021 revealed Each resident shall be cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life, and feelings of self-worth and self-esteem, and under #11 Staff promote, maintain, and protect resident privacy, including bodily privacy during assistance with personal care and during treatment procedures.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676301	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumn Winds Living & Rehabilitation	3301 Fm 3009 Schertz, TX 78154

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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 0656	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 39049

Based on interview and record review, the facility failed to develop and implement a comprehensive person-centered care plan for each that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental needs that are identified in the comprehensive assessment, and services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being for 7 of 10 residents (Resident #1, 2, 3, 4, 5, 6, and 7) reviewed for comprehensive care plans, in that:

1. The facility failed to ensure Resident #1, who needed to have one staff assist for transfer, had a care plan regarding how to transfer the resident from bed-to-chair.

2. The facility failed to ensure Resident #2, who needed to have one staff assist for transfer, had a care plan regarding now to transfer the resident from bed-to-chair.

3. The facility failed to ensure Resident #3, who was assessed as dependent for transfers, described as needing assistance of 2 or more helpers, had a care plan regarding how to transfer the resident from bed to chair.

4. The facility failed to ensure Resident #4, who was assessed as needing partial/moderate assistance for transfers, had a care plan regarding how to transfer the resident from bed to chair.

5. The facility failed to ensure Resident #5, who needed to have two staff with mechanical lift for transfer, had a care plan regarding now to transfer the resident from bed-to-chair.

6. The facility failed to ensure Resident #6, who was assessed as dependent for transfers, had a care plan regarding how to transfer the resident from bed to chair

7. The facility failed to ensure Resident #7, who was assessed as requiring substantial/maximal assistance for bed to chair transfers, had a care plan regarding how to transfer the resident from bed to chair.

This failure could place residents at risk for not receiving proper care and services.

The findings included:

1. Record review of Resident #1's face sheet, dated 11/08/2024, revealed the resident was [AGE] years old female and an original admitted [DATE] and re-admitted [DATE] with diagnoses that included: diffuse traumatic brain injury (severe traumatic brain injury), insomnia (difficulty sleeping), periapical abscess (pocket of infection around your tooth root), muscle wasting and atrophy (muscles to decrease in size and strength), and Type 2 diabetes mellitus (chronic condition of high level of sugar in blood).

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676301	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/08/2024
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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #1's quarterly MDS assessment completed on 09/26/2024 Section C (Cognitive Patterns) revealed a BIMS score of 11which indicated moderate cognitive impairment. Section GG (Functional Abilities and Goals) indicated Resident #1 required substantial/maximal assistance (helper dose more than half the effort) to chair/bed-to-chair transfer and toilet transfer. Record review of Resident #1's profile, dated 11/07/2024, revealed the resident needed to have one staff assist for bed-to-chair transfer. Record review of Resident #1's care plan, dated 01/08/2024, revealed there was no care plan regarding how to transfer the resident from bed-to-chair transfer. 2. Record review of Resident #2's face sheet, dated 11/08/2024, revealed the resident was [AGE] years old male and an original admitted [DATE] and re-admitted [DATE] with diagnoses that included: congenital and developmental myasthenia (inherited disorder that usually develops at or near birth or in early childhood and involves muscle weakness and fatigue), hypo-osmolality and hyponatremia (produced by retention of water, by loss of sodium or both), gastroparesis (paralysis of the stomach), and Type 2 diabetes mellitus (chronic condition of high level of sugar in blood). Record review of Resident #2's quarterly MDS assessment completed on 09/08/2024 Section C (Cognitive Patterns) revealed a BIMS score of 9 which indicated moderate cognitive impairment. Section GG (Functional Abilities and Goals) indicated Resident #2 required supervision (if the helper provides verbal cues or touching/steadying/contact guard assistance as resident completes activity) to chair/bed-to-chair transfer. Record review of Resident #2's profile, dated 11/07/2024, revealed the resident needed to have one staff assist for bed-to-chair transfer. Record review of Resident #2's care plan, dated 08/02/2023, revealed there was no care plan regarding how to transfer the resident from bed-to-chair transfer. 3. Record review of Resident #3's face sheet dated 11/06/2024, revealed the resident was a [AGE] year-old male with an original admitted [DATE] and re-admission on 05/14/2023 with diagnoses that included: Dementia (cognitive condition affecting memory, thinking and social abilities), Contracture-unspecified joint (stiffness or shortening of muscle causing restricted movement), Paroxysmal atrial fibrillation (occasional irregular and often fast heart rate that usually stops spontaneously), and Generalized edema (fluid retention). Record review of Resident #3 Quarterly MDS assessment dated [DATE], revealed a BIMS score of 11, indicating moderate cognitive impairment. Further review under Section GG (Functional Abilities and Goals) revealed Resident #3 was assessed as Dependent for bed to chair transfers, which was described as needing the assistance of 2 or more helpers. Record review of Resident #3's care plan, dated 06/21/2023 with last update 10/22/2024, revealed there was no care plan regarding how to transfer the resident from bed-to-chair. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Autumn Winds Living & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 3301 Fm 3009 Schertz, TX 78154	

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. Record review of Resident #4's face sheet dated 11/06/02024 revealed an original admitted [DATE] with re-admission on 10/18/2022, and diagnoses which included schizoaffective disorder bipolar type, atrial fibrillation (irregular and often very fast heartrate), convulsions (seizures), and Chronic pain syndrome. Record review of Resident #4's Quarterly MDS assessment dated ,d+[DATE]//2024 revealed a BIMS score of 10, indicating moderate cognitive impairment. Further review revealed under Section GG (Function Abilities and Goals) that Resident #4 was assessed as needing partial/moderate assistance for bed to chair transfers, described as Helper does Less than half the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort. Record review of Resident #4's Care Plan dated 06//21/2023, last updated 10/22/2024, revealed there was no information on care plan regarding how to transfer the resident from bed to chair. 5. Record review of Resident #5's face sheet, dated 11/08/2024, revealed the resident was [AGE] years old female and an original admitted [DATE] and re-admitted [DATE] with diagnoses that included: chronic obstructive pulmonary disease (lung disease causing restricted airflow and breathing problems), Type 2 diabetes mellitus (chronic condition of high level of sugar in blood), enterocolitis (inflammation that occurs throughout intestines), and muscle wasting and atrophy (muscles to decrease in size and strength). Record review of Resident #5's quarterly MDS assessment completed on 08/25/2024 Section C (Cognitive Patterns) revealed a BIMS score of 12 which indicated moderate cognitive impairment. Section GG (Functional Abilities and Goals) indicated Resident #5 required Not attempted due to medical issues to chair/bed-to-chair transfer. Record review of Resident #5's profile, dated 11/07/2024, revealed the resident needed to mechanical lift with two persons for bed-to-chair transfer. Record review of Resident #5's care plan, dated 06/07/2023, revealed there was no care plan regarding how to transfer the resident from bed-to-chair transfer. 6. Record review of Resident #6's face sheet dated11/06/2024 revealed the resident was a [AGE] year-old female with an original admitted d of 08/09/2021 and re-admission on 10/02/2024, and diagnoses which included: Cerebral Infarction (also known as ischemic stroke resulting for blockage of blood to part of brain), Hemiplegia and hemiparesis (weakness or paralysis on one side of body) following non-traumatic intracranial hemorrhage (bleeding in brain) affecting left dominant side and Anxiety Disorder (mental disorder characterized by significant and uncontrollable feelings of anxiety and fear). Record review of Resident #6's 5-day MDS assessment dated [DATE] revealed a BIMS score of 11, indicating moderate cognitive impairment. Further review under Section GG (Functional Abilities and Goals) revealed Resident #6 was assessed as dependent on bed to chair transfers and needing assistance of 2 or more helpers is required for resident to complete the activity. Record review of Resident #6's Care Plan dated 05/04/2023, and last updated 10/23/2024, revealed there was no care plan regarding how to transfer the resident from bed to chair. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER: Autumn Winds Living & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE: 3301 Fm 3009 Schertz, TX 78154	

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	7. Record review of Resident #7's face sheet dated 11/05/2024, revealed the resident was a [AGE] year-old female with an original admitted [DATE] and re-admission on 06/03/2024, and diagnoses which included: Congestive Heart Failure (inability of heart to pump well enough to supply normal amount of blood to the body); atrial fibrillation (irregular and often very fast heartrate); and need for assistance with personal care. Record review of Resident #7's Quarterly MDS assessment dated [DATE] revealed a BIMS score of 14, indicating normal cognitive function. Further review of Section GG (Functional Abilities and goals) indicated Resident #7 required substantial/maximal assistance described as Helper does more than half the effort. Helper lifts or holds trunk or limbs and provides more than half the effort for bed to chair transfers. Record review of Resident #7's profile, dated 11/07/2024, revealed the resident needed use of mechanical lift with two persons assist for bed-to chair transfer. Record review of Resident #7's Care Plan dated 05/24/2023 and last updated 11/07/2024 revealed there was no care plan regarding what type of transfer the resident required. Interview on 11/08/2024 at 12:05 p.m., MDS Coordinator LVN-G acknowledged LVN-G did not develop the care plan regarding how to bed-to-chair transfer Resident #1, #2, #3, #4, #5, #6, and #7 because there was information regarding how to bed-to-chair transfer on Resident #1, #2, #3, #4, #5, #6, and #7's profiles in Point of Care. Facility nurses and CNAs obtained knowledge regarding what kind of transfer the residents needed by looking at the profiles. Further interview with the MDS LVN-G stated she should have developed the care plan regarding transfer for Resident #1, #2, #3, #4, #5, #6, and #7 because transfer was one of care that staff should provide for safety. The potential harm was staff might provide incorrect transfer to Resident #1, #2, #3, #4, #5, #6, and #7, and it might cause injuries because of a lack of care by no care plans. Interview on 11/08/2024 at 12:45 p.m. with regional nurse consultant RN-H stated facility nurses and CNAs knew regarding how to transfer their residents by looking at the profile, and the MDS nurse had responsibility for developing the care plans, but care plan should have addressed transfer because transfer was one of care parts. Record review of the facility policy, titled Care Plans, Comprehensive Person-Centered, dated 12/2016, revealed . 8. The comprehensive, person-centered care plan will describe the services that are to be furnished to attain or maintain the resident's highest practicable, physical, mental, and psychosocial well-being.

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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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39049 Based on observations, interviews, and record reviews, the facility failed to ensure that a resident who was incontinent of bladder and bowel received appropriate treatment and services for 1 of 10 residents (Residents #10) reviewed for incontinent care, in that: When LVN-D and CNA-E was providing bowel and bladder incontinent care to Resident #10 on 11/06/2024 at 4:24 p.m., LVN-D wiped Resident #10's buttock by only one pass with a cleaning cloth wipe as the resident had bowel movement, and LVN-D put the new brief under the resident's buttock after changing gloves, but the resident's buttock had still residual of stool. These failures could place residents at-risk for infection due to improper care practices. The findings included: Record review of Resident #10's face sheet, dated 11/08/2024, reflected the resident was [AGE] years old, male, and admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses of cerebral infarction (disrupted blood flow to the brain due to problems with the blood vessels), type 2 diabetes mellitus (not control blood sugar levels), urinary tract infection (infection in urinary system), contracture to right hand (shortening of muscle), hemiplegia and hemiparesis (weakness or paralysis on one side), and muscle wasting and atrophy (thinning or loss of muscle tissue). Record review of Resident #10's quarterly MDS, dated [DATE], reflected the resident's BIMS score was 4 out of 15, which indicated the resident had severe cognitive impairment. Further record review of the MDS revealed the resident was dependent to chair/bed-to-chair transfer and substantial/maximal assistance (helper does more than half the effort) to personal hygiene. Further record review of the MDS indicated Resident #10 was always incontinent to bladder and bowel. Record review of Resident #10's care plan, dated 01/25/2024, reflected [Resident #10] has an infection related to a urinary tract infection - follow principles of infection control and universal precaution to incontinent care. Observation on 11/06/2024 at 4:24 PM revealed while LVN-D and CNA-E were providing incontinent care to Resident #10, Resident #10 had bowel movement. LVN-D cleaned the resident's buttock area by only one pass with a cleaning cloth wipe, then LVN-D changed his gloves to new gloves after sanitizing his hands while CNA-E was holding the resident. When LVN-D put the new brief under Resident #10's buttock area, the resident asked to LVN-D, What are you doing? LVN-D said, I am done cleaning you and putting the new brief now. The resident said, I am not clean yet. CNA-E looked at the resident's buttock area and said, Okay, I will clean you completely. LVN-D and CNA-E changed their position. LVN-D was holding Resident #10, and CNA-E started cleaning the resident's buttock area. When CNA-E wiped the resident's buttock area, there was residual of stool to Resident #10's buttock area. CNA-E cleaned the resident's buttock area completely and closed new brief to the resident. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumn Winds Living & Rehabilitation	3301 Fm 3009 Schertz, TX 78154

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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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 11/06/2024 at 4:43 PM with LVN-D acknowledged he did not clean Resident #10's buttock area completely. LVN-D stated he saw the resident had residual of stool when CNA-E cleaned the resident's buttock area. Further interview with the LVN-D stated he wiped Resident #10's buttock by only one pass when the resident had bowel movement, and he thought it was enough to clean the resident. However, when CNA-E was cleaning the resident, and LVN-D saw the residual of stool, he realized one pass for cleaning was not enough. It was mistake because LVN-D was nervous. LVN-D stated he should have cleaned the resident's buttock area completely by several wiping. The potential harm was the resident might have skin breakdown or infection due to incomplete cleaning. Interview on 11/06/2024 at 4:44 PM CNA-E stated LVN-D should have cleaned the resident's buttock area completely by several wiping because when CNA-E was cleaning the resident, CNA-E saw residual of stool. Interview on 11/06/2024 at 4:55 PM with DON stated LVN-D should have cleaned the resident's buttock area completely by several wiping because the resident had bowel movement, cleaning by only one pass was not enough to clean the resident completely. DON was responsible for overseeing incontinence care and monitored this care through skill check off. Record review of the facility policy and procedure, titled Perineal Care, revision date 02/2018, reflected . 3. If resident is heavily soiled with feces, turn resident on side and clean away feces with tissues, wipes, or incontinent brief. Discard soiled gloves along with the soiled brief and/or wipes in trash bag. Cover the resident, provide safety measures and wash hands with soap and water.

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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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 39049 Based on observation, interview, and record review, the facility failed to ensure all drugs and biological were stored in locked compartments of one out of two nursing carts (200-hall nursing cart) reviewed for storage, in that: The facility failed to ensure the 200-hall Nursing Cart was locked when left unattended. This failure could place residents at risk of misappropriation of medications or harm due to accidental ingestion of unprescribed mediations. The findings were: During an observation on 11/07/2024 at 1:08 PM, the 200-hall nursing cart was found unlocked and unattended. This surveyor was able to open all drawers revealing multiple blister packs and bottles of medication. Interview on 11/07/2024 at 1:10 PM with LVN-F stated she was helping a resident due to call-light on. LVN-F stated she did not realize she left the nursing cart unlocked. LVN-F stated it was important the nursing cart was locked at all times due to resident, visitor, and staff safety. LVN-F stated by the nursing cart being unlocked, anyone could get into the cart and take medications from the cart. Interview on 11/07/2024 at 1:10 PM the DON stated the 200-hall nursing cart should not have been unlocked as it would not be safe for residents and visitors. The DON stated if the nursing cart was not locked someone other than the nurse, like a resident with dementia, could open the medication cart, take out the medications and take them. DON was responsible for overseeing this and monitored if or not the nursing carts were locked sometimes. Record review of the facility's policy, titled Storage of Medications, revised 04/2007, revealed . 7. Compartments (including but not limited to drawers, cabinets, rooms, refrigerators, carts, and boxes) containing drugs and biologicals shall be locked when not in use, and trays or carts used to transport such items shall ne be left unattended if open or otherwise potentially available to others.

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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** 33866 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 1 of 8 residents (Resident #8) reviewed for infection control in that: CNA B and CNA C failed to follow Enhanced Barrier Precautions (EBP) by not wearing gowns while performing peri-care for Resident #8. This failure could place residents at risk for cross contamination and the spread of infection. Finding include: Record review of Resident #8's face sheet, dated 11/08/2024, reflected an admitted [DATE] with diagnoses which included: Rheumatoid lung disease (lung condition associated with rheumatoid arthritis which causes scarring, inflammation and nodules in lungs); Noninfective gastroenteritis (stomach virus) and colitis (inflammation in colon); Rheumatoid arthritis of right knee (type of arthritis where immune system attacks the tissue lining the joints); Type 2 diabetes mellitus (chronic condition of high level of sugar in blood), Major depressive Disorder (mental disorder characterized by at least two weeks of pervasive low mood, low self-esteem, and loss of interest or pleasure; Urinary tract infection (bladder infection). Record review of Resident #8's Physician Orders dated 11/08/2024 revealed and order effective 09/05/2024 for Enhanced-Barrier Precautions r/t [related to]Foley Catheter. Record review of Resident #8's Quarterly MDS assessment, dated 09/30/2024, reflected the resident had a BIMS score of 12, indicating she was moderately cognitively impaired. Resident required limited to extensive assistance with her ADL's. Record review of Resident #8's care plan, dated 09/26/2024, reflected problems which included: 1. urinary incontinence with interventions that included: provide incontinent care as needed post each incontinent episode and preventive skin care as per orders. 2. has an open wound/boil to her upper back-at risk of infection, with an intervention of follow facility isolation policy 3. risk for developing and/or spreading infection related to my medical condition (foley catheter) with an intervention to utilize enhanced barrier precautions as ordered Observation on 11/07/2024 at 1:43 p.m. with RN-A also present, revealed that there was an Enhanced Barrier Protection sign on the wall outside of Resident #8's room, to the left of the door, and a PPE supply drawer next to the entrance just inside the door to her room. Further observation revealed CNA B and CNA C were wearing only gloves, no gowns, while performing peri-care on Resident #8. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676301	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/08/2024
NAME OF PROVIDER OR SUPPLIER Autumn Winds Living & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 3301 Fm 3009 Schertz, TX 78154	

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with CNA B on 11/07/2024 at 1:46 p.m., CNA B stated she was not aware that Resident #8 was on Enhanced Barrier Precautions and did not see the sign outside her door, otherwise she would have donned both gloves and gown. During an interview with RN A on 11/07/2024 at 1:50 p.m. RN A stated she had also observed CNA B and CNA C not wearing gowns to provide peri-care to Resident #8. RN A stated that Resident had a wound on her back, and that it was important to following Enhanced Barrier Precautions when working with residents with wounds to prevent infection. During an interview with the DON on 11/08/2024 at 12:26 p.m., the DON stated that both gowns and gloves should be provided as part of Enhanced Barrier Precautions when providing peri-care to residents, and to help prevent the spread of infection. The DON also stated that all facility staff had been trained on Enhanced Barrier Precautions. Record review of the facility Enhanced Barrier Precautions Policy revised March 2024 revealed a policy statement which read: Enhanced barrier precautions (EBP's) are utilized to reduce the transmission of multi-drug resistant organisms (MDRO's) to residents. Further review revealed EBP's employ targeted gown and glove use in addition to standard precautions during high contact resident care activities when contact precautions do not otherwise apply and Examples of high-contact resident care activities requiring the use of gown and gloves for EBP's include: .providing hygiene, changing briefs or assisting with toileting