STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676372	A. Building B. Wing	05/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Twin Pines North Nursing and Rehabilitation Center	1301 Mallette Drive Victoria, TX 77904

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39251 Based on interview, and record review, the facility failed to ensure resident medical records are kept in accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are complete and accurately documented for 4 of 10 residents (Residents #3, #4, #5, and #9) reviewed for clinical records, in that: 1. The facility failed to ensure Resident #3's wound care treatments as ordered by the physician were documented. 2. The facility failed to ensure Resident #3's weekly skin assessments were documented per facility policy on a weekly basis. 3. The facility failed to ensure Resident #4's weekly skin assessment was documented accurately on 5/1/24. 4. The facility failed to ensure Resident #5's weekly skin assessments were documented per facility policy on a weekly basis. 5. The facility failed to ensure Resident #9's wound care treatments as ordered by the physician were documented. 6. The facility failed to ensure Resident #9's weekly skin assessments were documented per facility policy on a weekly basis. These deficient practices could place residents at risk for improper care due to inaccurate records. Findings included: 1. Record review of Resident #3's Admission Record, dated 5/8/24, revealed the resident was readmitted to the facility on [DATE] with diagnoses which included: Pleural Effusion (buildup of fluid between the tissues that line the lungs) , Type 2 diabetes (condition in which the body has trouble controlling blood sugar and using it for energy) , Osteomyelitis (serious infection of the bone), and peripheral vascular disease (circulatory condition in which narrowed blood vessels reduce blood flow to the limbs). (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

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #3's Care Plan, dated 12/5/23, revealed: The resident has an unstageable pressure ulcer to Lt. heel . Administer treatments as ordered . Record review of Resident #3's quarterly MDS assessment, dated 4/6/24, reflected the resident had a BIMS score of 15, suggesting intact cognition. Further review revealed the resident had an unstageable pressure ulcer. Record review of Resident #3's Order Summary Report, dated 5/8/24, revealed: Cleanse stage iv pressure ulcer to Lt. heel with wound cleanser, pat dry with 4x4 gauze, apply Therahoney to wound bed, apply Hydrofera Blue, cover with silicone foam dressing QOD &PRN every day shift every other day for Wound Care. Record review of Resident #3's April WAR revealed the resident did not have wound care to the pressure ulcer on the left heel documented on the following days: 4/7/24, 4/12/24, 4/14/24, and 4/18/24. Record review of Resident #3's May WAR revealed the resident did not have wound care to pressure ulcer to left heel documented on 5/4/24. Record review of Resident #3's progress notes revealed there was not documentation of wound care treatments on the above-mentioned dates. Attempted interview on 5/11/24 at 3:57 pm with LVN E was unsuccessful. 2. Record review of Resident #3's EMR revealed weekly skin assessments were not documented for the following dates: 2/28/24, 3/13/24, 3/27/24, and 4/24/24. 3. Record review of Resident #4's Admission Record, dated 5/8/24, revealed the resident was readmitted to the facility on [DATE] with diagnoses which included: Peripheral Vascular Disease (circulatory condition in which narrowed blood vessels reduce blood flow to the limbs), Chronic Kidney Disease (condition in which kidneys are damaged and cannot filter blood) , cognitive communication deficit (difficulty with thinking and language), Dementia (group of thinking and social symptoms that interferes with daily functioning) , Hemiplegia (paralysis of one side of the body) . Record review of Resident #4's comprehensive MDS assessment, dated 4/28/24, reflected the resident had a BIMS score of 14, suggesting intact cognition. Further review of this MDS revealed the did not have any arterial ulcers. Record review of Resident #4's Order Summary, dated 5/8/24, revealed: Cleanse arterial wound to Lt great toe with wound cleanser, pat dry with 4x4 gauze, apply betadine and LOTA QD till resolved. every day shift for Until Healed . Record review of Resident #4's Care Plan, dated 5/8/24, revealed The resident has arterial ulcer of the Lt. great toe r/t Vascular insufficiency . Record review of Resident #4's Initial Skin Assessment, dated 4/25/24, revealed .Left great toe around toenail bed has an infected/gangrene ulcer . (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #4's Weekly Ulcer Assessment, dated 4/29/24, revealed Resident #4 had an arterial wound to the left great toe. Record review of Resident #4's Weekly Skin Assessment, dated 5/1/24, revealed the resident did not have any wounds. Record review of Resident #4's Weekly Ulcer Assessment, dated 5/6/24, revealed Resident #4 had an arterial wound to the left great toe. 4. Record review of Resident #5's Admission Record, dated 5/8/24, revealed the resident was readmitted to the facility on [DATE] with diagnoses which included: atrial fibrillation (An irregular, often rapid heart rate that commonly causes poor blood flow), Dysphagia (difficulty swallowing) , cognitive communication deficit (difficulty with thinking and language) , and Dementia (group of thinking and social symptoms that interferes with daily functioning). Record review of Resident #5's Care Plan, dated 6/20/23, revealed: .The resident with potential for pressure ulcer development . Record review of Resident #5's quarterly MDS assessment, dated 3/8/24, reflected the resident had a BIMS score of 10, suggesting moderate cognitive impairment. Record review of Resident #5's EMR revealed weekly skin assessments were not documented for the following dates: 2/6/24, 2/20/24, 3/5/24, 3/19/24, 4/2/24, 4/16/24, and 4/30/24. 5. Record review of Resident #9's Admission Record, dated 5/8/24, revealed the resident was readmitted to the facility on [DATE] with diagnoses which included: Cellulitis (common bacterial skin infection) of Left Lower Limb, Ulcer to Left Lower Leg, Reduced Mobility, Peripheral Vascular Disease (circulatory condition in which narrowed blood vessels reduce blood flow to the limbs), Pressure Ulcer of Left Heel and Dementia (group of thinking and social symptoms that interferes with daily functioning) . Record review of Resident #9's Care Plan, dated 6/5/23, revealed: The resident has unstageable pressure ulcer to Lt. heel .Has non-pressure wound to Lt. 2nd toe Administer treatments as ordered .The resident has Venous wound to LLL .Administer treatments as ordered . Record review of Resident #9's quarterly MDS assessment, dated 4/16/24, reflected the resident had a BIMS score of 10, suggesting moderate cognitive impairment. Further review revealed the resident had an unstageable pressure ulcer. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #9's Order Summary Report, dated 5/11/24, revealed: .Cleanse non-pressure wound to Lt. 2nd toe with wound cleanser, pat dry with 4x4 gauze, apply skin prep, LOTA QD till resolved. every day shift for Wound Care . Cleanse unstageable pressure ulcer to Lt. heel with wound cleanser, pat dry with 4x4 gauze, apply Santyl nickel thick to wound bed, cover with calcium alginate and 4x4 gauze, wrap with kerlix QD & PRN till resolved every day shift for Wound Care . Cleanse venous wound to Lt. lower leg with Anasept wound cleanser, pat dry with 4x4 gauze, cover with adaptic, collagen wound care, cover with calcium alginate and super absorbent pad, wrap with kerlix QD &PRN. every day shift for Wound Care . Cleanse skin tear to Lt. lower posterior leg with wound cleanser, pat dry with 4x4 gauze, apply Therahoney, cover with adaptic and wrap with kerlix QD till resolved. every day shift for Skin Tear .Discontinued . Record review of Resident #9's March WAR revealed the resident did not have wound care treatment to the left second toe, left lower posterior leg, unstageable pressure ulcer to left heel, and venous wound to left lower leg documented on the following days: 3/17/24, 3/24/24, 3/26/24, 3/30/24, and 3/31/24. Record review of Resident #9's April WAR revealed the resident did not have wound care treatment to the left second toe, left lower posterior leg, unstageable pressure ulcer to left heel, and venous wound to left lower leg documented on the following days: 4/8/24, 4/12/24, 4/13/24, and 4/14/24. Record review of Resident #9's May WAR revealed the resident did not have wound care treatment to the left second toe, unstageable pressure ulcer to left heel, and venous wound to left lower leg documented on the following days: 5/4/24 and 5/5/24. Record review of Resident #9's progress notes revealed there was documentation of wound care treatments on the above-mentioned dates. 6. Record review of Resident #9's EMR revealed weekly skin assessments were not documented for the following dates: 2/14/24, 2/28/24, 3/13/24, 3/20/24, and 4/24/24, and 5/8/24. During an interview on 5/8/24 at 12:51 pm, LVN C said she was unaware of Resident #3's and Resident #9's missed treatments. She stated one day Resident #3 was at dialysis and asked the floor nurse to complete the wound care treatment when he returned but could not recall what day. LVN C said she did not audit resident records, the ADONs were responsible for auditing resident records. LVN C said the charge nurses were responsible for completing wound care treatments on her days off. LVN C said she did not know why the treatments were missed. LVN C said she worked on 3/21/24 and 3/31/24 but worked on the floor passing medications. She added she also worked on 4/5/24, 4/12/24, and 4/18/24 but did not know what happened on those days. LVN C said weekly skin assessments were completed weekly and there was a schedule at the nurses' station. LVN C further stated nurses were to document all skin issues observed, adding alerts were triggered by PCC and this informed her if she needed to assess the resident further. LVN C said if the weekly skin assessments were not completed accurately, she may not receive alerts. LVN C said the charge nurses were responsible for completing weekly skin assessments every week. LVN C further stated she did not know why the weekly skin assessments were not completed for the above-mentioned residents. During an interview on 5/11/24 at 11:40 am, LVN D said when skin assessments were completed only new skin issues were supposed to be documented. LVN D further stated he documented anything he saw whether it was a new issue or not. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 5/11/24 at 12:30 pm, ADON A said nurses were alerted by PCC when a resident's weekly skin assessment was due. ADON A further stated she did not believe weekly skin assessments were completed for all residents and said she believed weekly skin assessments were only required for residents receiving skilled services. ADON A said she and ADON B were responsible for ensuring weekly skin assessments were completed. They were also responsible for auditing resident records, including treatments and assessments. ADON A further stated records were audited every morning and any missing documentation was brought to the nurses' attention for completion. ADON A said she was not aware of the missing treatments for Resident #3 and Resident #9, adding they were assigned to ADON B. ADON A further stated sometimes the nurses complete the treatments but did not document them and other times they missed the treatments and it was the responsibility of the ADONs to let the nurses know if something was red meaning it had not been completed, in the EMR. ADON A said she probably knew there were missing weekly skin assessments for residents mentioned above and probably told the nurses to follow up but that was a lot of follow ups. During an interview on 5/11/24 at 2:00 pm, ADON B said there was a list at each nurses' station that listed when weekly skin assessments were due and that skin assessments were to be completed weekly on all residents. ADON B further stated resident records were reviewed in the morning meetings every Monday - Friday and either she or ADON A attended these meetings; adding if there was anything that needed to be addressed, it was addressed. ADON B said the DON completed the audits and if she saw something missing throughout the day, this was brought to the attention of the ADONs and LVN C, adding that she became aware of missing documentation of the DON brought it to her attention. ADON B said the floor nurses were responsible for completing weekly skin assessment and all skin issues should be documented head to toe. ADON B further stated the DON was responsible for ensuring weekly skin assessments were documented accurately. ADON B said the floor nurses were responsible for wound care treatments during the week and the RN supervisor on the weekends in the absence of LVN C. ADON B further stated when treatments were not completed, they appeared red in PCC and it was addressed with the nurse to know why it had not been completed and offered help, if needed. ADON B said she was not aware of Resident #3's and Resident #9's missed treatments. During an interview on 5/11/24 at 2:34 pm, RN F said she completed Resident #3's and Resident #9's treatments on some of the days but did not document them. RN F further stated she did not know on which days this happened. She stated sometimes she was busy and left documentation for the end of the shift and forgot to document. RN F further stated other days, she did not have time to complete wound care treatments and asked the night shift nurse to complete the treatments but was unable to recall on what days she forgot to document and what days she was unable to complete treatments. RN F said the expectations was for treatments were to be documented immediately after administration. RN F said she was not aware skin assessments were to be completed on a weekly basis until a few months ago, about February or January. RN F further stated she did not remember why she did not complete weekly skin assessments when she was assigned to Resident #5 and Resident #9, adding she was probably too busy or thought she had completed them and had not. Attempted interview on 5/11/24 at 3:57 pm with LVN E was unsuccessful. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 5/11/24 at 5:20 pm, the DON said she tried to audit resident records and that auditing was a collaboration between herself and the ADONs. She further stated the facility did not have a requirement as to how often resident records were audited. The DON said ADON A (treatment nurse) was responsible for ensuring wound care treatments were completed when she was at the facility and the charge nurses in the treatment nurse's absence. The DON said she was not aware of the missing treatments and skin assessments. Record review of the facility's policy, titled Documentation, dated 2003, revealed: Documentation is the recording of all information, both objective and subjective, in the clinical record of an individual resident. It includes observations . of the resident involving care and treatments. It has legal requirements regarding accuracy and completeness . The facility will maintain complete and accurate documentation for each resident on all appropriate clinical record sheets . Document completed assessments in a timely manner and per policy. Complete documentation in the electronic health record in a timely manner . Record review of the facility's policy, titled Skin Assessment, revised 8/15/16, revealed: . All residents should have a skin assessment on a weekly basis completed in PCC Record review of the facility's policy, titled Skin Integrity Management, revised 10/5/16, revealed: . Wound care should be performed as ordered by the physician .

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39251 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 and to help prevent the development and transmission of communicable diseases and infections for 3 of 4 residents (Residents #1, #8, and #10) reviewed for infection control, in that: 1. The facility failed to ensure CNA G used proper hand washing technique during catheter care for Resident #1. 2. The facility failed to ensure CNA G used proper hand hygiene during catheter care for Resident #10. 3. The facility failed to ensure RN F used proper infection control practices during wound care for Resident #8. These deficient practices could place residents at risk for infection and delayed wound healing. Findings included: 1. Record review of Resident #1's Admission Record, dated 5/8/24, revealed the resident was admitted to the facility on [DATE] with diagnoses which included: Dementia (group of thinking and social symptoms that interferes with daily functioning), Acute Kidney Failure (condition in which kidneys suddenly are unable to filter waste from blood). Obstructive and Reflux Uropathy (obstructed urinary flow). Record review of Resident #1's Care Plan, dated 1/2/24, revealed: The resident has Indwelling Catheter . Record review of Resident #1's quarterly MDS assessment, dated 3/5/24, revealed the resident had a BIMS score of 9, suggesting severe cognitive impairment. Further review of this document revealed Resident #1 had an indwelling catheter and required substantial/maximal assistance (helper does more than half the effort.) for toileting and bathing. Record review of Resident #1's Order Summary Report, dated 5/8/24, revealed an order for catheter care every shift, dated 12/6/23. Observation of catheter care for Resident #1 on 5/10/24 beginning at 10:12 am revealed CNA G, after completing hand hygiene, used a clean paper towel to close the faucet after drying her hands and then wiped her hands with the same paper towel before she threw it in the trash bin and donned gloves. Further observation following catheter care for Resident #1 revealed CNA G removed her gloves and gown, washed her hands for 11 seconds, used a clean paper towel to close the faucet after drying her hands and then wiped her hands with the same paper towel before she threw it in the trash bin. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 5/10/24 at 10:29 am, CNA G said she had not realized she wiped her hands with the same paper towels she used to close the faucet after providing catheter care for Resident #1. CNA G further stated she cross contaminated by doing that and this could spread germs to the resident and herself. CNA G said hands were supposed to be washed for at least 20 seconds. 2. Record review of Resident #10's Admission Record, dated 5/10/24, revealed the resident was readmitted to the facility on [DATE] with diagnoses which included: Acute Kidney Failure (condition in which kidneys suddenly are unable to filter waste from blood), Malnutrition, Dementia (group of thinking and social symptoms that interferes with daily functioning), and Anxiety (feeling of dread, fear, or uneasiness). Record review of Resident #10's Care Plan, dated 1/4/23, revealed: The resident has an ADL Self Care Performance Deficit . Record review of Resident #10's quarterly MDS assessment, dated 3/15/24, revealed the resident did not have BIMS score listed. Further review of this document revealed Resident #10's cognitive skills for decision making was severely impaired and was dependent (helper does all of the effort. Resident does none of the effort to complete the activity. Or the assistance of 2 or more helpers is required for the resident to complete the activity.) for toileting and bathing. Observation of Peri-care (washing the genitals and anal area) for Resident #10 on 5/10/24 at 1:52 pm revealed CNA G sanitized her hands for 5 seconds without allowing hands to dry before she began peri-care. Further observation revealed CNA G sanitized her hands for 2 seconds once peri-care was completed. During an interview on 5/10/24 at 2:13 pm, CNA G said when using hand sanitizer, it was supposed to be rubbed and allowed to dry so that it was effective. 3. Record review of Resident #8's Admission Record, dated 5/8/24, revealed the resident was readmitted to the facility on [DATE] with diagnoses which included: Dementia (group of thinking and social symptoms that interferes with daily functioning), Atrial Fibrillation (An irregular, often rapid heart rate that commonly causes poor blood flow), Asthma (condition in which airways become inflamed, narrow, and produce extra mucus, making it difficult to breathe), and Major Depressive Disorder (mental health disorder characterized by persistently depressed mood or loss of interest in activities). Record review of Resident #8's Care Plan, dated 10/2/23, revealed: The resident has a stage iii pressure ulcer to Rt. Lateral malleolus .Administer treatments as ordered . Record review of Resident #8's comprehensive MDS assessment, dated 4/5/24, revealed the resident had a BIMS score of 15, suggesting intact cognition. Further review of this document revealed the Resident #8 had an unhealed pressure ulcer. Record review of Resident #8's Order Summary Report, dated 5/8/24, revealed an order for Cleanse stage III pressure ulcer to Rt. lateral malleolus [bone on the outside of the ankle joint] with wound cleanser, pat dry with 4x4 gauze, cover with calcium alginate and a dry dressing QD till resolved. every day shift. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation of wound care to Resident #8's right lateral (side) ankle on 5/10/24 beginning at 8:48 am revealed RN F gathered supplies, donned PPE, explained procedure, removed resident's items from bedside table, removed gloves, and washed hands for 14 seconds. Further observation revealed RN F returned to treatment cart, retrieved tray with supplies and placed on bedside table, closed the door, sanitized hands, and donned gloves. RN F removed her gloves and returned to treatment cart. RN F then used scissors to cut tape without sanitizing the scissors. RN F closed the door, sanitized her hands, opened door, and returned to the treatment cart to retrieve more gloves. RN F re-entered the resident's room, closed the door, donned gloves without sanitizing or washing her hands, the right glove tore while she donned it. RN F proceeded to remove Resident #8's dressing and completed wound care. Further observation revealed RN F cut the clean dressing without sanitizing the scissors. RN F placed the dressing on the wound and secured with tape. RN F removed right glove and then the left touching the outside of the glove with her bare right hand. RN F then removed the gown touching the outside of the gown with her bare hands and placed in a biohazard bag. RN F did not sanitize or wash her hands before or after leaving Resident #8's room. During an interview on 510/24 at 9:22 am, RN F said it was important to wash hands for at least 30 seconds to make sure she was getting all the germs off her hands. RN F further stated there was no reason for her not sanitizing the scissors prior to cutting the tape and the dressing. RN F said she grabbed them without thinking. RN F said the gloves tore all the time and she should have donned a new pair after her gloves tore during Resident #8's wound care. RN F said she should not have touched the outside of the gown with her bare hands to avoid contaminating them. RN F further stated she had not realized she did not sanitize her hands before or after she left Resident #8's room. During an interview on 5/11/24 at 12:30 pm, ADON A said she was responsible for infection control and provided training quarterly. ADON A further stated staff were expected to sanitize or wash their hands when providing resident care, after removing gloves and before donning new gloves. ADON A added staff were expected to wash their hands for at least 20 seconds, dry them, use a clean paper towel to close the faucet, and dispose of the paper towel without wiping their hands with that paper towel. ADON A said she expected staff to remove their gloves and then the gown, pulling the gown off from the back and rolling it with the inside out without touching the outside of the gown. During an interview on 5/14/2024 at 2:05 pm, the DON stated it was her expectation for staff to practice appropriate infection control. If staffs' hands were heavily soiled, then proper handwashing should occur with soap and water . If a glove tore and hands were heavily soiled, then the glove should be changed after washing hands. During an interview on 5/14/2024 at 2:10 pm, the Administrator stated staff knew to use infection control practices when they took care of residents. The Administrator further stated staff should adhere to the CDC guidelines which the facility followed. Record review of the facility's policy titled, Infection Control Plan: Overview dated 03/2004, revealed: . The facility will require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. The facility will require staff to Donn and Doff PPE before and after contact with resident who needs isolation to prevent the spread of infection to others in the facility . (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the facility's policy titled, Fundamentals of Infection Control Precautions updated 03/2004, revealed: . Hand hygiene continues to be the primary means of preventing the transmission of infection. The following is a list of some situations that require hand hygiene . Before and after direct resident contact (for which hand hygiene is indicated by acceptable professional practice); Before and after performing any invasive procedure .Before and after entering isolation precaution settings . Before and after assisting a resident with personal care . Before and after changing a dressing; Upon and after coming in contact with a resident's intact skin . After handling soiled . dressings .After handling soiled equipment .After removing gloves . Recommended techniques for washing hands with soap and water include: wetting hands first with clean, running warm water, applying the amount of product recommended by the manufacturer to hands, and rubbing hands together vigorously for at least 20 seconds covering all surfaces of the hands and fingers; then rinsing hands with water and drying thoroughly with a new disposable towel; and turning off the faucet on the hand sink with the disposable paper towel . Recommended techniques for performing hand hygiene with an ABHR: Include applying product to the palm of one hand and rubbing hands together, covering all surfaces of hands and fingers, until the hands are dry . Non-invasive resident care equipment is cleaned daily or as need between use . Staff will wear intact disposable gloves in good condition and change after each use, which helps reduce the spread of microorganisms .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676372	A. Building B. Wing	05/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Twin Pines North Nursing and Rehabilitation Center	1301 Mallette Drive Victoria, TX 77904

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 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home. 39251 Based on interview and record review, The facility failed to designate one or more individual(s) as the infection preventionist(s) had completed specialized training in infection prevention and control for 1 of 1 Infection Preventionist (ADON A) reviewed for infection control training. The facility's Infection Preventionist did not have specialized infection control training. This failure could have placed the residents at risk for infectious outbreaks that may lead to decline in health. Findings included: Record review of email received on 5/11/24 at 3:58 pm from the Admin revealed Nursing Home Infection Preventionist Training Course for the Admin and the DON after investigator requested certification/training for ADON A. During an interview on 5/11/24 at 11:21 am LVN C said ADON A was responsible for infection control. During interview on 5/11/24 at 12:30 pm, ADON A said she was responsible for the facility's infection control. During an interview on 5/11/24 at 3:13 pm, ADON A said she was a certified Infection Preventionist but did not know where her certification was. ADON A further stated administration might have had a copy. During interview on 5/11/24 at 3:15 pm, the DON said ADON A was the infection preventionist and was certified. Record review of the facility's infection control policy titled, Infection Control Plan: Overview , dated 03/2024, revealed .Facility IP, DON, and Administrator will complete the CDC train course to provide initial and ongoing education of all healthcare workers in the theory and practice of infection control and prevention .