STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676424	A. Building B. Wing	01/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Farmersville Health and Rehabilitation	205 Beech St Farmersville, TX 75442

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47743 Based on observation, interview and record review the facility failed to ensure that residents, who needed respiratory care, were provided such care consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences for 4 of twelve residents (Resident #20, Resident #27, Resident #36, and Resident #57) reviewed for Respiratory Care. 1. The facility failed to ensure Resident #20's nasal cannula (flexible tube used to deliver oxygen to the nose through two prongs) on her wheelchair was properly stored when not in use on 01/05/2025. 2. The facility failed to ensure Resident #27's nasal cannula at the back of the wheelchair was properly stored when not in use on 01/05/2025. 3. The facility failed to ensure Resident #36's nasal cannula at the back of the wheelchair was properly stored when not in use on 01/05/2025. 4. The facility failed to ensure Resident #57's nasal cannula attached to the oxygen concentrator was properly stored when not in use on 01/05/2025. This failure could place residents at risk for respiratory infection and not having their respiratory needs met. Findings included: 1. Record review of Resident #20's Face Sheet, dated 01/06/2025, reflected a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #20 was diagnosed with upper and lower respiratory infection, emphysema (a lung disease that damages the air sacs in the lung causing shortness of breath), and chronic obstructive pulmonary disease (a chronic inflammatory lung disease that causes obstructed airflow from the lungs). Record review of Resident #20's Comprehensive MDS Assessment, dated 11/01/2024, reflected the resident had a moderate impairment in cognition with a BIMS score of 11. The Comprehensive MDS Assessment indicated the resident had oxygen therapy while a resident of the facility. (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: 676424	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/07/2025
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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #20's Comprehensive Care Plan, dated 11/10/2024, reflected the resident used Oxygen Therapy via nasal cannula @ 2-4 lpm continuously r/t SOB d/t COPD and one of the interventions was apply oxygen. The resident's care plan did not indicate that the resident was the one taking off her nasal cannula. Record review of Resident #20's Physician Orders, dated 08/18/2020, reflected OXYGEN - CONTINUOUSLY = Oxygen at 2-4 L/PM via nasal cannula continuously. Check every shift. Check O2 sats Q shift and keep O2 at or greater than 92%. Record O2 sats every shift. Observation and interview with Resident #20 on 01/05/2025 at 9:13 AM revealed the resident was sitting at the side of her bed. The resident was on oxygen via nasal cannula that was connected to an oxygen concentrator. The resident said she had the oxygen for as long she could remember. She said she wore her oxygen day and night. She said she would also use her oxygen when she went outside her room. It was observed that the resident had a nasal cannula attached to a portable oxygen tank. The nasal cannula was sitting on the wheelchair seat and was not bagged. It was also noted that there was no bag behind the wheelchair. She said she did not know she was supposed to put the nasal cannula in a plastic bag. 2. Record review of Resident #27's Face Sheet, dated 01/06/2025, reflected a [AGE] year-old male who was admitted to the facility on [DATE]. The resident was diagnosed with chronic obstructive pulmonary disease. Record review of Resident #27's Comprehensive MDS Assessment, dated 11/10/2024, reflected the resident was cognitively intact with a BIMS score of 15. The Comprehensive MDS Assessment indicated the resident was on oxygen therapy while a resident of the facility. Record review of Resident #27's Comprehensive Care Plan, dated 12/24/2024, reflected the resident used oxygen continuously and one of the interventions was apply oxygen. Record review of Resident #27's Physician Order, dated 10/25/2023, reflected OXYGEN - CONTINUOUSLY = Oxygen at 2_L/PM via nasal cannula continuously. Check every shift. Check O2 sats Q shift and keep O2 at or greater than 92%. Record O2 sats every shift. Observation on 01/05/2025 at 9:39 AM revealed Resident #27 was still sleeping. It was observed that the resident's wheelchair was placed at the foot of his bed. A portable oxygen tank was observed at the back of the wheelchair with a nasal cannula connected to it. The nasal cannula was coiled on the seat of the wheelchair. The nasal cannula was not bagged. Observation and interview with Resident #27 on 01/05/2025 at 1:46 PM revealed the resident was in his wheelchair inside the room. The resident was on oxygen administration via nasal cannula that was connected to the portable oxygen behind his wheelchair. Resident #27 stated he had respiratory issues and that was why he was using oxygen continuously. He said staff would assist him with transfer to bed and wheelchair and wheelchair to bed. He said staff would also assist him with his nasal cannula. He said he was not aware where the staff would put it after they take it off. He said he did not see any plastic bag for his nasal cannula. (continued on next page)

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Farmersville Health and Rehabilitation	205 Beech St Farmersville, TX 75442

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. Record review of Resident #36's Face Sheet, dated 01/06/2025, reflected a [AGE] year-old female who was admitted to the facility on [DATE]. The resident was diagnosed with chronic obstructive pulmonary disease. Record review of Resident #36's Comprehensive MDS Assessment, dated 11/05/2024, reflected the resident had a severe impairment in cognition with a BIMS score of 5. The Comprehensive MDS Assessment indicated the resident was on oxygen therapy while a resident of the facility. Record review of Resident #36's Comprehensive Care Plan, dated 12/24/2024, reflected the resident had oxygen therapy continuously 2 L/min via nasal cannula and the goal was the resident will have no signs and symptoms of poor oxygen absorption. Record review of Resident #36's Physician Order, dated 07/03/2024, reflected OXYGEN - CONTINUOUSLY = Oxygen at 2 L/PM via nasal cannula continuously. Check every shift. Check O2 sats Q shift and keep O2 at or greater than 92%. Record O2 sats every shift. Observation and interview with Resident #36 on 01/05/2025 at 9:20 AM revealed the resident was in her bed, awake. It was observed that the resident had a nasal cannula attached to a portable oxygen tank. The tube of the nasal cannula was sitting on the wheelchair seat. The prongs of the nasal cannula were hanging and about to touch the right wheel of the wheelchair. The nasal cannula was not bagged. 4. Record review of Resident #57's Face Sheet, dated 01/06/2025, reflected a [AGE] year-old female who was admitted to the facility on [DATE]. The resident was diagnosed with Alzheimer's disease (brain disorder that destroys memory and thinking). Record review of Resident #57's Comprehensive MDS Assessment, dated 11/05/2024, reflected the resident had a score of 99 on her BIMS summary score suggesting that the resident was not able to complete the interview to determine the BIMS score. The Comprehensive MDS Assessment indicated the resident was on hospice care while a resident of the facility. Record review of Resident #57's Comprehensive Care Plan, dated 11/24/2024, reflected the resident received hospice care and one of the interventions was to coordinate with hospice team. Record review of Resident #57's Physician Order, dated 08/19/2024, reflected HOSPICE - ADMIT = Admit to . for DX: ALZHEIMER'S DISEASE. Record review of Resident #57's Physician Order, dated 08/09/2024 reflected OXYGEN PRN = Oxygen at 2-4 L/PM via nasal canula OR 5-8 L/PM via mask PRN for SOB [SHORTNESS OF BREATH]. Record review of resident #57's Physician Order from Hospice, dated 5/16/2024, reflected Administer 2 to 4 liters per minute via nasal cannula as needed for dyspnea (shortness of breath). Observation and interview with Resident #57 on 01/05/2025 at 9:27 AM revealed the resident was in her bed, awake. An oxygen concentrator was observed on the resident's bedside. A nasal cannula was attached to the oxygen concentrator and was hanging on top of the oxygen concentrator. The nasal cannula was not bagged, and no plastic bag was observed. When asked about her use of oxygen, the resident did not answer and just smiled. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER: Farmersville Health and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE: 205 Beech St Farmersville, TX 75442	

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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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation and interview with RN A on 01/05/2025 at 9:55 AM, RN A stated the nasal cannulas should be in a plastic bag when the residents were not using them. She said they should be bagged to prevent cross contamination and respiratory infection. She said the residents using oxygen had respiratory issues and that was why they had orders for oxygen therapy. RN A entered Resident #20's room and saw the nasal cannula on the wheelchair that was not bagged. She disconnected the nasal cannula and said she would get a new nasal cannula for Resident #20. She said she would also get a plastic bag for the nasal cannula. While she was disconnecting the nasal cannula, Resident #20 asked her what she was doing. RN A told resident that she changed the nasal cannula because it was not bagged and was already deemed dirty. RN A also told the resident she should put her nasal cannula in a plastic bag every time she would remove it. RN A said the resident was the one taking it off, but staff should educate the resident or monitor if the resident put it in a bag. RN A went out of Resident #20's room and went to Residents' #57 and #36's room. RN A saw Resident #57's nasal cannula on top of the oxygen concentrator and Resident #36's nasal cannula on the resident's wheelchair. She disconnected both nasal cannulas and said she would also get the residents new nasal cannulas. RN A went out of Residents #57 and #36's room and went to Resident #27's room and saw the nasal cannula on the wheelchair that was not bagged. She disconnected Resident #27's nasal cannula and said she would do the same. RN A went to storage room and gathered some nasal cannulas and some plastic bags and went to the rooms of Residents #20, #27, #36, and #57, and changed their nasal cannulas and placed plastic bags behind the wheelchair and the oxygen concentrator. She said she did not notice the nasal cannulas were not bagged when she did her morning round. She said she would check the other residents with oxygen if their nasal cannulas were bagged if they were not using it. She also said that whoever transferred the resident to bed should put the residents' nasal cannulas in a bag. In an interview with the DON on 01/06/2025 at 11:38 AM, The DON stated the nasal cannulas should be bagged when the residents were not using them for infection control and prevention of cross contamination. She said whoever was caring for the resident should check if the nasal cannula was bagged when not in use or needed to be changed because it touched something dirty. She said the expectation was for the staff who transferred the residents to bed should have bagged the nasal cannulas that were in the wheelchairs. She said the staff should check during their rounds that the nasal cannula was bagged. She said she was made aware by RN A about the issue and already did an in-service about bagging the nasal cannula when not in use. She also said Resident #57 was on Hospice that was why she had an oxygen concentrator. She said Hospice provided it and had an order for it. In an interview with CNA C on 01/06/2025 at 11:56 AM, CNA C said the nasal cannulas should be bagged to prevent them from getting dirty. She said the staff that transferred the resident was responsible in bagging the nasal cannula. She said she did not notice the nasal cannulas were not bagged when she did her morning round. In an interview with the Administrator on 01/06/2025 at 12:27 PM, the Administrator stated the nasal cannulas should be properly stored to prevent respiratory infections or exacerbation of whatever respiratory issues the residents already had. She said the expectation was for the staff to be mindful during their rounds and make sure the nasal cannulas were bagged and kept clean. She said the DON already initiated the in-service about bagging the nasal cannulas. In an interview with RN A on 01/07/2025 at 9:21 AM, RN A stated Resident #57's oxygen was a standing order from hospice. She said the resident seldom used it. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Policy for bagging the nasal cannula was requested on 01/06/2025 at 12:44 PM via email but was not provided prior to exit. In an interview with the Administrator on 01/07/2025 at 9:31 AM, the Administrator said they do not have a policy specific to bagging the nasal cannula.

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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** 47743 Based observation, interview, and record review 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 one (Resident #34) of eight residents reviewed for Infection Control. The facility failed to ensure CNA B changed her gloves and performed hand hygiene while providing incontinent care to Resident #34 on 01/05/2025. This failure could place residents at risk of cross-contamination and development of infections. Findings included: Record review of Resident #34's Face Sheet, dated 01/06/2025, reflected a [AGE] year-old female who was admitted to the facility on [DATE]. The resident was diagnosed with acute kidney failure (a condition in which one or both kidneys no longer work on their own). Record review of Resident #34's Comprehensive MDS Assessment, dated 11/19/2024, reflected the resident had a score of 99 on her BIMS summary score implying that the resident was not able to complete the interview to determine the BIMS score. The Comprehensive MDS Assessment indicated the resident was always incontinent for both bowel and bladder. Record review of Resident #34's Comprehensive Care Plan, dated 12/01/2024, reflected the resident had urinary incontinence and one of the interventions was to give perineal care. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation and interview with CNA B on 01/05/2025 at 10:56 AM revealed CNA B entered Resident #34's room holding a plastic bag with a brief in it. She said she would change the resident's brief first and then she would transfer her to her wheelchair. CNA B put on a pair of gloves. She did not sanitize or wash her hands before putting on the pair of gloves and before starting incontinent care. CNA B then said the resident did not have any wipes. CNA B removed her gloves and said she would go out to get some wipes. After a few moments, CNA B returned with some wipes. CNA B put on a pair of gloves. CNA B, again, did not sanitize or wash her hands before putting on the gloves. She unfastened the brief on both sides and pushed the front part of the brief between the resident's thighs. CNA B pulled some wipes and cleaned the resident's perineal area (area between the thighs) using the front to back technique. After cleaning the perineal area, CNA B rolled the resident towards the wall and cleaned the resident's bottom. It was noted that the resident had some dry feces. CNA B pulled the soiled brief and threw it on the trash can. CNA B then opened the plastic bag, took the brief inside it, opened it, and put it under the resident. She did not change her gloves after cleaning the resident's bottom and before touching the new brief. She rolled back the resident, fixed the brief, and fastened it on both sides. CNA B stated hand hygiene should be done before doing incontinent care. She said she just put on a pair of gloves before doing incontinent care and did not even sanitize her hands. She said hands should be washed or sanitized to prevent infection. She said the gloves should be changed after she cleaned the resident's bottom and before touching the new brief because the gloves that she used to clean the resident's bottom were already soiled. She said she would be mindful the next time she does incontinent care to wash her hands and change her gloves during incontinent care. She said she had trainings for pericare but did not know why she forgot to wash her hands and change her gloves. In an interview with the DON on 01/06/2025 at 11:38 AM, The DON stated hand hygiene was the most effective way to prevent cross contamination and spread of infection. She said staff should do hand hygiene before and after any care. She said gloves should be changed after cleaning the resident's bottom because the gloves were already deemed dirty. She said the expectation was for the staff to wash their hands before and after any care and change their gloves when going from dirty to clean. She said she was made aware by CNA B about the issue, and she already did a one-on-one in-service with CNA B about hand hygiene and pericare. She said she will be doing an in-service for all the direct care staff about hand hygiene and pericare. She said she will personally monitor the staff. In an interview with the Administrator on 01/06/2025 at 12:27 PM, the Administrator stated not washing the hands before any care and not changing the gloves from soiled to clean could contribute to cross contamination and infection. She said the expectation was for the staff to follow the policy and procedures pertaining to infection control. She said the DON already in-serviced the staff about hand hygiene and pericare. Record review of the facility policy, Hand Washing undated, revealed Standard: Mechanical removal of pathogenic organisms from the skin is accomplished by hand washing . Policy: Hand washing is required before and after a procedure that involves direct or indirect contact with a resident, after contact with any wastes or contaminated materials, before handling any food or food receptacle, or at any time the hands are soiled. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the facility policy for Perineal Care undated, revealed Purpose: To cleanse the genitalia (organs of the reproductive system) and rectum. Procedure is given after each incontinent episode . Procedure . 4. Wash hands and put on gloves . 11 . clean the rectum by wiping from the front to the back . dry resident and change gloves . 12. Place a dry, clean incontinent pad under resident . 15. Place the soiled items in a plastic bag . 17. Remove gloves and wash hands. 50444

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F 0912 Level of Harm - Potential for minimal harm Residents Affected - Many	Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49459 Based on interview and record review, the facility failed to ensure 34 (Room numbers 2, 3, 4, 6, 7, 8, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37 and 39) out of 34 multiple-resident bedrooms, measured at least 80 square feet per resident. The facility failed to ensure multiple resident Room numbers 2, 3, 4, 6, 7, 8, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37 and 39 met the required minimum of 80 square feet per resident. This failure could place residents at risk of not having sufficient space. Findings included: Review during the survey's Offsite Survey Preparation, conducted on 01/02/2025, prior to the start of the survey on 01/05/2025, and documented on ASE-Q offsite revealed the facility had a room size waiver. During this survey's entrance conference on 01/05/25 at 9:30 AM, the Administrator revealed the facility had a room size waiver in place for the bedrooms measuring less than the required square footage. She also advised nothing has changed in the past years regarding resident's room square footage. Review of Form DADS 3740 (Bed Classifications Form), completed by the facility on 01/05/2025, revealed all 37 bedrooms in the facility had two beds and were classified as Medicare and Medicaid. Review of the facility's license on 01/05/2025 at 10:57 AM revealed the facility was licensed for 74 beds. Review of the resident bedroom measurements listing, undated provided by the Administrator on 01/07/2025 revealed the following: 1) Resident Rooms 2, 3 and 4 measured 127 square feet. 2) Resident Rooms 6, 8 and 10 measured 132 square feet 3) Resident room [ROOM NUMBER] measured 146 square feet 4) Resident rooms [ROOM NUMBERS] measured 147 square feet 5) Resident Rooms 12, 14, 15, 16, 17 and 19 measured 156 square feet 6) Resident room [ROOM NUMBER] measured 159 square feet (continued on next page)

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F 0912 Level of Harm - Potential for minimal harm Residents Affected - Many	7) Resident Rooms 20, 22, 24, 26 and 28 measured 151 square feet 8) Resident Rooms 23, 25, 27, 29, 30, 31, 32, 33, 34, 35, 36, 37 and 39 measured 153 square feet. No policy was provided prior to exit.