STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676477	A. Building B. Wing	05/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Caraday of Mount Vernon	501 Yates Street Mount Vernon, TX 75457

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46892 Based on observation, interview, and record review, the facility failed to ensure a resident who was unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming and personal and oral hygiene for 1 of 16 residents (Resident #24) reviewed for ADLs. The facility failed to provide Resident #24 assistance with removal of her facial hair. These failures could place residents at risk of not receiving services and care, and a decreased quality of life. Findings included: Record review of a face sheet dated 05/22/2024 indicated Resident #24 was a [AGE] year-old female initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety (loss of memory, language, problem solving and other thinking abilities that were severe enough to interfere with daily life without any behaviors). Record review of the Comprehensive MDS assessment dated [DATE] indicated Resident #24 was usually understood by others and was usually able to understand others. The MDS assessment indicated Resident #24 had a BIMS score of 1, which indicated her cognition was severely impaired. The MDS assessment indicated Resident #24 was dependent with all of her ADLs including shower/bathing self. The MDS assessment indicated Resident #24 did not reject care. Record review of the care plan with a target date of 08/08/2024 indicated Resident #24 had an ADL self-care performance deficit related to cognitive impairment. The care plan indicated Resident #24 required total assistance for her showers. Record review of the shower sheet dated 05/20/2024 indicated Resident #24 received a bed bath. During an observation on 05/20/2024 at 11:47 AM, Resident #24 had one long chin hair approximately 2 centimeters long and multiple other chin hairs approximately 0.5 centimeters long. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 05/21/2024 at 2:09 PM, CNA C said Resident #24 received her baths on Monday, Wednesday, and Friday. CNA C said she gave Resident #24 a bed bath yesterday, 05/20/2024. CNA C said she had not shaved Resident #24 because she had not noticed her facial hair. CNA C said Resident #24 did not refuse bathing or shaving. CNA C said it was important for facial hair to be removed because it was part of the residents everyday appearance and for their dignity. During an observation and interview on 05/21/2024 at 2:18 PM, Resident #24 had one long chin hair approximately 2 centimeters long and multiple other chin hairs approximately 0.5 centimeters long. Resident #24 said she did not want facial hair that she liked for it to be removed. Resident #24 said she did not refuse bathing or facial hair removal. During an observation and interview on 05/21/2024 at 2:28 PM, the DON said the CNAs were supposed to shave Resident #24, if that's what she wanted and if she allowed. The DON said she knew the CNAs shaved Resident #24 last week. The DON said the residents were shaved with their baths. The DON said the charge nurses reviewed the shower sheets daily and she reviewed the shower sheets daily to ensure bathing was completed. The DON said she rounded daily to ensure the residents appeared clean and shaved. The DON said it was important for facial hair to be removed so the residents could have a clean face. During an interview on 05/22/2024 at 3:16 PM, LVN D said she had not noticed Resident #24 had facial hair. LVN D said the nurses were responsible for monitoring the residents to ensure they were shaved and clean. LVN D said it was important for the residents to be shaved for their dignity. During an interview on 05/22/2024 at 3:50 PM, the ADON said the charge nurses were supposed to sign off on the shower sheets daily to ensure the residents were bathed and shaved. The ADON said facial hair should be remove don shower days. The ADON said there were room rounds completed to ensure the residents were well groomed. The ADON said it was important for the residents to be shaved because it was a dignity issue. During an interview on 05/22/2024 at 4:36 PM, the Administrator said she expected for facial hair to be removed. The Administrator said the CNAs should be shaving the residents during bathing. The Administrator said the charge nurses were responsible for ensuring the residents were shaved. The Administrator said it was important for facial hair to be removed for the resident's dignity. Record review of the facility's policy titled, Activities of Daily Living (ADLs), Supporting, revised March 2018, indicated, Residents will provided with care, treatment and services as appropriate to maintain or improve their ability to carry out activities of daily living (ADLs). Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene .

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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. 46892 Based on observation, interview, and record review the facility failed to ensure, in accordance with State and Federal laws, all drugs and biologicals were stored in a locked compartment, only accessible by authorized personnel for 1 of 1 medication carts (Medication Cart) reviewed for storage of medications. The facility failed to ensure the Medication Cart was secured and unable to be accessed by unauthorized personnel. This failure could place residents at risk for not receiving drugs and biologicals as needed, misuse of medications, and a drug diversion. Findings included: During an observation and interview on 05/21/2024 at 7:22 AM, there was an unlocked medication cart in the hallway by the entrance to the dining room. There were multiple residents around. LVN A was in the dining room. LVN A said it was her medication cart. LVN A said the Medication Cart should always be locked when she walked away from it. LVN A said medication carts should always be locked because they had medications in them. LVN A said if the medication cart was left unlocked residents could get into it and have a massive overdose. During an interview on 05/22/2024 at 3:48 PM, the ADON said the medication carts should be locked anytime the staff were away from the medication carts. The ADON said the DON and herself made rounds throughout the day to ensure the medication carts remained locked. The ADON said it was important for the medication carts to be locked so people could not get into them and get the medications that were other residents or that they did not have orders to, and because medications should not be accessible to the residents. During an interview on 05/22/2024 at 4:17 PM, the DON said the medication cart should be locked at all times when the staff were away from the medication cart. The DON said the charge nurse was responsible for ensuring the medication cart was locked. The DON said the ADON and herself monitored by doing daily rounds and if they noticed a medication cart was unlocked. They locked the medication cart and talked to the staff about it. The DON said it was important for the medication carts to be locked because a resident or anybody could go and open the cart. The DON said a confused resident could go and take medications that did not belong to them or take too much of a medication. During an interview on 05/22/2024 at 4:40 PM, the Administrator said the medication carts should always be locked unless the medication attendant was standing in front of the cart. The Administrator said the charge nurse and the person responsible for the medication cart were responsible for ensuring the medication cart was locked. The Administrator said it was important to ensure the medication carts were locked when away from them for security of the medications. The Administrator said leaving a medication cart unlocked could result in one of the residents or anybody getting something out if it. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of an undated, untitled policy provided by the facility indicated, 9.3 Medication Administration Facility staff should take all measures required by Facility Policy, Applicable Law, and the State Operations Manual when administering medications . During administration of medications, the medication cart is kept closed and locked when out of sight of the medication nurse or aide .

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 45879 Based on observation, interview and record review the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety for 1 of 1 kitchen reviewed for dietary services. 1. The dietary staff Cook K failed to maintain safe temperatures at or above 135 degrees Fahrenheit for hot foods. 2. The facility failed to ensure staff did not enter the kitchen without performing hand hygiene or wearing hair restraints. These failures could place residents at risk for foodborne illness and contamination. The findings include: During an observation and interview on 05/20/24 at 11:45 a.m., Cook K was checking the temperatures of the lunch meal that was held on the steam table. Cook K used 3 different thermometers to test the food temperature and they all read at different temperatures. The thermometer read at 180 then dropped to 110 degrees Fahrenheit and then up to 130 degrees Fahrenheit, etc . The thermometer would not hold a consistent temperature. Cook K said she tried to obtain the correct temperatures of all the food on the steam table but the thermometer was not reading the food temperature properly. Cook K said the temperatures should have been between 140- and 160 degrees Fahrenheit but with the way the thermometer was reading she could not ensure the food temperature was correct. During an observation and interview on 05/20/24 at 12:10 p.m., the DM observed Cook K check the temperatures on the steam table. The DM stated the temperatures on the steam table should have been greater or equal to 165 degrees Fahrenheit. The DM said if the temperatures on the steam table were below 165 degrees Fahrenheit, the facility policy was to reheat the food. During an observation on 05/20/24 at 12:20 p.m., Cook K reheated the food on the steam table. During an observation on 05/20/24 at 12:30 p.m., the DM obtained a new thermometer from the Administrator . The DM calibrated the thermometer and gave it to Cook K to test the food. During an observation on 05/20/24 at 12:35 p.m., Cook K attempted to re-temp the food and the thermometer was still not reading all the food consistently. The temperatures were as follows: 1. The steak fingers were held at an unknown degree Fahrenheit because the thermometer was not providing a consistent temperature. 2. The mechanical soft was held at unknown degrees Fahrenheit because the thermometer was not providing a consistent temperature. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. The pureed steak fingers were held at 128 degrees Fahrenheit. 4. The corn fritters were held at an unknown degrees Fahrenheit. 5. The carrots were held at 150 degrees Fahrenheit. 6. The pureed carrots were held at 159 degrees Fahrenheit. 7. The rice was held at 150 degrees Fahrenheit. 8. The pureed rice was held at 185 degrees Fahrenheit. 9. The gravy was held at 134.4 degrees Fahrenheit. During an observation and interview on 05/20/24 at 12:50 p.m., the DM instructed Cook K to serve the food because she knew it was at the correct temperature. After all, she said they had reheated the food and it was hot. During an observation on 05/20/24 at 1:19 p.m., the Maintenance Supervisor entered the kitchen and got ice out of the ice machine without performing hand hygiene or wearing a hair restraint. During an interview on 05/20/24 at 2:20 p.m., the Maintenance Supervisor said he came into the kitchen to get some ice. He said he was unaware he needed to perform hand hygiene or wear a hairnet. The Maintenance Supervisor said if he went around the food, he could see why he needed to do hand hygiene and wear a hair restraint, but he did not. He said after thinking about it, he could see it as cross-contamination. During an interview on 05/21/24 at 1:44 p.m., the DM said she was aware the Maintenance Supervisor went into the kitchen to get ice. She said it was not the correct thing to do. She said he should have gone to the front window and asked for ice from the kitchen staff. She said he should have performed hand hygiene and wore a hair restraint before entering the kitchen area. She said without hand hygiene or wearing a hair restraint could lead to cross-contamination. The DM said she knew to reheat the food when it was not at the correct temperature. She said she never had the thermometers not work properly. She said she knew the food was at the correct temperature although the thermometer was not working correctly because they had re-heated the food. She said she knew if the food was not at the correct temperature it could lead to foodborne illness. During a phone interview on 05/21/24 at 2:31 p.m., the Dietician said the DM was responsible for the kitchen. He said the kitchen staff should take the temperature of all food and if it was not at the correct temperature of 135 degrees or above, they should re-heat the food until it reached 165 degrees Fahrenheit. He said they should always have a functioning thermometer in the kitchen. He said if the food were below 135 degrees Fahrenheit it could cause bacteria to grow. He said if the food was not tested then the staff was not aware at what temperature they were serving food and this could cause foodborne illness. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 05/22/24 at 3:30 p.m., the ADON said she was unaware of the kitchen process of checking the temperature of the food. She said she knew if the food temperature was not at the correct temperature it could lead to foodborne illness. The ADON said hairnets should always be worn in the kitchen to prevent hair from getting into the food. She said anyone who entered the kitchen should perform hand hygiene to prevent infection control. She said no one knew what could be on their hands. She said the DM was responsible for ensuring hand hygiene was performed, hairnets were worn, and temperatures were being done before serving the residents. During an interview on 05/22/24 at 4:02 p.m., the DON said she expected the kitchen staff to check food temps before the food was served. She said without checking the food temperatures, the food could be taken out hot, cold, or not at the correct temperature which could cause stomach discomfort. She said everyone should wear a hair restraint and perform hand hygiene while in the kitchen area. She said to prevent hair or bacteria from entering the food and for infection control issues. During an interview on 05/22/24 at 4:25 p.m., the Administrator said she expected the kitchen staff to temp the food before it was served and not to serve the food if it was unsafe. She said she expected staff to wear hair nets to keep hair off the food and perform hand hygiene to ensure hands were clean. She said the DM was responsible for ensuring the temperature of the food was safe before serving, hair nets were worn, and hand hygiene was being performed for hygiene reasons. Record review of the facility's policy, Food Holding and Service, dated 2018, reflected To ensure that all food served by the facility is of good quality and safe for consumption, all food will be held and served according to the state and United States Food Codes and Hazard Analysis Critical Control Points guidelines. Procedure: 1. Serve all hot foods at a temperature of 135 F or greater and all cold food at 41 F or less. Adjust the temperature to account for the time the food will be held prior to service on the steam table and on the tray carts. 2. Hold foods prior to service for less than one hour, maintaining the temperatures noted above. Keep foods covered to maintain temperatures except for foods that will be served crispy. 3. Place food on steam table no more than 30 minutes prior to meal service. 4. If hot foods drop below 135 F, reheat to 165 F for a minimum of 15 seconds. Record review of the facility's policy, Employee Sanitation, dated 2018, indicated The Nutrition & Foodservice employees of the facility will practice good sanitation practices in accordance with the state and US Food Codes in order to minimize the risk of infection and foodborne illness. Procedure: 3. Employee Cleanliness Requirements a. All employees must wear clean outer clothing. b.Hairnets, headbands, caps, beard coverings, or other effective hair restraints must be worn to keep hair from food and food-contact surfaces. 5. Hand washing: a. Employees must wash their hands and exposed portions of their arms at designated hand-washing facilities at the following times: A1. After touching bare human body parts other than clean hands and clean, exposed portions of arms. Immediately before engaging in food preparation including working with exposed food, clean equipment and utensils, and unwrapped single-service and single-use articles. A5. During food preparation, as often as necessary to remove soil and contamination and to prevent cross-contamination

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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** 45810 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 6 of 16 residents (Resident #4, Resident #133, Resident #14, Resident #13, Resident #21, Resident #6) reviewed for infection control practices. 1. The facility failed to ensure CNA L performed hand hygiene and changed gloves while providing incontinent care for Resident #4. 2.The facility failed to ensure LVN A cleaned the electronic wrist blood pressure monitor after she checked Resident #13's blood pressure, before checking Resident #14's blood pressure. 3.The facility failed to ensure LVN A performed hand hygiene after administering medications to Resident #13. 4.The facility failed to ensure MA B performed hand hygiene after administering medications to Resident #21, before checking Resident #6's blood pressure. 5. The facility failed to ensure RN E performed hand hygiene while providing wound care. 6. The facility failed to ensure staff was aware of Resident #133 contact isolation precautions. These failures could place residents at risk for cross contamination and the spread of infection. Findings included: 1. Record review of Resident #4's face sheet, dated 05/20/24, reflected he was a [AGE] year-old male who readmitted to the facility on [DATE]. Resident #4 had diagnoses which included Multiple Sclerosis (autoimmune disease in which the nerve cells in the brain and spinal cord are damaged causing mental and physical problems), Herpes viral infection (uncurable virus that causes blisters to form), depression, hypertension (high blood pressure) and diabetes mellitus (disease causing too much sugar in the blood). Record review of Resident #4's quarterly MDS, dated [DATE], reflected he had a BIMS score of 15, which indicated he was cognitively intact. He required total assistance with bathing, bed mobility, transfers, and toileting, and setup for eating. Record review of Resident #4's care plan, revised on 11/08/23, reflected he had an ADL self-care deficit related to his diagnosis of multiple sclerosis and required 2 staff for toileting. (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 observation on 05/20/24 at 11:33 AM revealed CNA C assisted CNA L with perineal care for Resident #4. Both CNAs had gloves on when surveyor entered Resident #4's room. The CNAs said they performed hand hygiene prior to placing gloves on. CNA L wiped Resident #4 with a wipe to his left groin and discarded it in a plastic bag, wiped with a separate wipe to his right groin and discarded it in a plastic bag, and then wiped his peri area with a wipe and discarded it in a plastic trash bag. CNA L and CNA C rolled Resident #4 to his right side and CNA L used a wipe to clean his buttocks and discarded the wipe in a plastic trash bag. CNA L removed the dirty brief and placed in plastic bag and failed to remove gloves and provide hand hygiene prior to picking up clean brief to place on Resident #4. CNA L applied the new brief, removed gloves, and placed in the plastic trash bag. No hand hygiene was performed. During an interview on 05/20/24 at 11:47 AM, CNA L said she typically would have changed gloves in between clean and dirty if the resident would have had a bowel movement. She then said she should have had hand sanitizer and gloves in the room to change between the clean and dirty. CNA L said it placed Resident #4 at risk for infection when she did not change her gloves and sanitize her hands in between clean and dirty. CNA L said the facility provided perineal care check offs completed by ADON and she had one not long ago but unsure of the actual date. During an interview on 05/22/24 at 03:41 PM, the ADON said the CNAs should have washed their hands prior to care and change gloves when soiled, as well as when the CNA went from a clean to dirty surfaces and dirty to clean surfaces, hand hygiene should have been completed between changing the gloves. The ADON said she was responsible for ensuring the CNAs properly performed perineal care and she completed perineal care checkoffs with the CNA staff in March 2024. She said the facility completed proficiency of perineal care upon hire, annually, and as needed. The ADON said the improper hand hygiene and changing gloves placed a risk for infection. During an interview on 05/22/24 at 04:12 PM the DON said her expectation was for the CNAs to wash hands prior to care and after the care and between clean and dirty. She said the failure of not changing gloves and using hand hygiene, or not cleaning residents properly placed a risk of the spread of bacteria and urinary tract infections. The ADON and the DON are responsible and ADON completes the check offs. During an interview on 05/22/24 at 04:34 PM, the Administrator said she expected the CNAs to follow the facility policy and procedure for changing gloves and sanitizing their hands. The Administrator said the ADON was primarily responsible for checkoffs and ensuring the CNAs were competent in providing perineal care, then the DON should have been monitoring as well. She said the failure placed the risk of infection. 46892 2. Record review of a face sheet dated 05/22/2024 indicated Resident #13 was a [AGE] year-old male initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included essential primary hypertension (high blood pressure). Record review of the Quarterly MDS assessment dated [DATE] indicated Resident #13 was able to make himself understood and understood others. The MDS assessment indicated Resident #13 had a BIMS score of 15, which indicated his cognition was intact. (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 Order Summary Report dated 05/22/2024 indicated Resident #13 had an order for Carvedilol 12.5 mg (medication used for high blood pressure) 1 tablet by mouth two times a day hold for blood pressure less than 100/60 and pulse less than 60. Record review of Resident #13's care plan with a target date of 07/22/2024 indicated he received diuretic therapy (medications that help you get rid of fluid in the body) related to hypertension (high blood pressure). The care plan did not specifically address checking Resident #13's blood pressure. 3. Record review of a face sheet indicated Resident #14 was a [AGE] year-old female initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included essential primary hypertension (high blood pressure). Record review of the Quarterly MDS assessment dated [DATE] indicated Resident #14 was usually able to make herself understood and usually understood others. The MDS assessment indicated Resident #14 had a BIMS score of 9, which indicated her cognition was moderately impaired. Record review of the Order Summary Report dated 05/22/2024 indicated Resident #14 Metoprolol Tartrate (medication used to treat high blood pressure) 25 mg 1 tablet by mouth two times a day. Record review of Resident #14's care plan with a target date 06/25/2024 indicated she had cardiac (heart) disease related to high blood pressure to administer medications as ordered by the physician. During an observation of medication administration on 05/21/2024 beginning at 7:40 AM, LVN A checked Resident #13's blood pressure, and then laid the electronic wrist blood pressure monitor on top of the medication cart and started preparing Resident #13's medications. LVN A administered Resident #13's medications. Returned to her medication cart and started documenting on the computer. LVN A did not perform hand hygiene after exiting Resident #13's room prior to touching her computer. LVN A did not disinfect the electronic wrist blood pressure monitor. LVN A performed hand hygiene and took the same electronic wrist blood pressure monitor that was not disinfected to check Resident #14's blood pressure. LVN A checked Resident #14's blood pressure, and then laid it on top of the medication cart. During an interview on 05/21/2024 at 9:47 AM, LVN A said the electronic wrist blood pressure monitor should be cleaned in between each use. LVN A said she had not cleaned it because she was nervous. LVN A said it was important to clean the electronic wrist blood pressure monitor after each use to prevent the transfer of germs from one person to the next. LVN A said hand hygiene should be performed prior to getting medications ready and after every patient. LVN A said she should have performed hand hygiene upon exiting Resident #13's room and prior to touching her computer and other items. LVN A said she had not performed proper hand hygiene during medication administration because her routing was thrown off and she was nervous. LVN A said it was important to perform hand hygiene to prevent spreading anything from one resident to another to herself and then spread it to someone else. 4. Record review of a face sheet dated 05/22/2024 at 11:53 AM indicated Resident #21 was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses which included atherosclerotic heart disease of native coronary artery without angina pectoris (buildup of cholesterol plaque in the walls of arteries causing obstruction of blood flow). (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 Comprehensive MDS assessment dated [DATE], indicated Resident #21 was able to make herself understood and understood others. The MDS assessment indicated Resident #21 had a BIMS score of 13, which indicated her cognition was intact. Record review of Resident #21's care plan with a target date of 08/25/2024 indicated she had cardiac (heart) disease to administer medications as ordered by the physician. 5. Record review of a face sheet dated 05/22/2024 indicated Resident #6 was an [AGE] year-old female initially admitted to the facility on [DATE] and readmitted to the facility on [DATE] with diagnoses which included essential primary hypertension (high blood pressure). Record review of the Comprehensive MDS assessment dated [DATE] indicated Resident #6 was usually able to make herself understood and was usually able to understand others. The MDS assessment indicated Resident #6 had a BIMS score of 11, which indicated her cognition was moderately impaired. Record review of the care plan with a target date of 08/01/2024 indicated Resident #6 had cardiac (heart) disease related to high blood pressure to administer medications as ordered by the physician. During an observation and interview on 05/22/2024 at 8:19 AM, MA B administered medications to Resident #21. MA B removed her gloves and discarded them. MA B exited Resident #21's room. MA B did not perform hand hygiene. MA B went to Resident #6's room to check her blood pressure. MA B returned to her medication cart and was about to start preparing Resident #6's medications. The State Surveyor intervened to ask MA B when she should perform hand hygiene. MA B said she forgot to perform hand hygiene. MA B said hand hygiene should be performed before medication preparation and after administering medications. MA B said hand hygiene should be performed after glove removal. MA B said she had not performed hand hygiene properly because it was her first day back from being off and she was in a hurry. MA B said if hand hygiene was not performed properly, it could spread infection from one person to the next. During an interview on 05/22/2024 at 3:43 PM, the ADON, also the Infection Control Preventionist, said during medication administration the staff should sanitize hands in between each resident and wash their hands every third residents. The ADON said hand hygiene should be performed prior to giving medications and after administering medications. The ADON said hand hygiene should be performed after glove removal. The ADON said she performed audits monthly on hand hygiene and she had not noticed any issues with the nursing staff. The ADON said it was important to perform hand hygiene because you did not know what you could transfer from one resident to the next. The ADON said the electronic wrist blood pressure monitor should be cleaned between each resident. The ADON said she ensured the staff was cleaning during the competency checks completed annually and as needed. The ADON said if the electronic wrist blood pressure monitor, and other equipment were not cleaned infections could be transferred. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676477	A. Building B. Wing	05/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Caraday of Mount Vernon	501 Yates Street Mount Vernon, TX 75457

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 05/22/2024 at 4:19 PM, the DON said electronic wrist blood pressure monitor should be cleaned in between residents. The DON said the ADON monitored the staff to ensure they were doing this by the competency checks. The DON said it was important for the electronic wrist blood pressure monitor to be cleaned properly to keep down the spread of bacteria between the residents. The DON said hand hygiene should be performed before and after medication administration. The DON said hand hygiene should be performed after glove removal. The DON said the ADON and herself monitored the staff to ensure they performed hand hygiene properly by completing the annual competencies. The DON said it was important for hand hygiene to be performed to keep down the spread of bacteria. During an interview on 05/22/2024 at 4:40 PM, the Administrator said she expected for the staff to follow the policy and procedure for hand hygiene. The Administrator said the DON and ADON completed competencies to monitor this, and the pharmacy consultant observed for this as well. The Administrator said the staff not performing adequate hand hygiene placed the residents at risk for the spread of infection. The Administrator said she expected for the staff to follow the policy for cleaning equipment after each use. The Administrator said the DON and ADON monitored the staff to ensure they were cleaning the electronic wrist blood pressure monitors by the competency checks that were completed. The Administrator said not cleaning the electronic wrist blood pressure monitor after each use placed the residents at risk for the spread of infection. 45879 6. Record review of Resident #133's face sheet, dated 05/22/24, reflected an [AGE] year-old male who was admitted to the facility on [DATE]. Resident #133 had diagnoses which included fracture of the right wrist, fracture of the right shoulder, high blood pressure, and Heart failure (which occurs when the heart muscle doesn't pump blood as well as it should). Record review of Resident #133's admission MDS assessment, dated 05/17/24, reflected he understood and was understood by others. Resident #133 had a BIMS score of 12, which indicated he was moderately cognitively impaired. Resident #133 required extensive assistance with dressing, personal hygiene, bathing, bed mobility, transfers, limited assistance with toileting, and set-up for eating. The MDS did not indicate any skin issues. Record review of Resident #133's care plan, dated 05/15/2024, reflected he had an acute skin/wound infection. The intervention was for staff to provide the required transmission-based precautions. Record review of Resident #133 care plan, dated 05/15/2024, reflected he had an actual impairment to the skin integrity of the right elbow. The intervention was for staff to follow facility protocols for the treatment of injury. Record review of Resident #133's wound culture, dated 05/15/2024, reflected Staphylococcus aureus, Staphylococcus sciuri, and Staphylococcus haemolyticus (all bacteria-caused skin infections). Record review of Resident # 133's physician orders, dated 05/17/2024, reflected: Mupirocin External Ointment 2 % (Mupirocin) Apply to right elbow topically every day shift for wound care, clean with wound cleanser, dry with gauze, apply ointment to the wound area, and cover with dry dressing daily and as needed until healed. (continued on next page)

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	676477	A. Building B. Wing	05/22/2024

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident # 133's physician orders, dated 05/17/2024, reflected: Apply TAO to abrasion to the left shoulder and leave open to air daily and as needed until healed everyday shift for wound care. Record review of Resident # 133's physician orders, dated 05/17/2024, reflected: Apply TAO to scabs to Left forearm and leave open to air daily until healed everyday shift for wound care. Record review of Resident # 133's physician orders, dated 05/17/2024, did not reflect an order for isolation. During an observation on 05/20/24 at 11:18 a.m., Housekeeper F was coming out of Resident #133 room with gloves on. Housekeeper F said she did not wear PPE while cleaning Resident #133's room because she did not provide him with any care. Housekeeper F said she had only been working at the facility for 2 days and was unaware why Resident #133 was on contact isolation. Resident #133 had contact precautions signs posted outside of his room door. During an interview on 05/20/24 at 11:23 a.m., LVN A said Resident #133 had a wound infection. She said she had given him his morning medication but did not wear any PPE. She said she was not aware she needed to wear PPE when giving him his medication. She said she was aware PPE must be worn when providing personal care for Resident #133. During an observation and interview on 05/21/24 at 11:17 a.m., RN E was preparing to do Resident #133's treatment. She set up her supplies and explained to Resident #133 she would be doing his wound care. Resident #133 had contact precautions signs posted on his wall. She applied her gown and gloves and entered Resident #133's room. Resident #133 was lying in his bed with some brown-like substance on his shirt and sling. RN E lifted Resident #133's arm to remove the dressing but no dressing was noted on his right elbow. She cleaned his right elbow, changed her gloves without hand hygiene, and then applied his ordered dressing. RN E then cleaned Resident #133's left upper back area and applied TAO ointment; she changed her gloves without hand hygiene. RN E then cleaned Resident #133's left forearm area and applied TAO ointment. RN E removed her PPE, took the biohazard trash bag out of the room, and performed hand hygiene. RN E said she did not perform hand hygiene between cleaning his wound and applying new gloves. She said she should perform hand hygiene to prevent the spread of infection because he did have staph. During an observation on 05/21/24 at 12:47 p.m., CNA G entered Resident #133's room with his lunch tray without applying any PPE. Resident #133 had contact precautions signs posted outside of his room door. During an interview on 05/21/24 at 1:44 p.m., the DM said she was unaware of any residents on isolation. She said if a resident was in isolation, she would prepare their trays last and have a signed paper on the tray which indicated isolation to alert staff of precautions. She said she was usually notified by the nurses or administration personnel if a resident was required to be on isolation. During an interview on 05/21/24 at 1:47 p.m., CNA G said she went into Resident #133's room to deliver his lunch tray and did not wear any PPE. She said she did not touch anything. She said to her knowledge she was not supposed to wear any PPE to serve his tray. She said Resident #133 had staph. (continued on next page)

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	676477	A. Building B. Wing	05/22/2024

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation and interview on 05/21/24 at 02:09 p.m., LVN D said if a resident was in an isolation room staff should wear gowns, gloves, and or masks depending on the reason for isolation. She said Resident #133 had staph. She said if a resident was on isolation precautions, they should have an order. LVN D looked at Resident #133's orders and did not see any orders for isolation. She said the nurse who obtained the order for isolation should have placed the order in the electronic system. She said the signs were posted on the door or wall to alert staff and visitors to wear PPE if needed. She said they should wear PPE to prevent infection. Record review of Resident # 133 physician orders, dated 05/22/2024, reflected contact precautions related to staph in the wound every shift, after State surveyor intervention. During an observation and interview on 05/22/24 at 11:10 a.m., Resident #133 was being propelled in the hallway by Therapist H. Therapist H said he was unaware of Resident #133's contact isolation precautions, he said he thought it was enhanced barriers only. The DOR said Resident #133 was not in isolation and had been coming to therapy with other residents. She said she was not aware he was in contact isolation. During an interview on 05/22/24 at 1:40 p.m., the Laundry Supervisor said there was no one in the facility who required isolation precautions with laundry. During an interview on 05/22/24 at 3:30 p.m., the ADON said Resident #133 was admitted on [DATE] on enhanced barrier precautions(an approach to the use of personal protective equipment (PPE) to reduce transmission of Multidrug-Resistant Organisms), and on 05/17/24 they received a positive staph wound culture, and Resident #133 was placed on contact isolation. She said staff were supposed to be wearing gowns and gloves in the room and before entering the room. She said she had not done an in-service to change Resident #133 from enhanced barrier to contact precautions. She said she did an in-service today (05/22/24) after realizing some staff were confused about his precautions. She said they usually, discussed residents who required isolation in their clinical morning meetings. She said she was unaware if the DM, Laundry Supervisor, or the DOR attended the morning meeting where they discussed Resident #133 was on contact isolation. She said she expected the nurse to gown up, perform proper hand hygiene before and after wound care, in between glove changes from dirty to clean, and in between the dressing changes. She said not wearing PPE or performing hand hygiene placed the residents at risk for the spread of infection. During an interview on 05/22/24 at 4:02 p.m., the DON said she expected the nurse to perform wound care correctly. She said staff should change their gloves between clean and dirty and use hand hygiene. She said nurse management was responsible for ensuring staff knew how to perform wound care and hand hygiene. She said they did competencies yearly. The DON said failure to do appropriate wound care and handwashing could cause infections and the spread of staph. She said Resident #133 should have been in contact isolation when they became aware he had staph from a wound culture received on 05/17/24. She said staff should wear gowns and gloves when they entered his room. She said they usually did not do in-services about isolation but they discussed it in the morning meetings and communicated by word of mouth. She said all department heads were supposed to attend the morning meetings. She said the Laundry Supervisor and the DM attended some of the meetings but the DOR was usually at the meetings. She said if they missed the morning meeting then the Administrator would relay the information. She said she and the infection preventionist nurse were responsible for ensuring staff were aware of Resident #133 being in contact isolation. (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 05/22/24 at 4:25 p.m., the Administrator said she expected all staff to use proper hand hygiene techniques between dirty and clean areas with all care. The Administrator said the DON/ADON was responsible for ensuring staff were trained on incontinent care, wound care, and infection control. She said improper hand hygiene could place the resident at risk for the spread of infection. She said Resident #133 was on enhanced barrier precautions when he was admitted but should have been on contact isolation after receiving his wound culture results. She said he had the contact precautions sign on his door, and staff needed to ask the nurse what to do and if any risk for the residents. She said they did numerous infection control in-services. Record review of the facility's policy, Handwashing/Hand Hygiene, dated August 2019, reflected This facility considers hand hygiene the primary means to prevent the spread of infections. 2. All personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors .7. Use an alcohol-based hand rub containing at least 62% alcohol; alternatively, soap (antimicrobial or non-antimicrobial) and water for the following situations: a. Before and after coming on duty. b. Before and after direct contact with residents .e. Before and after handling an invasive device (e.g., urinary catheters, intravenous access sites) . g. Before handling clean or soiled dressings, gauze pads, etc.; h. Before moving from a contaminated body site to a clean body site during resident care; i. After contact with a resident's intact skin; j After contact with blood or bodily fluids; k. After handling used dressings, contaminated equipment, etc. m. After removing gloves; n. Before and after entering isolation precaution settings. (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, Isolation - Categories of Transmission-Based Precautions, dated August 2019, reflected, Policy: Transmission-based precautions are initiated when a resident develops signs and symptoms of a transmissible infection; arrives for admission with symptoms of an infection; or has a laboratory-confirmed infection; and is at risk of transmitting the infection to other residents . 2. Transmission-based precautions are additional measures that protect staff, visitors, and other residents from becoming infected. These measures are determined by the specific pathogen and how it is spread from person to person . 5. When a resident is placed on transmission-based precautions, appropriate notification is placed on the room entrance door and the front of the chart so that personnel and visitors are aware of the need for and the type of precaution. A. The signage informs the staff of the type of CDC precaution(s), instructions for the use of PPE, and/or instructions to see a nurse before entering the room. B. Signs and notifications comply with the resident's right to confidentiality or privacy. Contact precautions are implemented for residents known or suspected to be infected with microorganisms that can be transmitted by direct contact with the resident or indirect contact with environmental surfaces or resident-care items in the resident's environment. 2. Contact precautions are also used in situations when a resident is experiencing wound drainage, fecal incontinence or diarrhea, or other discharges from the body that cannot be contained and suggest an increased potential for extensive environmental contamination and risk of transmission of a pathogen, even before a specific organism has been identified. 3. Contact precautions are used for residents infected or colonized with MDROs in the following situations: a. When a resident has wounds, secretions, or excretions that are unable to be covered or contained . 7. Staff and visitors wear gloves (clean, non-sterile) when entering the room. a. While caring for a resident, staff will change gloves after having contact with infective material (for example, fecal material and wound drainage). b. Gloves are removed and hand hygiene performed before leaving the room. c. Staff avoid touching potentially contaminated environmental surfaces or items in the resident's room after gloves are removed. 8. Staff and visitors wear a disposable gown upon entering the room and remove it before leaving the room and avoid touching potentially contaminated surfaces with clothing after the gown is removed. 9. When transporting individuals with skin lesions, excretions, secretions, or drainage that is difficult to contain, contact precautions are taken during resident transport to minimize the risk of transmission. Record review of the facility's policy Perineal Care, revised February 2018, reflected: Purpose The purpose of this procedure are to provide cleanliness and comfort to the resident, to prevent infection and skin irritation, and to observe the resident's skin condition .3. Wash and dry your hands thoroughly. Put on gloves .9. Discard disposable items into designated containers. 10. Remove gloves and discard into designated container. 11. Wash and dry hands thoroughly or use hand sanitizer. 12. Put on clean gloves and apply protective ointment if needed and clean brief. Record review of the facility's policy titled, Policies and Practices-Infection Control, revised October 2018, reflected This facility's infection control policies and practices are intended to facilitate maintaining a safe, sanitary and comfortable environment and to help prevent and manage transmission of diseases and infections (continued on next page)

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