STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	745017	A. Building B. Wing	05/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Lodge of Saginaw Health and Wellness	848 W McLeroy Blvd Saginaw, TX 76179

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 0620 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Not require residents to give up Medicare or Medicaid benefits, or pay privately as a condition of admission; and must tell residents what care they do not provide. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32227 Based on interview and record review the facility failed to implement an admissions policy that did not request or require residents to waive potential facility liability for loss of personal property for 1 of 1 policy reviewed. The facility failed to not request or require residents or potential residents to waive potential facility liability for losses of personal property. This failure could place residents at risk of misappropriation of their personal property. Findings included: Review of Resident #1's MDS dated [DATE] revealed the resident was an [AGE] year-old female admitted to the facility on [DATE]. Her diagnoses included hydronephrosis (excess fluid in a kidney due to backup of urine), diabetes, dementia, depression, and anxiety. The resident had a BIMS of 15, cognition intact. Review of Resident #1's Grievance/Concern Report dated [DATE] completed by the Social Worker reflected the following: .Concern/Details Resident reports that she is missing $800.00 and all her credit cards from her wallet. She states she's unsure if she lost it in the hospital or here at the facility. She last remembers seeing it the day before arriving. Action Taken: [Administrator] interviewed resident. SS spoke with spouse who confirmed she had the cash here at the facility and he already cancelled the credit cards and most of them were expired. Reported to [police], state, and notified family (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 0620 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation and interview on [DATE] at 11:34 AM revealed Resident #1 lying in bed. The resident was asked about her missing money, and she stated she had either $1,100 or $1,200 in her wallet, and it went missing along with her credit cards. The resident stated she was unsure of when it was taken, but it had occurred when she first arrived at the facility. The credit cards were cancelled, and she was questioned by the police. Resident #1 said her husband thought there was about $600 in her wallet, but he was not aware there was more money in there. The resident also stated she did not hear anything further on the matter from the facility. Interview on [DATE] at 3:51 PM with the Social Worker revealed Resident #1 reported she had money and credit cards missing within the first week she arrived at the facility. The resident initially told the Social Worker she was not sure if she had lost the money at the hospital before she was admitted to the facility. The resident told the Social Worker no one had entered her room, and she and staff looked in the room and through the resident's belongings, but they were not able to find the money. The Social Worker said she called the resident's family who stated the resident did have the money when she arrived at the facility. The incident was reported to the Administrator. Interview on [DATE] at 12:33 PM with the Administrator revealed he was made aware Resident #1 had reported she had $800 missing out of her wallet. At first, the resident told the Social Worker she was unsure if the money had been lost at the hospital or when she arrived at the facility. The police were called, and they came to the facility and spoke with the resident. The Administrator stated the police told him they did not believe it was a legitimate case because the resident's story kept changing as to the amount that was missing. Review of Resident #3's MDS dated [DATE] revealed the resident was a [AGE] year-old female admitted to the facility on [DATE]. Her diagnoses included dementia, metabolic encephalopathy (problem in the brain caused by a chemical imbalance in the blood), fibromyalgia, and history of pulmonary embolism (blood clot in the lungs). The resident's BIMS was 14, cognition intact. Review of Resident #3's Grievance/Concern Report dated [DATE] completed by the Social Worker revealed the following: .Concern/Details Resident reports $20 is missing from her room. Resident states her son brought it to her for the day they went on the lunch outing. 'The day before yesterday' she had it in her pillowcase and it had fallen out on the floor. Resident states she put it in her money pouch in her drawer Action Taken: SS searched resident room with permission. Money was not recovered. Response: Spoke to [Resident #3] and again offered the resident trust fund and lock box. Both were refused again by [Resident #3]. Resident did not have any idea what happened to the money and moved the location of the money. There was no indication the money was stolen, just missing. (continued on next page)

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F 0620 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on [DATE] at 12:19 PM with Resident #3 revealed she had $20 go missing from a little bag she kept in her nightstand. Resident #2 said residents did not wander in her room, and there was no staff she could blame at the time. The resident also stated she had been offered a trust fund which she declined but said she had not been offered a lock box. Interview on [DATE] at 3:51 PM with the Social Worker revealed Resident #3 reported to her that she was missing $20 from her money bag that she kept in her dresser. The Social Worker searched her room, and the money was never found. The resident also told the Social Worker, she kept it in her pillowcase at times. The Social Worker further stated Resident #3 was offered a lock box and trust fund to keep her money but had decline both options. Interview on [DATE] at 12:33 PM with the Administrator revealed he had been aware of Resident #3's missing money, and the resident had been offered a trust fund account and a lock box, which the resident declined. The Administrator said during resident admission, they were encouraged and educated not to have anything of value. If residents had something go missing, they offered the residents a trust fund account or a lock box. The Administrator stated they told families if they knew the staff stole or took something, they would replace the missing item. He also said he was not aware they were not allowed to have the statement that the facility assumed no responsibility for the loss of personal items. Review of a form titled Inventory of Personal Belongings that is part of the resident's admission packet that is signed by the resident/responsible party reflected the following: .Community strongly urges Resident/Responsible Party/Representative that due to a variety of factors, including access to Resident's room by other Residents and visitors as well as the particular physical or emotional state of Resident, it may not be appropriate for Resident to retain possession of items of particular economic or sentimental value. Community assumes no liability for the security of personal items retained by Resident or kept in Resident's room

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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** 42859 Based 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 one (Resident #4) of 1 resident reviewed for infection control during wound care. LVN C failed to change gloves and perform hand hygiene while providing wound care to Resident #4. These failures could place residents at risk of infection, slow wound healing, and or a decline in health. Findings included: Review of Resident #4's entry MDS assessment dated [DATE] revealed Resident #4 was an [AGE] year-old male admitted to the facility on [DATE] with diagnosis which included non-Hodgkin's lymphoma (a type of cancer that begins in the lymphatic system). Resident #4 had a BIMS score of 13 which indicated Resident #4's cognition was intact. The MDS also revealed Resident #4 required surgical wound care. Review of Resident #4's wound care orders, dated 05/30/24, reflected as of 11/14/23: Clean left clavicle surgical wound with NS or wound cleanser. Dry, cover wound with silver alginate and cover with bordered gauze and change daily and as needed for wound care AND one time a day for wound care. Observation on 05/31/24 at 09:43 AM revealed LVN C performing wound care on Resident #4. She washed hands and explained the procedure to Resident #4. She put all the supplies together and went to the bed side. LVN C put on gloves without performing hand hygiene and removed the old dressing. The wound was observed to be draining. She discarded the old dressing and removed her gloves. Without performing hand hygiene, she put on a new pair of gloves, cleansed the wound with gauze soaked with wound cleanser, pat dried the wound, and touched the wound while wearing the same gloves. LVN C then took silver alginate, applied it on the wound, and covered the wound with a dry dressing without performing hand hygiene or changing her gloves. Interview on 05/31/24 at 9:50 AM with LVN C revealed she did not perform hand hygiene before putting on gloves, after removing the old dressing, and after cleansing the wound. LVN C stated she was not directed to perform hand hygiene between the procedure but before and after the procedure. LVN C stated she knew it was best standard of practice to wash hands after removing her gloves, but she forgot. She stated she was supposed to perform hand hygiene after she removed the old dressing and before and after she cleaned the wound with normal saline. LVN C stated changing gloves and performing hand hygiene during wound care would prevent contamination of the wound which could cause infection. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 05/31/2024 at 11:48 AM with the DON revealed her expectation was for the nurses to perform hand hygiene after removal of an old dressing and with contamination. The DON stated the nurse was supposed to wash her hands after removing the old dressing and her gloves, and then again after cleansing the wound the nurse was supposed to change her gloves and perform hand hygiene. The DON stated the risk of not changing gloves and performing hand hygiene during the wound care was that it would lead to cross contamination of the wound and then infection. She stated she had done training on wound care and also LVN C was assessed on skills and no documentation was presented. The DON stated the person that did the skills assessment with LVN C was not in the facility. Review of the facility's Wound Care policy, revised October 2010, reflected: .4. Put on exam gloves. Loosen tape and remove dressing. 5. Pull glove over dressing and discard into appropriated receptacles. Wash and dry hands thoroughly. Put on gloves. .8. Pour liquid solutions directly on gauze sponges on their papers. 9. Wear exam gloves for holding gauze to catch irrigation solutions that are poured directly over wound the wound. 10. Wear sterile gloves when physically touching the wound or holding a moist surface over the wound. .13. Dress wound. Pick up sponge with paper and apply directly to area. [NAME] tape with initials, time and date and apply to dressing