STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	745021	A. Building B. Wing	02/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lindale Specialty Care Center	13905 Fm 2710 Lindale, TX 75771

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44637 Based on observation, interview and record review the facility failed to treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life for 1 of 7 residents (Resident #3) reviewed for dignity. The facility did not ensure Resident #3's urinary catheter drainage bag was covered on 2/6/25, 2/7/25, and 2/11/25. These failures could place residents at risk of a diminished quality of life, loss of dignity and self-worth. Findings included: 1.Record review of the face sheet dated 2/7/25 indicated Resident #3 was an [AGE] year-old female readmitted to the facility on [DATE] with diagnoses including heart failure, chronic kidney disease, neuromuscular dysfunction of the bladder (a condition where the nerves controlling bladder function are damaged, leading to impaired bladder muscle activity and loss of bladder control), and muscle weakness. Record review of the physician's orders dated 2/7/25 indicated Resident #3 had an order for privacy bag for the urinary drainage bag at all times while in bed, while walking, and in wheelchair starting 3/10/24. Record review of the MDS dated [DATE] indicated Resident #3 understood others and was understood by others. The MDS indicated she had a BIMS of 13 was cognitively intact. The MDS indicated Resident #3 had an indwelling urinary catheter. Record review of the care plan revised on 11/25/24 indicated Resident #3 had an indwelling /suprapubic catheter (a medical device that drains urine from the bladder directly through the abdominal wall) related to neurogenic bladder with interventions including position catheter bag and tubing below the level of the bladder and away from entrance room door. (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and interview on 2/6/25 at 10:16 a.m. revealed Resident #3's catheter drain bag was observed to not have a privacy cover/bag and was facing the door. Resident #3 said it bothered her sometimes that her catheter drain bag was not covered for privacy. During an observation on 2/7/25 at 9:12 a.m. Resident #3's catheter drain bag did not have a privacy cover/bag and was facing the door. During an observation on 2/11/25 at 9:52 am Resident #3's catheter bag did not have a privacy bag/cover in place and was facing the door. During an interview on 2/12/25 at 12:09 p.m. CNA L said the nurses were responsible for ensuring residents had privacy covers on their urinary catheter drain bags. CNA L said the importance of privacy covers on urinary catheter drain bags was resident privacy. During an interview on 2/12/25 at 12:14 p.m. LVN H said nurses were responsible for ensuring residents had privacy covers on their urinary catheter drain bag. LVN H said this was her first day back at the facility and she was unaware Resident #3 had not had a privacy cover over her urinary catheter drain bag. LVN H said privacy covers should be on urinary catheter drain bags all the time and Resident #3 should have had a privacy cover. LVN H said the importance of privacy covers on urinary catheter drain bags was dignity. During an interview on 2/12/25 at 12:40 p.m. the Regional Nurse said she expected residents with urinary catheters to always have a privacy cover over their drainage bags. The Regional Nurse said the importance of privacy covers on drainage bags was for dignity. Record review of the facility's Resident Rights policy dated 4/2022 indicated, .The resident has a right to be treated with respect and dignity .

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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 - Immediate jeopardy to resident health or safety Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44637 Based on observations, interview and record review the facility failed to ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice for 2 of 3 residents (Resident #1 and Resident #2) reviewed for tracheostomy care. The facility failed to ensure proper care was provide to Resident #1 on [DATE] when she was in respiratory distress due to her tracheostomy's inner cannula (a removable, cylindrical tube that fits inside the outer cannula of a tracheostomy tube) being obstructed resulting in Resident #1 being hospitalized . The facility failed to ensure they had full-time qualified staff to perform proper tracheostomy care on Resident #2's tracheostomy in accordance with professional standards. These failures resulted in an identification of an Immediate Jeopardy (IJ) on [DATE] at 3:20 p.m. While the IJ was removed on [DATE], the facility remained out of compliance at no actual harm with a scope identified as a pattern due to the facility's need to complete in-service training and evaluate the effectiveness of the corrective systems. This failure could place residents at risk for serious harm, impairment, or death. Findings Included: 1. Record review of the face sheet dated [DATE] indicated Resident #1 was a [AGE] year-old female readmitted to the facility on [DATE] with diagnoses including cardiac arrest, cerebral infarction (ischemic stroke), pneumonia, hypertension, cough, and pulmonary edema (a condition caused by excess fluid in the lungs). Record review of the MDS dated [DATE] indicated Resident #1 was usually understood by others and understood others. The MDS indicated Resident #1 had a BIMS of 00 and was severely cognitively impaired. The MDS indicated Resident #1 had a tracheostomy and required suctioning. The MDS indicated Resident #1 experienced shortness of breath or trouble breathing when lying flat. Record review of the care plan revised on [DATE] indicated Resident #1 had a tracheostomy and was at risk for complications/infections with interventions including extra emergency trach and ambu bag (a portable device that delivers positive pressure ventilation to patients who are breathing inadequately or not at all) kept in room/ bedside at all times, if inner cannula becomes dislodged call 911 immediately, place oxygen over the tracheal stoma (an artificial opening created in the front of the neck to provide an airway for breathing), and give extra cannula to EMT upon arrival. (continued on next page)

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F 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of the nursing progress note written by LVN A on [DATE] indicated, .I went to suction [Resident #1] and had resistance, and no visible mucous came out from this [Resident #1's] trach which alarmed me. [Resident #1] said help me, I then ran to get the weekend supervisor and asked for her pulse ox (an electronic device that measures the saturation of oxygen carried in the red blood cells) and asked her could she come help me further assess [Resident #1]. The pulse ox read 77% (normal oxygen level is , d+[DATE]%) and [Resident #1] appeared in distress so I called 911, while they were on the phone we then reassessed [Resident #1's] vitals her [oxygen] then read 56% and he [blood pressure was] ,d+[DATE] (normal blood pressure is ,d+[DATE]). EMT arrived in the room right when [Resident #1] went unresponsive and wanted to check for pulse before initiating CPR. No pulse was detected this nurse performed chest compressions until EMT got their equipment out and took over. EMT asked this nurse to try and suction [Resident #1] still nothing would come out, EMT tried to use the ambu bag on [Resident #1] and could not get air through, EMT then asked for a spare trach I grabbed it from the box, when he removed the current trach it was visibly clogged with mucous. This nurse then suctioned [Resident #1] and was able to get yellow blood tinged mucous. EMT was then able to get the bag to function properly and a pulse. [Resident #1's] mouth filled with foamy saliva. I then suctioned [Resident #1's] mouth and EMT did the last of their assessment and transferred [Resident #1] to [the] emergency room . Record review of the hospital records from Resident #1's admitted [DATE] indicated Resident #1's active hospital problems included cardiac arrest with assessment: suspect respiratory cause due to mucous plugging and acute and chronic respiratory failure with assessment: suspect cause due to mucous plugging. Record review of the facility's discharge summary dated [DATE] indicated Resident #1's discharge date d was [DATE] with the reason for discharge being Resident #1 passed away at the hospital. The discharge summary indicated Resident #1's discharge date was [DATE]. During an interview on [DATE] at 12:37 p.m. the Medical Director said he was familiar with Resident #1. The Medical Director said Resident #1 had gone to the hospital for cardiac arrest while in the facility and returned to the facility with a tracheostomy and feeding tube. The Medical Director said if a nurse attempted to suction a resident, met resistance, and no visible mucous was removed it seemed reasonable, and he would assume it was standard practice, to remove the inner cannula of the trach and ensure there was no obstruction. The Medical Director said an obstruction such as a mucous plug would cause a decrease in oxygen saturation and increase in blood pressure. The Medical Director said he was aware Resident #1 had passed away but was unaware of the exact date or cause of death. During an interview attempt on [DATE] at 12:16 p.m. LVN A did not answer the phone and the surveyor was unable to leave a voicemail. During an interview attempt on [DATE] at 12:17 p.m. RN Weekend Supervisor B did not answer the phone and the surveyor was unable to leave a voicemail. Record review of the Tracheostomy Validation Checklist dated [DATE] indicated LVN A correctly answered the question regarding signs and symptoms of airway obstruction or infection. Record review of the Tracheostomy Care Validation Checklist dated [DATE] indicated LVN A satisfactorily demonstrated trach care including removing and cleaning an inner cannula of a tracheostomy. (continued on next page)

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F 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	2. Record review of the face sheet dated [DATE] indicated Resident #2 was a [AGE] year-old-male readmitted to the facility on [DATE] with diagnoses including acute and chronic respiratory failure, tracheostomy status, and pneumonitis (inflamed lung tissue) due to inhalation of food and vomit. Record review of the MDS dated [DATE] indicated Resident #2 was rarely/never understood by others and rarely/never understood others. The MDS indicated Resident #2 did not have a BIMS completed. The MDS indicated Resident #2 had a tracheostomy and required suctioning. The MDS indicated Resident #2 experienced shortness of breath or trouble breathing when lying flat. Record review of the care plan revised on [DATE] indicated Resident #2 had a tracheostomy (Bivona (Bivona tracheostomy tube is a silicone tube designed for airway management, featuring a cuff that, when inflated, creates a seal between the tube and the trachea to protect against aspiration and optimize respiration) size 6) related to impaired breathing mechanics, respiratory failure and is at risk for complications/infections with interventions including extra emergency trach and ambu bag (a portable device that delivers positive pressure ventilation to patients who are breathing inadequately or not at all) kept in room/ bedside at all times, if inner cannula becomes dislodged call 911 immediately, place oxygen over the tracheal stoma (an artificial opening created in the front of the neck to provide an airway for breathing), and give extra cannula to EMT upon arrival. During an interview on [DATE] at 10:50 a.m. the DON said that the nurses in the facility did not remove and clean cannulas for trach patients. The DON said only the RT could remove or change a cannula. The DON said if a trach cannula became dislodged nurses were required to call EMS and could not reinsert the cannula. The DON said the facility had a RT on staff PRN who came in once a week to change/clean trachs. During an interview on [DATE] at 11:02 a.m. the DON said he thought the surveyor was asking specifically about Resident #2's trach which was a Bivona trach when asking about removing and cleaning tracheostomies and cannulas. During an interview on [DATE] at 11:03 a.m. the Regional Nurse said nursing staff could and were expected to perform trach care including removing, disposing of, and replacing inner cannulas for residents who have a Shiley trach (a tracheostomy tube that uses an inner removeable cannula). The Regional Nurse said if when suctioning a tracheostomy and resistance was met and no mucous was being suctioned out, she would expect the nurse to remove the inner cannula, check for a mucous plug in the cannula, and replace with a new inner cannula. The Regional Nurse said if a resident was in respiratory distress, she would expect the nurse to call for EMS and do everything they could in the meantime including changing the inner cannula to ensure the resident's airway as much as possible. The Regional Nurse said it was out of nurses' scope of practice to remove or change a Bivona tracheostomy. She said it had to be performed by EMS or an RT. (continued on next page)

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F 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of the facility's Tracheostomy Care policy dated ,d+[DATE] indicated, The facility will ensure that residents who need respiratory care, including tracheostomy care and tracheal suctioning, is provided such care consistent with professional standards of practice, the comprehensive care plans and resident goals and preferences .The facility will provide necessary respiratory care and services, such as oxygen therapy, treatments, mechanical ventilation, tracheostomy care and/or suctioning. Tracheostomy care will be provided according to the physician's orders, comprehensive assessment and individualized care plan such as monitoring for the resident specific risks for possible complications, psychosocial needs as well as suctioning as appropriate .The facility will ensure staff responsible for providing tracheostomy care including suctioning are trained and competent according to professional standards of practice . The Administrator was notified on [DATE] at 3:38 p.m. that an Immediate Jeopardy situation was identified due to the above failure. The Administrator was provided the Immediate Jeopardy template on [DATE] at 3:42 p.m. The facility's Plan of Removal was accepted on [DATE] at 9:00 a.m. and included: Alleged Issues: The facility failed to ensure proper care was provided to Resident #1 when she was in respiratory distress due to her tracheostomy's inner cannula was obstructed. The facility failed to ensure they had full time qualified staff to perform proper tracheostomy care on Resident #2's tracheostomy in accordance with professional standards. Goal: Facility will be in compliance with federal health, safety, and/or quality regulations. Its employees or service providers are to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish or emotional distress. Approaches: The Director of Nursing, Clinical Support Specialist, and VP of Clinical Operations will deliver all following in service education to nurses one on one. 1. Nursing staff will be in-serviced to respond to medical emergencies for residents, when their tracheostomy becomes clogged, a mucus plug is identified, or resident is having difficulty breathing. This in-service was initiated on [DATE] by the Director of Nursing. All nursing staff will be in-serviced prior to them arriving to the facility for their next shift. The Director of Nursing, Clinical Support Specialist, and VP of Clinical Operations will deliver all following in service education to nurses one on one. This in-service includes, In: the event of an emergency with a resident that has a tracheostomy, you attempt to suction and are unable to clear the mucus plug, IMMEDIATELY REMOVE THE INNER CANNULA AND REPLACE IT. IF THERE IS NOT AN INNER CANNULA, YOU MUST DECANNULATE THE OUTER CANNULA AND REPLACE IT. This should clear the airway enough to suction the mucus out. There will be an emergency inner cannula in the box at the beside with an ambu bag, and extra trach for EMS if needed. Immediately call your DON, provider, and RP. Document all findings 2. The facility Medical Director was informed of the IJ on [DATE] by the VP of Clinical Operations. 3. Resident #1 expired in the hospital [DATE]. (continued on next page)

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F 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	4. Resident #2 will be provided for appropriately, with having all nurses trained in decannulation/re-cannulation of tracheostomy, in the case of a mucus plug/blockage, by the facility respiratory therapist, or by the Director of Nursing, who will be trained by the facility respiratory therapist on [DATE]. 5. The Director of Nursing, Clinical Support Specialist, and VP of Clinical Operations will deliver all following in-service education to nurses one on one. All nursing staff will be in-serviced prior to them arriving to the facility for their next shift. This will begin immediately, [DATE]. Competency with return demonstration will be completed by [DATE]. No nurse will be allowed to work on the floor until their competency is completed. 6. The DON will review new hire orientation packet to ensure these above in-services are completed prior to the first shift on the floor, including tracheostomy competencies including decannulation/re-cannulation emergency procedures. The VP of Clinical Operations provided this in-service to the Director of Nurses on [DATE]. 7. Facility policy was updated to reflect decannulation and re-cannulation of tracheostomy is necessary in an emergency situation where the airway is compromised by a mucus plug, and the suction catheter meets resistance by the VP of Clinical Operations on [DATE]. 8. Physician orders added to each resident with a tracheostomy, to include, may decannulate and re-cannulate tracheostomy if unable to establish patent airway or mucus plug present, per LVN/RN by the VP of Clinical Operations on [DATE]. 9. Resident orders updated to include a tracheostomy one size smaller to be included in emergency supply box at bedside, by the VP of Clinical Operations on [DATE]. The facility does have tracheostomies one size smaller available in the facility at this time for all residents in the facility with tracheostomies. Monitoring: The 24-hour report in the EMR which runs all progress notes in real time, will be monitored daily in the clinical meeting for changes in condition by the clinical team, DON/ADON/MDS. The DON or designee will perform random in person audits with nursing staff to ensure they understand the tracheostomy decannulation/re-cannulation procedure, at least 3 nursing staff weekly X1 month. This process will begin [DATE]. DON/ADON's will make rounds daily Monday-Friday, the weekend RN supervisor will round on all residents on the weekend, on all residents in facility to ensure no changes in condition are in progress regarding trach status. This process will be ongoing effective [DATE]. Assessment: The Director of Nursing and VP of Clinical Operations viewed each resident with a tracheostomy to ensure all emergency supplies were present at bedside on [DATE]. QAPI Committee review: An interim QAPI committee meeting was completed on [DATE]. IDT will review for compliance monthly in QAPI X3 months. (continued on next page)

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F 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On [DATE] the surveyor confirmed the facility implemented their plan of removal sufficiently to remove the Immediate Jeopardy (IJ) by: During an observation and interview on [DATE] at 9:00 a.m. the DON showed the surveyor the trach supplies at bedside for 2 of 2 residents currently in the facility with tracheostomies. The supplies were observed to contain a tracheostomy the same size and one size smaller for each resident. The DON said staff training had started on [DATE]/5 and would continue ,d+[DATE] times weekly for 1 month and then as needed. The DON said he would be documenting the trainings and reviews. Record review of orders, effective [DATE], for 2 of 2 residents currently in the facility with tracheostomies indicated, If tracheostomy becomes blocked with mucus plug, nurse is not able to advance suction catheter due to blockage, the tracheostomy must be decannulated, and re-cannulated immediately. Two nurses or a nurse and RT must be present to complete procedure. As soon as new tracheostomy is in place, and patent airway established, call 911 and send to ER and orders also indicated tracheostomy supplies would include a tracheostomy one size smaller than the resident currently had in place. Record review of the facility's Tracheostomy Decannulation policy dated [DATE] indicated, Decannulation of a tracheostomy tube can occur accidently or may be indicated when a resident no longer requires the use of a tracheostomy tube. Policies and protocols to address accidental or planned decannulation of a tracheostomy tube will be based on professional standards of practice and carried out by trained clinicians in accordance with Federal, State, or local guidance, regulations, or State practice acts/laws .Clinicians with training in accordance with State practice acts/laws may only reinsert a tracheostomy tube if accidental decannulation occurs, or emergency blockage is in place, in an established stoma as per facility protocols . Ensure that the resident has a spare tracheostomy tube with obturator in the correct size and one size smaller available at beside at all times. Record review of Tracheostomy Care-Changer Inner Cannula/Outer Cannula Skills Checklists dated [DATE]-[DATE] indicated the DON, LVN C, LVN D, LVN E, the Treatment Nurse, and LVN F were checked off by the RT and LVN G, LVN H, LVN J were checked off by the DON. Record review of the QAPI sign-in sheet dated [DATE] indicated the facility had a QAPI meeting regarding the IJ with meeting attendees including the Medical Director, Administrator, DON, and Regional Nurse. Staff interviewed (DON, RN K, LVN G, LVN J, Treatment Nurse, and LVN F) who worked across all shifts on [DATE] from 9:00 a.m. to 10:22 a.m. were able to verbalize what to do in the event of meeting resistance and not getting an visible mucous out when suctioning a tracheostomy including removing the inner cannula of tracheostomies with inner cannulas to remove any obstruction or with the assistance of another nurse decannulating a resident and re-cannulating a resident with a tracheostomy that did not have an inner cannula to remove any obstruction. Staff interviewed said the importance of ensuring tracheostomies did not have an obstruction was to maintain a patent airway. On [DATE] at 10:30 a.m., the Administrator was informed the IJ was removed; however, the facility remained out of compliance the facility remained out of compliance with a scope identified as a pattern due to the facility's need to complete in-service training and evaluate the effectiveness of the corrective systems.

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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** 44637 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 7 residents (Resident #3, Resident #4, Resident #5, Resident #6, Resident #7, and Resident #8) and 6 of 7 staff (CNA M, CNA N, the Treatment Nurse, CNA P, CNA L and CNA R) observed for infection control. The facility failed to ensure CNA M and CNA N changed gloves and performed hand hygiene while performing incontinent care on Resident #4. The facility failed to ensure CNA N did not use a disposable wipe more than once when performing incontinent care on Resident #4. The facility failed to ensure the Treatment Nurse changed gloves and performed hand hygiene while performing wound care on Resident #5 and Resident #6. The facility failed to ensure Resident #6 had an order for EBP and had had EBP precautions posted by her door. The facility failed to ensure the Treatment Nurse wore PPE while performing wound care on Resident #6. The facility failed to ensure CNA L and CNA P wore PPE while performing incontinent care on Resident #3. The facility failed to ensure CNA R changed gloves and performed hand hygiene and did not use a disposable wipe more than one while performing incontinent care on Resident #7. The facility failed to ensure Resident #8's suction canister was emptied for 4 days after he was discharged to the hospital. These failures could place residents and staff at risk for cross-contamination, spread of infection and could potentially affect all others in the building. Findings Include: (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1. During an observation on 2/6/25 at 1:20 p.m. CNA M and CNA N performed incontinent care on Resident #4. CNA N, with gloved hands, adjusted the wheelchair, closed the privacy curtain, and adjusted the bedding on Resident #4's bed. CNA N removed her gloves and put on new gloves without performing hand hygiene. CNA M locked Resident #4's wheelchair and assisted CNA N in transferring Resident #4 to her bed. CNA N used the bed control to position Resident #4's bed, did not remove her gloves or perform hand hygiene, then removed Resident #4's pants. CNA M removed Resident #4's dirty brief and did not remove her gloves or perform hand hygiene, then used a disposable wipe to clean Resident #4's bottom. CNA M did not remove her gloves or perform hand hygiene. CNA N wiped Resident #4's pubic/vaginal area with the same disposable wipe three times, disposed of the wipe, obtained a clean wipe and wiped Resident #4's pubic/vaginal area 4 times with the same wipe. CNA N was observed not folding the wipe when she reused it. CNA N did not remove her gloves or perform hand hygiene. CNA M and CNA N applied barrier cream to Resident #4's bottom and vaginal area. CNA M then removed her gloves, did not perform hand hygiene, realized they were placing the new brief on Resident #4 upside down, rolled the resident on her side, repositioned the clean brief, and then secured the brief on the resident without gloves on. While wearing the same gloves CNA N wore during incontinent care, she retrieved Resident #4's oxygen tubing from a bag, placed the tubing on Resident #4's face, and turned on the oxygen concentrator. During an interview on 2/6/25 at 1:44 p.m. CNA N said she had worked PRN at the facility for approximately 1 year. CNA N said she had just received her CNA credentials. CNA N said hand hygiene should be performed before and after providing care to a resident. CNA N said gloves should be changed after touching a resident. CNA N said a disposable wipe could be used twice in the same area if it was folded after the first wipe. When asked why she had used a disposable wipe 3 and 4 times without folding it during incontinent care on Resident #4 CNA N said she thought she had folded it. CNA N said using a wipe multiple times could cause an infection. CNA N said she did not remove her gloves or perform hand hygiene after completing incontinent care and before touching and applying Resident #4's oxygen tubing. CNA N said not changing her gloves or performing hand hygiene after incontinent care and prior to touching and applying oxygen tubing could result in a resident becoming ill. CNA N said she was nervous being watched perform incontinent care by the surveyor and that is why she made mistakes. 2. During an observation on 2/7/25 10:36 a.m. the Treatment Nurse performed wound care on Resident #5's right thigh. The Treatment Nurse donned clean gloves, prepared wound care supplies, removed her gloves, and did not perform hand hygiene. The Treatment Nurse donned PPE including clean gloves without performing hand hygiene. The Treatment Nurse cleansed the area to Resident #5's right thigh with wound cleanser and gauze, did not remove her gloves, did not perform hand hygiene, applied skin prep to the area, and then touched the area with her gloved hand to assess if the skin prep had dried. The Treatment Nurse removed her PPE and gloves, and then washed her hands prior to exiting the room. 3. Record review of the face sheet dated 2/7/25 indicated Resident #6 was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses including stage 3 pressure ulcer (full-thickness tissue loss where subcutaneous fat is visible within the wound) of the sacrum, weakness, hypertension, and difficulty walking. Record review of the physician's orders dated 2/7/25 indicated Resident #6 did not have an order for EBP. (continued on next page)

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	745021	A. Building B. Wing	02/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lindale Specialty Care Center	13905 Fm 2710 Lindale, TX 75771

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the MDS dated [DATE] indicated Resident #6 understood others and was understood by other. The MDS indicated Resident #6 had a BIMS of 14 and was cognitively intact. Record review of the care plan initiated on 1/15/24 indicated Resident #6 had actual impairment to skin integrity of the Sacrum (largem triangular bone at the base of the spine that forms the back wall of the pelvis) related to surgical wound classified as stage 3 due to surgery more than 100 days ago. During an observation on 2/7/25 at 10:45 Resident #6 did not have EBP precautions posted by her door. During an observation on 2/7/25 at 10:46 a.m. the Treatment Nurse performed wound care on Resident #6's sacral wound. The Treatment Nurse performed hand hygiene, gathered wound care supplies, entered the room, washed her hands, and donned clean gloves. The Treatment Nurse then used the bed control to adjust Resident #6's bed, moved the bedside table, pulled the Resident #6's pants down, and opened her brief without changing gloves or performing hand hygiene afterwards. The Treatment Nurse cleansed and dried the wound to Resident #6's sacrum, did not change her gloves or perform hand hygiene and then applied skin prep, collagen sheet, and a dressing to the sacral wound. The Treatment Nurse then closed Resident #6's brief, pulled up her pants, lowered the bed, and assisted her in transferring to the wheelchair. The Treatment Nurse did not wear PPE (gown) while performing wound care on Resident #6. During an interview on 2/7/25 at 11:02 a.m. the Treatment Nurse said hand hygiene should be performed before and after care and after removing a dirty dressing or touching something dirty, gloves should be removed, hand hygiene performed, and clean gloves put on before continuing care. The Treatment Nurse said she should have changed her gloves and performed hand hygiene after touching the bedside table, the resident's brief, prior to entering Resident #5's room, after cleaning the wounds, prior to applying clean treatment, and after touching the bed controls. The Treatment Nurse said the importance of changing gloves and proper hand hygiene was to prevent the spread of bacteria. The Treatment Nurse said EBP should be in place for residents with wounds, tracheostomies (an opening in the trachea from outside the neck to help air and oxygen reach the lungs), colostomies (an opening in the colon through the abdominal wall), urinary catheters, and IV's. The Treatment Nurse said Resident #6 should have been on EBP and she did not even realize she was not. The Treatment Nurse said the infection preventionist was responsible for ensuring residents were on EBP. The Treatment Nurse said the importance of EBP was an extra route of protection against bacteria and diseases for residents more susceptible to contractions to due open areas in the skin or inserted medical devices. During an interview on 2/7/25 at 1:45 p.m. the Regional Nurse said the DON and ADON were responsible for ensuring enhanced barrier precaution signage was in place for residents requiring such precautions. The Regional Nurse said the ADON was the infection preventionist and responsible for ensuring PPE was available in residents' rooms requiring EBP and that the EBP orders were in the electronic medical record. 4. Record review of the face sheet dated 2/7/25 indicated Resident #3 was an [AGE] year-old female readmitted to the facility on [DATE] with diagnoses including heart failure, chronic kidney disease, neuromuscular dysfunction of the bladder (a condition where the nerves controlling bladder function are damaged, leading to impaired bladder muscle activity and loss of bladder control), and muscle weakness. (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 physician's orders dated 2/7/25 indicated Resident #3 had an order for EBP: Staff must use gown and gloves during high contact resident care activities that could possibly to result in transfer of MDROs to hands and clothing of staff. Enhanced Barrier Precautions are recommended for residents known to be colonized or infected with a MDRO as well as those who are not confirmed to have an MDRO (e.g., residents with wounds or indwelling medical devices) starting 4/15/24. Record review of the MDS dated [DATE] indicated Resident #3 understood others and was understood by others. The MDS indicated she had a BIMS of 13 and was cognitively intact. The MDS indicated Resident #3 had an indwelling urinary catheter. Record review of the care plan revised on 11/25/24 indicated Resident #3 required EBP: Staff must use gown and gloves during high-contact resident care activities that could possibly to result in transfer of MDROs to hands and clothing of staff. Enhanced Barrier Precautions are recommended for residents known to be colonized or infected with a MDRO as well as those who are not confirmed to have an MDRO (e.g., residents with wounds or indwelling medical devices). During an observation on 2/7/25 at 11:17 a.m. CNA L and CNA P performed incontinent and suprapubic catheter care on Resident #3. CNA L and CNA P did not wear PPE (gown) while performing incontinent care on Resident #3. During an interview on 2/12/25 at 12:09 p.m. CNA L said she had been trained on EBP. CNA L said she knew a resident was on EBP because they would have a sign outside their door. CNA L said if a resident was on EBP and direct care was being provided PPE including gloves, a gown, and a mask were required. CNA L said on 2/7/25 when performing incontinent care on Resident #3 she should have had on PPE as Resident #3 was on EBP due to having a urinary catheter. CNA L said the importance of EBP was to prevent the spread of germs. 5. During an observation on 2/7/25 at 1:30 p.m. CNA R performed incontinent care on Resident #7. CNA R performed hand hygiene, provided privacy by closing the door, arranged the supplies, and then donned gloves. CNA R adjusted Resident #7's bed with the bed control, pulled the privacy curtain, pulled down Resident #7's pants, and opened his brief. CNA R used 1 disposable wipe not folded to wipe around the base of Resident #7's penis, then across the head of the penis and down the shaft of the penis. CNA R used 1 disposable wipe not folded to wipe the tip of Resident #7's penis while retracting the foreskin and then down the penis shaft and around the base of the penis. CNA R used 1 disposable wipe to wipe in the groin area on both sides on three different occasions while performing incontinent care. CNA R then doffed her gloves, did not perform hand hygiene, and donned a pair of clean gloves. CNA R had Resident #7 roll to his side and used 1 disposable wipe per swipe to clean. CNA R then doffed her gloves, did not perform hand hygiene, and donned a pair of clean gloves. CNA R positioned the clean brief under Resident #7, applied barrier clean to his bottom, and then doffed her gloves, did not perform hand hygiene, and donned a pair of clean gloves. CNA R fastened Resident #7's clean brief and then doffed her gloves, did not perform hand hygiene, and donned a pair of clean gloves. CNA R repositioned the bed, gathered dirty supplies, doffed her gloves, exited the room, disposed of dirty supplied (used gloves, used wipes, dirty brief), and performed hand hygiene. (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 2/7/25 at 1:41 p.m. CNA R said hand hygiene should be performed before and after providing resident care and between glove changes. CNA R said she did not perform hand hygiene between gloves changes because she was nervous. CNA R said the importance of performing proper hand hygiene was because of germs. CNA R said a disposable wipe should be once, thrown away, and a new wipe used. CNA R said she used the disposable wipes multiple times when performing incontinent care on Resident #7 because she was nervous. CNA R said the importance of only using a disposable wipe once was to prevent the spread of bacteria. 6. Record review of the face sheet dated 2/11/25 indicated Resident #8 was an [AGE] year-old male readmitted to the facility on [DATE] with diagnoses including tracheostomy status, hypertension, COPD, diabetes, weakness, and lack of coordination. Record review of the MDS dated [DATE] indicated Resident #8 usually understood others and was usually understood by others. The MDS indicated Resident #8 had a BIMS of 01 and was severely cognitively impaired. The MDS indicated Resident #8 required suctioning and tracheostomy care. Record review of the care plan revised on 1/19/25 indicated Resident #8 had a tracheostomy and is at risk for increased secretions, congestion, respiratory infections and infections to tracheostomy site. Record review of the nursing progress notes dated 2/7/25 at 8:45 indicated Resident #8 was sent out to the ER to be evaluated for feeding formula being all over his trach. The progress noted indicated Resident #8 left the facility via EMS at 9:04 a.m. During an observation on 2/7/25 at 9:13 a.m. Resident #8's undated suction canister was on the bedside table with 300 ml of yellow/green sputum mixed with water. During an observation on 2/11/25 at 9:36 a.m. Resident #8's undated suction canister was on the bedside table with 300 ml of yellow/green sputum mixed with water. During an interview on 2/12/25 at 12:40 p.m. the Regional Nurse said she expected staff to perform hand hygiene when going from dirty to clean and before and after donning and doffing gloves. The Regional Nurse said the importance of proper hand hygiene was to prevent cross contamination. The Regional Nurse said gloves should be changed when going from dirty to clean when providing care. The Regional Nurse said the importance of proper hand hygiene and glove changes was to prevent cross contamination. The Regional Nurse said the ICP was responsible for ensuring the signage was in place next to or on a resident's door for EBP. The Regional Nurse said nurse management was responsible for entering an EBP order in the residents' medical records. The Regional Nurse said if a resident was on EBP staff were required to wear a gown and gloves when providing care. The Regional Nurse said resident with wounds, ostomies, or any medically implanted device were required to be on EBP. The Regional Nurse said the importance of EBP was to prevent MDRO transmission. The Regional Nurse said suction canisters should be emptied after each use. The Regional Nurse said a suction canister should not sit for 4 days without being emptied. The Regional Nurse said the importance of emptying suction canisters was to prevent bacteria build-up. (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 Infection Prevention and Control Program policy dated 3/2022 indicated, This facility has established and maintains 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 .All staff are responsible for following all policies and procedures related to the program .All staff should assume that all residents are potentially infected or colonized with an organism that could be transmitted during the course of providing resident care services .hand hygiene [NAME] be performed in accordance with our facility's established hand hygiene procedures .Single-use disposable equipment is an alternative to sterilizing reusable medical instruments. Single-use devices must be discarded after use and are never used for more than one resident .All staff shall demonstrate competence in relevant infection control practices. Direct care staff shall demonstrate competence in resident care procedures established by our facility . Record review of the facility's Hand Hygiene policy dated 7/2022 indicated, All staff will perform proper hand hygiene procedures to prevent the spread of infection to other personnel, residents, and visitors. The applies to all staff working in all locations within the facility .The use of gloves does not replace hand hygiene. If your task requires gloves, perform hand hygiene prior to donning gloves, and immediately after removing gloves . The Hand Hygiene Table attached to the Hand Hygiene policy indicated when hand hygiene should be performed including between resident contacts, after handling contaminated objects, before applying and after removing personal protective equipment, including gloves, before and after handling soiled dressings, after handling items potentially contaminated with blood, body fluids, secretions, or excretions, when, during resident care, moving from a contaminated body site to a clean body site, and when in doubt. Record review of the Enhanced Barrier Precautions policy dated 3/2024 indicated, It is the policy of this facility to implement enhanced barrier precautions for the prevention of transmission of multidrug-resistant organisms. Enhance Barrier Precautions (EBP) refer to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employ targeted gown and gloves use during high contact resident care activities .An order for enhanced barrier precautions will be obtained for residents with any of the following: i. Wounds (e.g., chronic wounds such as pressure ulcers, diabetic foot ulcers, unhealed surgical wounds, and chronic venous stasis ulcers) and/or indwelling medical devices if the resident is not know to be infected or colonized with a MDRO .High-contact resident care activities include: a. Dressing, b. Bathing, c. Transferring, d. Providing hygiene, e. Changing Linens, f. Changing briefs or assisting with toileting, g. Device care or use: central lines, urinary catheters, feeding tubes, tracheostomy/ventilator tubes, h. Wound care: any skin opening requiring a dressing . Record review of the facility's Tracheostomy Care-Suctioning policy dated 7/2022 indicated, The facility will ensure that residents who need respiratory care, including tracheal suctioning, are provided such care consistent with professional standards of practice, the comprehensive person-center care plan and resident goals and preferences. Tracheal suctioning is performed by a licensed nurse to clear the throat and upper respiratory tract of secretions that may block the airway .Replace the suction collection canister when three-quarters full .