STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455745	A. Building B. Wing	10/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Timberwood Nursing and Rehabilitation Center	4001 Hwy 59 North Livingston, TX 77351

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** 43994 Based on observations, interviews, and record review the facility failed to ensure each resident was treated with respect, dignity, and care for 1 of 12 residents (Resident # 78) observed for care. CNA B failed to sit while feeding Resident #78 by the nurse station on 10/14/2024. This failure could place residents at risk of not being treated with dignity and respect. Findings included: Record review of an Admission Record dated 10/15/2024 for Resident #78 indicated he admitted to the facility on [DATE] and was [AGE] years old with diagnoses of dementia, BPH (enlarged prostate gland), and generalized anxiety disorder (excessive worry about everyday issues and situation). Record review of an Admission MDS Assessment for Resident #78 dated 9/30/2024 indicated he had severe impairment in thinking with a BIMS score of 5. He required substantial/maximal assistance with eating. Record review of a care plan dated 9/25/2024 for Resident #78 indicated he had potential nutritional problem related to altered diet and interventions included to provide assistance or cueing with meals as needed. During an observation on 10/14/2024 from 11:56 AM - 12:04 PM, Resident #78 was seated in a wheelchair by the nurse station. CNA B placed his lunch tray in front of him on an overbed table and stood the entire time while feeding him. During an interview on 10/14/2024 at 12:05 PM, CNA B said she had been employed at the facility for 2 years and worked 12 hours shifts from 6 am-6 pm. She said she was assigned to work on the hall with Resident #78. She said Resident # 78 had to be assisted with all meals. She said she should have been sitting while feeding him, but they recently moved the chairs. She said she was taught to always sit when feeding residents. She said she had a skills check off with the Staff Coordinator in June 2024 and feeding was a skill on the checklist. She said she would not feel any different if she was a resident and staff stood by her to feed her. (continued on next page)

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	Record review of a CNA Comprehensive Clinical Competency Review dated 6/8/2024 indicated CNA B skills checklist requirements were met that included eating support. During an interview on 10/15/2024 at 2:35 PM, the Staffing Coordinator said she had been employed at the facility since 2011. She said she was responsible for trainings with nurse aides and tried to do it every 6 months. She said yearly she would conduct trainings which included feeding. She said all staff were aware that they were not supposed to stand while feeding residents. She said it could be a dignity issue when staff were feeding residents standing up. During an interview on 10/16/2024 at 11:11 AM, the ADON said she had been employed at the facility for 7 years and 10 months in her current position. She said she was responsible for infection control and assisted with training staff. She said when staff were assisting a resident with feeding, they should be seated and not standing. She said it was part of their check offs and was aware of CNA B standing while feeding a resident. She said they would make sure that staff knew to sit and not stand going forward and would try to get residents to eat in the dining room for all meals. She said it would bother her or make her feel degraded if staff stood to feed her. During an interview on 10/16/2024 at 11:27 AM, the DON said staff should be sitting when feeding a resident. She said staff had been educated on how they should be positioned while feeding a resident. She said it would make her feel like they were towering over them if staff stood while feeding. She said they would plan to train staff they should be seated while feeding or take the residents to the dining room. During an interview on 10/16/2024 at 11:38 AM, the Administrator said staff should be seated while feeding a resident. He said they would in-service staff on feeding residents. He said it would make him feel like staff were too busy or did not have enough time if they stood while feeding him. Record review of a facility policy titled Resident Rights: Dignity and Respect revised 10/2015 indicated, .It is the policy of this facility that all residents be treated with kindness, dignity, and respect .

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46273 Based on observations, interviews, and record review the facility failed to ensure a resident who was incontinent of bladder received appropriate treatment and services to prevent urinary tract infections for 1 of 3 residents (Resident #74) reviewed for quality of care. The facility failed to ensure Residents #74 had a physician's order for an indwelling urinary catheter (drains urine from your bladder into a bag outside your body). This failure could place residents at risk for urinary tract infections and catheter related injuries. Findings included: Record review of a facility face sheet dated 10/16/24 for Resident #74 indicated that she was a [AGE] year-old female admitted to the facility on [DATE] and subsequently readmitted on [DATE] with diagnoses that included: acute pulmonary edema (a condition caused by too much fluid in the lungs, making it difficult to breathe), peripheral vascular disease (a condition in which narrowed arteries reduce blood flow to the arms or legs), and primary pulmonary hypertension (a type of high blood pressure that affects the arteries in the lungs and the right side of the heart). Record review of a Nursing Home PPS assessment dated [DATE] for Resident #74 indicated that she had a BIMS score of 15 which indicated she was cognitively intact. She was dependent with most ADLs. She had an indwelling catheter and was always incontinent of bowel. Record review of a comprehensive care plan dated 4/14/24 for Resident #74 indicated that she had an indwelling catheter due to obstructive uropathy and had the following intervention: .change catheter bag and tubing as ordered . Record review of a physician's order summary report dated 10/16/24 for Resident #74 indicated that she had no order for an indwelling catheter or changing the bag and tubing . During an observation on 10/14/24 at 2:41 pm Resident #74 was observed lying in bed sleeping. Foley bag was observed hanging on bedside with privacy cover in place. During an interview on 10/16/24 at 10:31 am the DON said her ADON was responsible for ensuring indwelling catheter orders were put in and she was not sure how it got missed. She said not having an order in place could cause the catheter to not be changed timely. She said going forward she would ensure orders were in place. During an interview on 10/16/24 at 10:44 am the Administrator said nursing was responsible for putting orders in and residents could be at risk for infections. Facility did not have a policy for indwelling catheter management.

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46273 Based on observations, interviews, and record review, the facility failed to ensure residents received parenteral fluids administered consistent with professional standards of practice and in accordance with physician orders for 2 of 3 residents (Resident #49 and Resident #75) reviewed for parenteral fluids. The facility failed to manage Resident #49's and Resident #75's PICC line dressing per professional standards and per the physician's order. This failure placed residents at risk of developing an infection. Findings included: Record review of a facility face sheet dated 10/14/24 for Resident #49 indicated that he was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses that included cellulitis of left lower limb (a bacterial infection of your skin and the tissue beneath your skin), type 2 diabetes mellitus (uncontrolled blood sugars), and hyperlipidemia (high cholesterol). Record review of a comprehensive MDS assessment dated [DATE] for Resident #49 indicated that he had a BIMS score of 15, indicating that he was cognitively intact. Section N (Medications) indicated that he was receiving antibiotics and section O (Special Treatments, Procedures, and Programs) indicated that he was receiving IV medications and had IV access. Record review of a comprehensive care plan dated 9/24/24 for Resident #49 indicated that he was receiving IV medications due to cellulitis and had the following intervention: .Check dressing at site daily . Record review of a physician's order summary report dated 10/14/24 for Resident #49 indicated that he had the following order dated 9/18/24: .Midline care: change central line/midline dressing Q (every) 7 days . Record review of a facility face sheet dated 10/14/24 for Resident #75 indicated that she was an [AGE] year-old female admitted to the facility on [DATE] and subsequently readmitted on [DATE] with diagnoses that included extradural and subdural abscess (an infection of the central nervous system that classically presents with midline back pain, fever, and neurologic deficits), subdural hemorrhage (a collection of blood outside the brain), and aphasia (a language disorder that affects communication due to brain injury or stroke). Record review of a Nursing Home PPS MDS assessment dated [DATE] for Resident #75 indicated that she had a BIMS score of 3, which indicated that she had severely impaired cognition. Section N (Medications) indicated that she was receiving antibiotics and section O (Special Treatments, Procedures, and Programs) indicated that she was receiving IV medications and had IV access. Record review of a comprehensive care plan dated 9/25/24 for Resident #75 indicated that she required IV antibiotics and had the following intervention: .administer antibiotic as per MD orders . (continued on next page)

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	455745	A. Building B. Wing	10/16/2024

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of a physician's order summary report dated 10/14/24 for Resident #75 indicated that she had the following order dated 9/19/24: .PICC line care: change PICC line dressing Q 7 days . During an observation and interview on 10/14/24 at 2:15 pm Resident #49 was observed lying in bed. He had a PICC line in his upper left arm with a dressing that was dated 9/29/24. He said he had been in the facility approximately 10 days to 2 weeks and could not remember anyone in the facility changing the dressing on his IV site. During an observation on 10/14/24 at 2:44 pm Resident #75 was observed lying in bed. PICC line dressing was observed dated 10/3/24. Resident did not speak. During an interview on 10/16/24 at 10:31 am the DON said nurses were responsible for changing the PICC line dressings and she was unsure what happened with Resident #49 and Resident #75 or how they got missed. She said she had already held in-services and would be following up on those in-services to ensure this did not happen again. She said residents could be at risk of infections if dressings were not changed properly. During an interview on 10/16/24 at 10:44 am the Administrator said nurses were responsible for changing the PICC line dressings and residents could be at risk for infections. He said he expected his staff to follow physician's orders. The facility did not have a policy on IV management.

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	455745	A. Building B. Wing	10/16/2024

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43994 Based on observations, interviews, and record review, the facility failed to have sufficient nursing staff with the appropriate competencies and skill sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable, physical, mental, and psychosocial well-being for 2 of 8 staff (CNA B and CNA D) reviewed for competent nursing care. 1. CNA D failed to clean Resident #64's penis during incontinent care provided on 10/15/2024. 2. CNA B failed to clean Resident #78's penis properly during catheter and incontinent care provided on 10/15/2024. These deficient practices affect residents who depend on nursing care and could place residents at risk for infection and harm. The findings included: 1. Record review of an Admission Record for Resident #64 dated 10/15/2024 indicated he admitted to the facility on [DATE] and was [AGE] years old with diagnoses of cognitive social or emotion deficit following CVA (stroke that affected thinking and emotion), dysphagia (difficulty swallowing), and hemiplegia (paralyzed on one side). Record review of a Quarterly MDS assessment dated [DATE] for Resident #64 indicated he did not have any impairment in thinking with a BIMS score of 14. He required partial/moderate assistance with toileting hygiene. He was always incontinent of urine/bowel. Record review of a care plan revised on 12/7/2023 for Resident #64 indicated he had bowel/bladder incontinence related to activity intolerance with interventions to check as required for incontinence. Wash, rinse, and dry perineum (area between the genitals and anus). During an observation on 10/15/2024 at 10:24 AM in the room of Resident # 64, CNA D and HA F were present to provide incontinent care. CNA D provided incontinent care to Resident #64 and only cleaned both of his inner thighs and his rectum but did not clean his penis. During an interview on 10/15/2024 at 10:38 AM, CNA D said she had been employed at the facility for 7 months worked 6 am-6 pm but had been a CNA for over [AGE] years. She said during the care provided to Resident #64, she should have cleaned his penis, lifted it up to clean and wipe the tip of it. She said she had a skills check off shortly after being hired. She said residents could get an infection if they were not cleaned properly. Record review of a CNA Comprehensive Clinical Competency Review Skills Checklist dated 2/28/2024 for CNA D indicated she was successfully checked off with perineal care for a male resident. (continued on next page)

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	455745	A. Building B. Wing	10/16/2024

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Record review of an Admission Record dated 10/15/2024 for Resident #78 indicated he admitted to the facility on [DATE] and was [AGE] years old with diagnoses of dementia, BPH (enlarged prostate gland), and generalized anxiety disorder (excessive worry about everyday issues and situation). Record review of active physician orders for Resident #78 dated 10/15/2024 indicated an order for catheter (device inserted into the body to drain the bladder) care every shift started on 9/24/2024. Record review of an Admission MDS Assessment for Resident #78 dated 9/30/2024 indicated he had severe impairment in thinking with a BIMS score of 5. He required substantial/maximal assistance with toileting. He was occasionally incontinent of urine and frequently incontinent of bowel. He had an indwelling catheter. Record review of a care plan for Resident #78 dated 9/26/2024 indicated he had an indwelling catheter for urinary retention with interventions that included to use enhanced barrier precautions. He was at risk for urinary retention related to BPH with interventions to provide catheter care if foley was present. During an observation on 10/15/2024 at 11:00 AM in the room of Resident #78, CNA B and CNA E were present to perform catheter care. Both sanitized their hands and applied gloves. CNA E placed a towel in the basin of water she had and went into the bathroom to put soap on the towel. CNA E pulled the foreskin back on his penis and wiped down the catheter tubing and placed the towel in a plastic bag. She placed another towel in the water and wiped down the tubing a second time and placed the towel in a bag. CNA E removed wipes from a bag and wiped his scrotum and he was rolled onto his left side. His rectum was cleaned, and a clean brief was applied. During an interview on 10/15/2024 at 11:20 AM, CNA E said she had been employed at the facility for 9 months and worked days from 6 am-6 pm. She said she had just started on the floor about a month ago and was also a medication aide. She said when she provided care to Resident #78, she should have pulled the foreskin back farther, did not wipe in a circular motion to clean the penis, and did not go back and dry after. She said she has not had a check off since being a nurse aide on the floor and residents could be at risk for contamination and infections. Record review of a Perineal Care check off dated 1/2/2024 for CNA E indicated she was a new hire moved to CNA 10/15/2024 and met the perineal care requirements dated 10/15/2024. During an interview on 10/15/2024 at 2:35 PM, the Staffing Coordinator said she had been employed at the facility since 2011. She said she was responsible for training the nurse aides on perineal care and tried to do it every 6 months. She said one day last week she gave all nurse aides handouts on perineal care and conducted random checks on staff. She said with male residents if they were uncircumcised, they were supposed to pull the foreskin back and clean. She said they would be doing more training with staff and there was risk for infections. She said they started a new checklist for staff for incontinent care and provided a copy. (continued on next page)

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	455745	A. Building B. Wing	10/16/2024

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of an Incontinent Care Skills Checklist revised July 27, 2011, indicated the steps and procedures for male perineal care, . 6. Wash tip of penis at urethral meatus first, using circular motion, cleanse from meatus outward and down shaft. If catheter is present, gently wipe the catheter tubing with new wipe from the meatus outward for at least 4 inches of tubing. 7. Gently cleanse scrotum. Lift carefully and wash underlying skin folds and groin. Using a new wipe, cleanse the inside of the first groin area downward from top to bottom, then get a new wipe, and cleanse the other groin area . During an interview on 10/16/2024 at 11:11, the ADON said she had been employed at the facility for 7 years and 10 months in her current position. She was responsible for infection control and sometimes assisted with training of staff. She said staff should clean male residents by cleaning around the tip of penis, down shaft, and groin area and that was with or without a catheter. She said if the resident had a catheter, then to clean the catheter and put water in a basin in the room and make sure to dry after care and before putting a brief on. She said the Staffing Coordinator was responsible for conducting the checkoffs with staff. She said residents could be at risk of infections and increased risk for UTI's. She said that staff were trained on skills on hire, annually, and PRN after that. During an interview on 10/16/2024 at 11:27 AM, the DON said the Staffing Coordinator conducted check offs with staff on hire, annually, and as needed if they required more education. She said when providing care to a male resident, they should wipe the penis and surrounding area. She said there could be a risk of infections if they were not cleaned properly. Record review of a facility policy titled Nursing Staff Competency revised 12/2023 indicated, .It is the policy of this facility to have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. b. Competency in skills and techniques necessary to care for residents' needs include but not limited to: basic nursing skills . Record review of a facility policy titled Indwelling Urinary Catheter Care revised 12/2023 indicated, .It is the policy of this facility that each resident with an indwelling catheter will receive catheter care daily and as needed (PRN) to promote hygiene, comfort, and decrease the risk of infection. 9. Moisten the washcloth and apply soap to the washcloth, clean the catheter in a downward motion (front to back) beginning at the urinary meatus (insertion point) and at least 4 inches down (from resident toward the collection bag). Use a clean portion of the washcloth for one cleansing motion. 11. Dry the resident perineal area with a clean .

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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. 40124 Based on observations, interviews, and record review the facility failed to store and distribute food in accordance with professional standards for food service safety in 1 of 1 kitchen reviewed for kitchen sanitation. Dietary Assistant A failed to follow policy when she discarded her gloves and bare-handed foods during lunch meal preparation for 5 residents receiving a pureed diet. This failure could place residents who ate a pureed diet from the kitchen at risk for food-borne illness and/or transmission-based infections. Findings included: During an observation and interview on 10/14/24 at 11:00 a.m. Dietary Assistant, hire date 7/21/22, pureed chicken breasts for 5 residents. DA A, then dropped the used grinder in the 3-compartment sink and took off her gloves. Without washing her hands and donning gloves, DA A opened a loaf of bread, positioned it beside the grinder, measured cooked beans and put them in the grinder. DA A turned on the grinder, touched the table, and turned the grinder off. DA A then tore 3 slices of bread up with her bare hands and added them to the beans and proceeded to puree. She removed the lid to the grinder and added 3 slices of bread, tearing them with her bare hands. The Dietary Manager was observing with this state surveyor and did not intervene. The Dietary Manager said DA A should have washed her hands and applied gloves before tearing the bread and adding it to the beans for puree. The Dietary Manager said that not doing so could cause food borne illness . During an interview on 10/24/24 at 11:15 am the Dietary Manager stated she was responsible for training all dietary staff and dietary staff were trained on kitchen sanitation to include not bare handing food items and glove changing. She stated she would begin retraining all staff because of the cross-contamination risk and expected all staff to follow all kitchen sanitation rules. During an interview on 10/24/24 at 2:43 PM the Administrator provided a facility policy regarding kitchen sanitation. He stated the Dietary Manager was responsible for oversight of kitchen sanitation as well as the training for the dietary staff. He stated that if sanitation measures were not followed in the kitchen, it could cause resident illness and contamination. He stated he expected all dietary staff to follow the regulations for kitchen sanitation. During an interview on 10/15/24 at 9:00 am the Dietary Clinical Support Manager said all staff in the kitchen were expected to follow policy and regulations regarding food handling and sanitation. She said that in-servicing had already been provided to the kitchen staff . The Dietary Clinical Support Manager said that not washing hands and applying gloves when handling foods could cause risk for contamination of food. (continued on next page)

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	455745	A. Building B. Wing	10/16/2024

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of a facility policy dated July 2014 titled Food Preparation and Service indicated, . service employees shall prepare and serve food in a manner that complies with food handling practices. 6. Bare hand contact with food is prohibited. Gloves must be worn when handling food directly. However, gloves can also become contaminated and /or soiled and must be changed between tasks. Disposable gloves are single-use items and shall be discarded after each use.

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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** 43994 Based on observations, interviews, and record review the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 3 of 6 residents (Resident #55, #20, and #78) and 2 of 8 staff (CNA B, and CNA E) reviewed for infection control. The facility failed to ensure staff did not reuse gowns for Resident's #55 and #20 who were on enhanced barrier precautions on 10/14/2024. CNA B and CNA E failed to wear a gown while providing catheter care for Resident #78, did not sanitize or wash their hands between glove changes, and touched clean items with dirty gloves on 10/15/2024. These failures could place residents at risk of exposure to infectious diseases due to improper infection control practices. Findings included: 1. Record review of an Admission Record dated 10/15/2024 for Resident # 55 indicated she admitted to the facility on [DATE] and was [AGE] years old with diagnoses of hemiplegia and hemiparesis (paralyzed on one side of the body), dysphagia (difficulty swallowing), and disruption of wound. Record review of active physician orders for Resident #55 dated 10/15/2024 indicated an order for enhanced barrier precautions started on 9/25/2024 that indicated ppe required for high contact care activities. Indication: MRSA/ESBL (infections that are resistant to many antibiotics) in wound to foot. Record review of a care plan revised on 10/15/2024 for Resident #55 indicated she had an actual impairment to skin integrity related to stage 4 pressure wound to left hallux joint area with interventions to use enhanced barrier precautions. Record review of a Quarterly MDS assessment dated [DATE] for Resident #55 indicated she did not have any impairment in thinking with a BIMS score of 13. She had 1 stage 4 pressure ulcer (wound deep into the muscle). During an observation on 10/14/2024 at 10:25 AM in the room of Resident#55 had a sign on her door that read EBP precautions that indicated to wear a gown and gloves while providing care. PPE was noted hanging on the door that included gloves and gowns. Resident #55 was in bed resting with her eyes closed. 2 blue gowns were hanging on the wall in the room. 2. Record review of an Admission Record for Resident #20 dated 10/15/2024 indicated he admitted to the facility on [DATE] and was [AGE] years old with diagnoses of heart failure, pressure ulcer of sacral region stage 4 (wound to tailbone deep into the muscle), and hypertension. (continued on next page)

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	455745	A. Building B. Wing	10/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Timberwood Nursing and Rehabilitation Center	4001 Hwy 59 North Livingston, TX 77351

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of a Significant Change MDS Assessment for Resident #20 dated 9/6/2024 indicated he had moderate impairment in thinking with a BIMS score of 8. He was dependent with all ADL's. Record review of active physician orders for Resident #20 dated 10/15/2024 indicated he had an order for enhanced barrier precautions: ppe required for high resident contact care activities. Indication arterial wound (skin injuries caused by poor circulation), MRSA in wound to sacrum (tailbone), and ESBL in urine that started on 9/11/2024. Record review of a care plan for Resident #20 revised on 9/11/2024 indicated he was at risk for infection related to multidrug resistant ESBL in urine with interventions to use enhanced barrier precautions. During an observation and interview on 10/14/2024 at 10:59 AM in the room of Resident #20 had a sign on the door for EBP and indicated to wear a gown and gloves while providing care. There were 2 blue gowns hanging on the wall in the room. Resident #20 was in bed awake, alert to person only with confusion noted. During an observation on 10/14/2024 at 3:05 PM in the room of Resident #20 the 2 blue gowns were still hanging on the wall in the room. During an observation and interview on 10/14/2024 at 3:31 PM, HA F was present on the hall where Resident #55 and #20 resided. She said she had been employed at the facility for 6 months. She said she did not provide direct care on her own and assisted another CNA. She said that hall had about 3-4 residents who were on EBP that required the staff to wear a gown and gloves when care was provided. She said they were not supposed to reuse the gowns. Resident #20's room door was open, and she said they had been reusing the gowns in the room and were not supposed to. She said they removed the gowns hanging in the room of Resident #55 earlier that day. She said the ADON, and the DON talked with staff and discussed on who and what was to be worn when residents were to be placed on EBP. She said there was a risk for cross contamination if staff reused gowns. 3. Record review of an Admission Record dated 10/15/2024 for Resident #78 indicated he admitted to the facility on [DATE] and was [AGE] years old with diagnoses of dementia, BPH (enlarged prostate gland), and generalized anxiety disorder (excessive worry about everyday issues and situation). Record review of active physician orders for Resident #78 dated 10/15/2024 indicated an order for catheter care every shift started on 9/24/2024. An order for enhanced barrier precautions: ppe required for high resident contact care activities: indication-foley every shift started on 9/24/2024. Record review of an Admission MDS Assessment for Resident #78 dated 9/30/2024 indicated he had a severe impairment in thinking with a BIMS score of 5. He required substantial/maximal assistance with toileting. He was occasionally incontinent of urine and frequently incontinent of bowel. He had an indwelling catheter. Record review of a care plan for Resident #78 dated 9/26/2024 indicated he had an indwelling catheter for urinary retention with interventions that included to use enhanced barrier precautions. He was at risk for urinary retention related to BPH with interventions to provide catheter care if foley was present. (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 10/15/2024 at 11:00 AM in the room of Resident #78, CNA B and CNA E were present to provide catheter care. There was a sign on the door that indicated EBP. Both sanitized their hands and applied gloves. CNA B pulled off Resident #78's shorts and opened his brief. CNA E put water in a pan and wet a towel and went into the bathroom and to put soap on the towel. CNA E pulled the foreskin back on his penis and wiped down the catheter tubing and placed the towel in a plastic bag. CNA E placed another towel in the water and wiped down the tubing and placed the towel in a bag. CNA E removed her gloves and placed them in the trash, without sanitizing or washing her hands put on clean gloves. CNA E removed wipes from a bag and wiped his scrotum x2 wipes and feces was present. CNA E removed her gloves and placed them in the trash and placed gloves on her hands without sanitizing them. CNA E removed wipes from plastic bag and CNA B rolled the resident onto his left side and wiped his rectal area using 3 wipes and removed his brief and placed it in the trash. CNA B wiped 3 times again and placed a clean brief underneath his buttocks and secured it without changing her gloves. CNA E removed her gloves and placed gloves on hands without sanitizing them. CNA B removed her gloves and sanitized her hands and put on clean gloves. CNA B placed Resident #78's shorts back on him. CNA E removed the pan of water and emptied it in the bathroom, trash and towels were removed and placed in the hallway cart outside of resident room door, and gloves removed and placed in the trash. CNA E sanitized her hands. CNA B removed her gloves and sanitized her hands. During a joint interview on 10/15/2024 at 11:20 AM, CNA E said she had been employed at the facility for 9 months, worked days from 6 am-6 pm, and had started on the floor as a nurse aide about a month ago and worked as a medication aide. She said during the care provided to Resident #78, when she changed gloves, she did not sanitize her hands. She said during catheter care she did not pull the foreskin back enough, did not wipe in a circular motion to clean, and did not go back and dry. CNA E said she had sanitizer in her pocket but did not use it and did not wear a gown when care was provided. CNA E said she thought the EBP was for his roommate. She said she had not had a skills check off since being a nurse aide on the floor. CNA B said she should have changed her gloves when she went from dirty to clean and she touched the clean brief with dirty gloves. She said Resident #78 was on EBP and they did not wear a gown during the care provided. Both said residents could be at risk for contamination and infections. Record review of a CNA Comprehensive Clinical Competency Review dated 6/8/2024 indicated CNA B skills checklist requirements were met that included perineal care. Record review of a CNA Comprehensive Clinical Competency Review-Skills Checklist for CNA E dated 1/2/2024 indicated she was successfully checked off on catheter care. Record review of a Perineal Care check off dated 1/2/2024 for CNA E indicated she was a new hire moved to CNA 10/15/2024 and met the perineal care requirements dated 10/15/2024. During an interview on 10/15/2024 at 2:35 PM, the Staffing Coordinator said she had been employed at the facility since 2011. She said she was responsible for trainings with nurse aides on perineal care and tried to do it every 6 months. She said every year she would train staff on ppe and handwashing. She said one day last week she gave all nurse aides handouts on perineal care and handwashing and did random checks on staff. She said with male residents if they were uncircumcised, they were supposed to pull the foreskin back and clean. She said they were supposed to wash or sanitize their hands after glove changes. She said they were not supposed to touch anything clean with dirty gloves. She said they would be doing more training with staff going forward. She said there was a risk for infection control. (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 10/16/2024 at 11:11 AM, the ADON said she had been employed at the facility for 7 years and 10 months in her current position. She was responsible for infection control and sometimes assisted with training of staff. She said staff should clean male residents by cleaning around the tip of penis, down shaft, and groin area and that was with or without a catheter, if they had a catheter, clean it. She said if they had a catheter, staff were to take a basin of water in the room to clean and make sure to dry the resident after care and before putting a brief on. She said staff should sanitize their hands after the brief was removed, before and after care provided, and between glove changes. She said the Staffing Coordinator was responsible for conducting the checkoffs with staff. She said residents could be at risk of infections and increased risk for UTI's. She said Resident #78 was on EBP for his catheter and staff should wear a gown and gloves when care was provided, and the staff had been aware of the change since April 2024. She said staff can reuse the gowns each shift, but only wear them for that shift and for one resident. She said they had a hard time before getting supplies and were running out of supplies. She said that staff were trained on skills on hire, annually, and prn after that. She said they conducted an in-service with staff on yesterday 10/15/2024 on EBP. During an interview on 10/16/2024 at 11:27 AM, the DON said Resident #78 was on EBP for his catheter and staff should be wearing a gown and gloves when providing care. She said they informed the staff that they could reuse the gowns for the same residents for the day. She said they did have a shortage of ppe but not anymore. She said residents could be at risk of infection. She said the Staffing Coordinator conducted check offs with staff on hire, annually, and as needed if they required more education. She said when providing care to a male resident, they should wipe the penis and surrounding area, perform hand hygiene before, during and after care, when changing from dirty to clean, and when gloves were removed. Record review of a facility in-service dated 10/15/2024 on EBP was conducted at the facility by the ADON to staff and CNA B, CNA D, HA F, and CNA E were in attendance as indicated by their signatures. During an interview on 10/16/2024 at 11:38 AM, the Administrator said the IP and all staff were responsible for all things infection control. He said they had been reviewing infection control measures frequently. He said they would plan to do more education along with observations of staff. He said there was a risk of infection and cross contamination. Record review of an indwelling urinary catheter care policy revised on 12/2023 indicated, .It is the policy of this facility that each resident with an indwelling catheter will receive catheter care daily and as needed to promote hygiene, comfort, and decrease the risk of infection. 9. Moisten the washcloth and apply soap to the washcloth or using moistened disposable wipes, clean the catheter in a downward motion (front to back) beginning at the urinary meatus (insertion point) and at least 4 inches down (from resident toward the collection bag). Use a clean portion of the washcloth or fresh disposable wipe for one cleansing motion. 10. Repeat the procedure without soap to rinse as needed. 11. Dry the resident perineal area with a clean cloth . (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 a facility policy titled IPCP Standard and Transmission-Based Precautions: Infection Control revised 10/2022 indicated, .It if the policy of this facility to implement infection control measures to prevent the spread of communicable diseases and conditions. 3. Enhanced Barrier Precautions (EBP): expand the use of PPE and refer to the use of gown and gloves during high contact resident care activities that provide opportunities for indirect transfer of MDROs to staff hands and clothing then indirectly transferred to residents or from resident to resident. (e.g)., residents with wounds and indwelling medical devices are at especially high risk of both acquisition of and colonization with MDROs). c. Examples of high-contact resident care activities requiring gown and gloves use for Enhanced Barrier Precautions include: vii. device care or use, indwelling urinary catheter . Record review of a facility policy titled Hand Hygiene undated indicated, .This facility considers hand hygiene the primary means to prevent the spread of infections. 1. All personnel shall be trained and or regularly in-serviced on the importance of hand hygiene in preventing the transmission of healthcare-associated infections. 4. Use an alcohol-based hand rub containing at least 62% alcohol; or, alternatively, soap and water for the following situations: h. Before moving from a contaminated body site to a clean body site during resident care; m. After removing gloves. 6. The use of gloves does not replace hand washing/hand hygiene .