STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675880	A. Building B. Wing	08/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sterling County Nursing Home	309 Fifth St Sterling City, TX 76951

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48593 Based on interviews and record review, the facility failed to develop and implement a comprehensive, person-centered care plan for each resident that included measurable objectives and time frames to meet, attain, and/or maintain the resident's highest practicable physical, mental, and psychosocial well-being for 2 of 12 residents (Resident #22 and #6) reviewed for care plans. 1. The facility failed to have a care plan in place to accurately address Resident #6's oxygen use. 2. The facility failed to have a care plan in place to accurately address Resident #22's 1/4 side rail use. This failure could affect residents by placing them at risk of not receiving individualized care and services to meet their needs. The findings included: Resident #6 Resident #6 was a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #6 had medical diagnoses that included chronic diastolic congestive heart failure, heart disease, acute kidney failure, morbid obesity due to excess calories, and shortness of breath. Review of Resident #6's Quarterly MDS assessment dated [DATE] revealed a BIMS (Brief Interview for Mental Status) score of 14 indicating the resident was cognitively intact. She required maximum assistance and dependent on staff for all ADL's except for eating. She used a wheelchair for mobility. Under section O for Respiratory treatments C1. Oxygen therapy was selected as continuous while a resident at the facility. Record review of Resident #6's had order summary dated August 2024 that include, GIVE OXYGEN AT 1-10 LITERS VIA FACE MASK OR NASAL CANNULA CONTINUOUS. - every day and night shift Hospice has delivered a black concentrator that can deliver up to 10L, OXGEN: Oxygen AT 2-4 LPM CONTINUOUS via NC. Titrate for comfort. every shift. (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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #6's care plan dated 07/24/2024 revealed there was no care plan for oxygen use. Interview on 08/08/24 at 03:18 PM with MDS E stated that she would check orders and medical diagnosis for items that should be care planned. MDS E stated that there should be a care plan for oxygen especially for continuous oxygen use. MDS E stated that the care staff could look at the care plan and if her continuous oxygen use was not on there, they could miss that she needs to have O2 on continuously. Review of Resident #22's Admission Record, dated 8/7/24, revealed she was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses including dementia, high blood pressure, arthritis, and neuropathy (nerve disorder causing numbness or tingling). Review of Resident #22's Quarterly MDS Assessment, dated 6/24/24, revealed: She scored a 10 of 15 on her mental status exam (indicating moderate cognitive impairment) She had range of motion impairment on one side of the lower extremity and used a walker. She was independent in all of her ADLs including transfers and sitting to standing. Review of Resident #22's care plan, last revised on 6/27/24, revealed no care plan for side rails. Observation and interview on 8/6/24 at 10:49 a.m. revealed Resident #22 had 1/4 rails on both sides of her bed. Resident #22 said she did not know why she had the rails; they were built onto the bed. Resident #22 said she did not mind the rails, but she did not use them. Interview and record review on 08/08/24 at 03:34 PM the MDS Coordinator stated indicators for care plans started with cognition, pain, diagnoses, then MDS triggers. The MDS Coordinator stated 1/4 side rails would be just for mobility since they did not keep Resident #22 in the bed but would require a care plan. The MDS Coordinator stated the system for side rails was therapy did an assessment, if rails were indicated ADON got a consent from the resident or the responsible party. The MDS Coordinator said once the consent was obtained, she would get the order and do the care plan. The MDS Coordinator checked Resident #22's electronic file and said she did not see a consent for side rails. Review of undated facility policy titled Comprehensive Person-Centered Resident Care Planning revealed, in part: A comprehensive person-centered care plan is developed and implemented for each resident, consistent with the resident's rights, and will incorporate resident-centered goals and wishes about their care, activities, and lifestyle to include measurable short-term and long-term objectives and time frames to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.

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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** 30057 Based on observations, interviews, and record review, the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment to help prevent the development and transmission of communicable diseases and infections for 3 (Resident #1, #12 and #28) of 4 residents reviewed for infection control practices. LVN A failed clean and sanitize the glucometer (portable device that measure blood glucose levels) with the appropriate sanitizing wipes while checking Resident #1 and Resident #12's blood sugar. RN D failed to wash or sanitize her hands in between glove changes during wound care for Resident #28. This failure could affect the residents by placing them at risk for the spread of infection. Finding included RESIDENT #1 Record review of Resident #1's admission record dated 08/08/2024 indicated she was admitted to the facility on [DATE] with diagnosis of type 2 diabetes. She was [AGE] years of age. Record review of Resident #1's care plan dated 08/06/24 indicated in part: Problem: Diabetes: Resident is at increased risk for complications related to diabetes type 2. Goal: Resident will have blood glucose within normal . Interventions: Accu-checks as ordered per MD. Record review of Resident #1's order summary report with active orders as of: 08/08/2024 indicated in part: ACCUCHECKS (a proprietary blood glucose measuring system used for monitoring of glucose) CALL MD IF ABOVE 400 OR BELOW 60 HOLD INSULIN FOR BLOOD GLUCOSE BELOW 110 CLEAN GLUCOMETER BEFORE & AFTER EACH USE before meals and at bedtime. order date 11/09/2023. Record review of Resident #12's admission record dated 08/08/2024 indicated she was admitted to the facility on [DATE] with diagnosis of type 2 diabetes. She was [AGE] years of age. Record review of Resident #12's care plan dated 10/06/23 indicated in part: Problem: Diabetes: Resident is at risk for hyper/hypoglycemia (high/low blood sugar). Goal: Diabetic status will remain stable evidenced by blood glucose levels within resident's normal limits and absence of signs of hypoglycemia or hyperglycemia for the next 90 days. Interventions: Accu-checks as ordered per MD. Record review of Resident #12's order summary report with active orders as of: 08/08/2024 indicated in part: ACCUCHECK TID AND HS CALL MD IF ABOVE 400 OR BELOW 60 HOLD INSULIN FOR BLOOD GLUCOSE BELOW 110 CLEAN GLUCOMETER BEFORE &AFTER EACH USE before meals and at bedtime related to TYPE 2 DIABETES. Order date 03/01/2024. (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 08/06/24 at 11:08 AM LVN A performed a blood sugar check by checking Resident #12's blood with the use of a glucometer and a test strip. The LVN used an alcohol prep pad to clean and sanitize the glucometer after checking the resident's blood sugar. During an observation 08/06/24 at 11:15 AM LVN A performed a blood sugar check by checking Resident #1's blood with the glucometer she had previously cleaned and sanitized with the alcohol pad. During an interview on 08/06/24 at 04:36 PM LVN A said that she usually used the germicidal wipes and not the alcohol prep pads to clean and sanitize the glucometer in between resident use. The LVN said the reason she used the alcohol prep pad was because it was there, and she got nervous because the State Surveyor was observing her. LVN A said she knew it was inappropriate to use the alcohol pads to clean and sanitize the glucometer but again she said she had gotten nervous and used the wrong thing to sanitize the glucometer. The LVN said she had been trained to use the germicidal wipes to sanitize the glucometers in between residents. LVN A said if she did not use the germicidal wipes then that could possibly lead to cross contamination and the spread of germs. The LVN again said she had gotten nervous and messed up and had not used the correct wipes to clean the glucometer. During an interview on 08/08/24 at 02:00 PM the DON was made aware of the observation of LVN A sanitizing the glucometer with an alcohol pad in between checking resident's blood sugars. The DON said it was expected for the nurses to use the germicidal wipes to sanitize the glucometer in between resident use. The DON said the alcohol pads were not appropriate as they did not sanitize the glucometer as the germicidal wipes did plus it was the manufacturers recommendation to use germicidal wipes to sanitize the glucometer. The DON said if the nurses did not use the germicidal wipes that could possibly lead to cross contamination such as the spread of germs. The DON said she was responsible for doing the training on how to sanitize the glucometer and had recently done some training with the staff to include the nurse that had not used the germicidal wipe. The DON said the failure occurred because the nurse probably got nervous and used the alcohol wipe since it was available instead of using the germicidal wipes. During an interview on 08/08/24 at 02:28 PM the Administrator said was made aware of the observation of LVN A sanitizing the glucometer with an alcohol pad in between checking resident's blood sugars. The Administrator said the nurses were supposed to use the wipes in the containers with the purple tops (Germicidal wipe container). The Administrator said it was the DON's responsibility to train the nursing staff on proper sanitizing of the glucometers . RESIDENT #28 Resident #28 was a [AGE] year-old female. Resident #28 was admitted to the facility on [DATE] with diagnosis that included a fracture of unspecified part of the lumbosacral spine and pelvis, urinary tract infection, dementia, and moderate protein calorie malnutrition. Record review of Resident #28's MDS dated [DATE] revealed a BIMS score of 03 indicating severe cognitive impairment. Under Section M - Skin Conditions, M1200. Skin and Ulcer/Injury Treatments selected was pressure ulcer/injury care, application of nonsurgical dressings (with or without topical medications) other than to feet, and applications of ointments/medications other than to feet. (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 Resident #28's care plan revealed in part a problem of pressure ulcer: Resident has an unstageable pressure ulcer to right inner elbow measurements (6/14/2024) unstageable, stage 3 pressure ulcer to her right elbow: (6/14/24) and is at risk for impaired healing r/t advanced age and impaired mobility to right upper extremity. With interventions that include provide wound care to Stage 3 pressure ulcer to right elbow as ordered per MD . Provide wound care to Unstageable Pressure ulcer to right inner elbow as ordered per MD. Record review of Resident #28's order summary for August 2024 revealed in part wound care: abrasion/lesion to rt front thigh, apply gentamycin ointment to wound bed, cover w/bordered dressing daily until healed monitor for s/s of infection. every day and night shift. Wound Care: Right elbow skin tear- cleanse with wound cleanser, pat dry w/gauze, apply gentamycin ointment to wound bed, cover w/bordered dressing daily until healed. Everyday shift for pressure ulcer May use TAO until Gentamycin is available. Wound Care: Right inner elbow pressure ulcer - unstageable - cleanse with wound cleanser, apply Mupirocin ointment, cover w/gauze, secure w/ cover roll stretch tape, daily and PRN, apply Ace wrap to protect dressing, until healed. as needed for dressing soiled, wet, or dislodged. Wound Care: Right inner elbow pressure ulcer - unstageable - cleanse with wound cleanser, apply Mupirocin ointment, cover w/gauze, secure w/ cover roll stretch tape, daily and PRN, apply Ace wrap to protect dressing, until healed, every day shift for pressure ulcer. Observation of wound care on 08/08/24 at 02:21 PM performed for Resident #28 by RN D with the ADON assisting with resident positioning. RN D did not wash hands prior to prep for care. RN D did use hand sanitizer. RN D did not clean the bedside table prior to care. RN D placed a sterile drape as a barrier on the bedside table then flipped the barrier over. RN D placed all the supplies on top of this barrier. RN D placed extra gloves on the resident's bed. After removing the dressing to the resident's elbow, RN D removed gloves and changed into new gloves. RN D did not use hand sanitizer or wash hands between glove changes. RN D grabbed keys out of her pocket wearing the same gloves she bandaged the elbow with then removed gloves. After returning from outside of the room to obtain a bandage from the supply cart, RN D hand sanitized hands and then applied gloves. RN D placed extra gloves on the resident's bed. After taking the old dressing off of the resident's leg, RN D did not change gloves between dirty dressing and clean dressing. RN D then reached into her pockets looking for a marker to date the bandage. RN D touched all four of her pockets on her scrubs with the same gloves. Without changing gloves RN D, touched her watch and, dated the dressing, then placed the marker and scissors back in her pockets. In an interview on 08/08/24 at 03:01 PM with RN D stated she thought she could have been more organized prior to her care but did not think she needed to change anything. RN D stated she does normally clean the bedside table with either Sani-wipes or Bleach wipes. RN D stated she was just nervous. After walking through the wound care she provided, RN D realized she did not change gloves or hand sanitize between glove changes. RN D stated this could be a concern for cross contamination. In an interview on 08/08/24 at 03:30 PM the ADON, who was present for the incontinent care, did not have a concern with the care RN D provided. After going through the wound care that was provided, the ADON acknowledged that RN D did not change gloves or hand sanitize. The ADON stated all items should be cleaned before and after use. The ADON stated all staff should be washing hands or using hand sanitizer before care, between glove changes, and after care . (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the facility's policy titled Obtaining a fingerstick glucose level and dated October 2011 indicated in part: The purpose of this procedure is to obtain a blood sample to determine the resident's blood glucose level. Equipment and supplies - The following equipment and supplies will be necessary when performing this procedure: Disinfected blood glucose meter (glucometer) with sterile lancet. Always ensure that blood glucose meters intended for reuse are cleaned and disinfected between resident uses. Clean and disinfect reusable equipment between uses according to the manufacturer's instructions and current infection control standards of practice. According to Center for Disease Control (CDC), Whenever possible, assign blood glucose meters to a person and do not share them. Dedicated meters should be cleaned and disinfected per the manufacturer's instructions and, at a minimum, anytime the device is reassigned to a different person. Dedicated meters should be stored in a manner that prevents cross-contamination and inadvertent use for the wrong patient. If blood glucose meters must be shared, the device should be cleaned and disinfected after every use, per the manufacturer's instructions, to prevent the spread of blood and infectious agents. If the manufacturer does not specify how the device should be cleaned and disinfected, it should not be shared. Retrieved from https://www.cdc.gov/injection-safety/hcp/infection-control/index.html. August 08, 2024 .