STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675948	A. Building B. Wing	05/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Park Place Manor	810 E 13th Ave Belton, TX 76513

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44700 Based on observation, interview, 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 one (1) of four (4) residents (Resident #1) reviewed for indwelling catheter care and one (1) of seven (7) medication carts (Medication Cart #1) reviewed for contamination. 1. The facility failed to ensure CNA A appropriately sanitized his hands during indwelling catheter care for Resident #1. 2. The facility failed to ensure LVN B kept medication cart #1 free from contamination of exposed food and drink. These failures could result in the spread of diseases to residents which could result in decreased quality of life, illness, and hospitalization . Findings include: 1. Review of Resident #1's face sheet dated 5/18/2024 reflected a [AGE] year-old male admitted to the facility on [DATE] with diagnoses that included: Chronic Respiratory Failure, Epilepsy (seizure disorder) Disorders of Kidney and Ureter , (tube leading from the kidneys to the bladder) Hypertension, Benign Prostatic Hyperplasia (enlargement of the Prostate gland) and Urine Retention. Review of Resident #1's quarterly MDS assessment dated [DATE] reflected a BIMS score of 12 suggesting moderate cognitive impairment. Review of the MDS section on Bladder and Bowel reflected Resident #1 had an indwelling catheter. Review of Resident #1's care plan dated 5/17/2024 reflected the problem Resident has an indwelling catheter. At risk for UTI, complications r/t Urinary Retention, BPH, difficulty starting/stopping urine flow, urinary obstruction, and adverse reactions to medication; with a goal of Resident will have no injuries, infections or complications related to indwelling catheter and interventions that included: Catheter care per facility policy and PRN. (continued on next page)

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

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #1's orders reflected an order dated 2/15/2024 for Foley catheter care ad output every shift During an observation on 5/18/2024 at 1:04 pm, CNA - A was performing catheter care on Resident #1. CNA - A doffed his gloves after taking Resident #1's brief off and performed hand hygiene using alcohol-based hand rub (ABHR). CNA-A was observed applying the ABHR and rubbing just the palms of his hands together. CNA - A was not observed rubbing the backs of his hands, between his fingers or under his fingernails with the ABHR. CNA-A was then observed fanning his right hand around in the air. During an interview on 5/18/2024 at 1:32 pm, CNA-A stated he had been waving his right hand around in the air to dry his hand from the ABHR, realized it was wrong and caught himself. He stated he had received training on hand hygiene but failed to properly sanitize all surfaces of his hands before donning a new set of gloves while performing catheter care. He stated he had been working at the facility about a month and did not recall getting training on how to properly perform catheter care. He stated not properly sanitizing your hands during resident care could spread germs and cause infections to residents. During an interview on 5/23/204 at 1:48 pm, the DON stated staff was supposed to be performing hand hygiene before starting catheter care and when changing gloves. She stated washing hands was best, but it was acceptable for staff to use hand sanitizer providing they sanitized all surfaces of their hands in a motion just like washing their hands. She stated it was not ok to fan hands in the air to speed up the drying of hand sanitizer on the hands. She stated this would expose the hands to more germs and be an infection control concern. She stated this would not meet her expectations and that staff received training as part of the onboarding process and mentorship on how to correctly perform catheter care. Review of the facility's in-service sheet dated 5/3/2024 titled Catheter care/Indwelling reflected CNA-A's name and signature on the form which was pointed out and verified by the DON. 2. During an observation on 5/18/2024 at 9:49 am, Medication Cart #1 was noted to have a drink cup with a dark liquid in it and a straw sticking out, on the top of the med cart. Further observation revealed medication cart #1 had an open white bag with a food item in the bag also sitting on top of medication cart #1. During an interview on 5/18/2023 at 1:38 pm, the DON stated food and drink should definitely not be on the cart. She stated there should also be no food or drink at the nurse's station and all food and drink should have been put away as it would be an infection control issue. During an interview on 5/18/2024 at 2:08 pm, RN B stated she was the one that had left the food and drink on medication cart #1. She stated she normally put her food and drink items in the conference room, but it was locked when she came in. She stated she had had a staff call out and had gotten in a hurry to count the carts with the off going medication aide and had just set those items down. She stated she had been trained on how to properly handle personal food and drink items and they were not allowed on the carts or at the nurses station. She stated having food and drink on a med cart, there was a risk of cross contamination with other items including resident medications. She stated all residents in the facility were at risk of infection from cross contamination. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/23/2024 at 9:23 am, the AD stated food and drink was not to be stored on medication carts as it is against their policy. She stated they should not be stored on medication carts for infection control purposes - to prevent the spread of infection She stated staff should take their food or drink to the breakroom and go there to eat or drink. Review of undated, facility policy titled Hand washing reflected the Purpose: Hand washing will be regarding by this facility as the single most important means of preventing the spread of infections. Review of undated, facility procedure titled Hand washing, Procedure 430 reflected the purpose: medical asepsis to control infection, to reduce transmission of organisms from resident to resident; to reduce transmission of organisms form nursing staff to resident; to reduce transmission of organisms from resident to nursing staff. Review of facility's policy titled Medication Storage in the Facility dated 4/1/2023, reflected 15. Medication storage areas are kept clean, well-lit and free of clutter. Review of facility's policy titled Equipment and Supplies for Administering Medications dated 4/1/2023, reflected The facility maintains equipment and supplies necessary for the preparation and administration of medications to residents; 2. The charge nurse on duty makes sure equipment and supplies relating to medication storage and use are clean and orderly.