STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676235	A. Building B. Wing	10/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rock Creek Health and Rehabilitation	1414 College Street Sulphur Springs, TX 75482

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 - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47006 Based on observations, 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 2 of 2 residents (Resident #1 and Resident #2) reviewed for enhanced barrier precautions and infection control practices with foley catheter care. 1. The facility failed to ensure CNA B and the DON wore enhanced barrier precautions while performing foley catheter care for Resident #1 on 10/23/2024. 2. The facility failed to ensure RN A and CNA C wore enhanced barrier precautions and performed hand hygiene while performing foley catheter care for Resident #2 on 10/23/2024. These failures could place residents and staff at risk for cross contamination and the spread of infection. The findings included: 1. Record review of the face sheet, dated 10/23/24, reflected Resident #1 was a [AGE] year-old male who admitted to the facility on [DATE] with a diagnosis of obstructive and reflux uropathy (when your urine can't flow [either partially or completely] through your ureter, bladder, or urethra due to some type of obstruction and instead flows backward, or refluxes, into your kidneys) and benign prostatic hyperplasia without lower urinary tract symptoms (condition in which the flow of urine is blocked due to the enlargement of prostate gland). Record review of the admission MDS assessment, dated 08/06/2024, reflected Resident #1 had clear speech and was understood by others. The MDS reflected Resident #1 was usually able to understand others. The MDS reflected Resident #1 had a BIMS score of 10, which indicated moderately impaired cognition. The MDS reflected Resident #1 had no behaviors or refusal of care. The MDS reflected Resident #1 had an indwelling catheter. Record review of the comprehensive care plan, revised 07/31/2024, reflected Resident #1 had an indwelling foley catheter. The comprehensive care plan further reflected Resident #1 required the use of enhanced barrier precautions. The interventions included: gloves and gown should be worn during .catheter care . (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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 10/23/2024 beginning at 2:51 PM, signage was observed on Resident #1's door that stated EBP steps .perform hand hygiene .wear gown .wear gloves .dispose of gown and gloves in room . Use EBP during high-contact care activities for residents with indwelling medical devices (.urinary catheter .) . A plastic cart with multiple drawers was located outside the door that held isolation gowns. CNA B and the DON knocked and entered Resident #1's room. CNA B assisted Resident #1 into the bed, pulled down his pants, and provided foley catheter care without applying enhanced barrier precautions. The DON was in the room with CNA B. The DON assisted CNA B with the foley catheter care without applying enhanced barrier precautions. 2. Record review of the face sheet, dated 10/23/2024, reflected Resident #2 was an [AGE] year-old female who admitted to the facility on [DATE] with a diagnosis of neuromuscular dysfunction of the bladder (occurs when a person's nerves, spinal cord, or brain have problems sending electrical signals to the bladder). Record review of the admission MDS assessment, dated 10/13/2024, reflected Resident #2 had clear speech and was usually understood by others. The MDS reflected Resident #2 was usually able to understand others. The MDS reflected Resident #2 had a BIMS score of 11, which indicated moderately impaired cognition. The MDS reflected Resident #2 had no behaviors or refusal of care. The MDS reflected Resident #2 had an indwelling catheter. Record review of the comprehensive care plan, revised on 10/09/2024, reflected Resident #2 had an indwelling foley catheter. The comprehensive care plan further reflected Resident #2 required the use of enhanced barrier precautions. The interventions included: gloves and gown should be worn during .catheter care . During an observation on 10/23/2024 beginning at 3:36 PM, signage was observed on Resident #1's door that stated EBP steps .perform hand hygiene .wear gown .wear gloves .dispose of gown and gloves in room . Use EBP during high-contact care activities for residents with indwelling medical devices (.urinary catheter .) . A plastic cart with multiple drawers was located outside the door that held isolation gowns. RN A and CNA C knocked and entered Resident #2's room. CNA C and RN A assisted Resident #2 with foley catheter care without applying enhanced barrier precautions. CNA C and RN A did not perform hand hygiene during glove changes while performing foley catheter care on Resident #2. During an interview on 10/23/2024 beginning at 3:49 PM, CNA C stated Resident #2 had signage outside her door for enhanced barrier precautions. CNA C stated she was unsure why Resident #2 required the use of enhanced barrier precautions. CNA C stated most residents were on enhanced barrier precautions because they had wounds, or infections in their urine. CNA C stated she should have asked the nurse why a resident had signage on their door for enhanced barrier precautions. CNA C stated she was provided in-service training on enhanced barrier precautions at the facility. CNA C stated hand hygiene should have been performed during glove changes. CNA C stated she should have used alcohol rub or hand washing before applying new gloves. CNA C stated she just forgot to sanitize her hands before applying new gloves. CNA C stated it was important to ensure enhanced barrier precautions were used and hand hygiene was performed during glove changes to protect herself and the residents from contamination and prevent the spread of infection. (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 10/23/2024 beginning at 3:56 PM, RN A stated enhanced barrier precautions were implemented for residents with a foley catheter or wound. RN A stated she believed enhanced barrier precautions were only used when changing a foley catheter or emptying the urinary drainage bag. RN A was unsure if enhanced barrier precautions were required while performing foley catheter care. RN A stated she was provided training on enhanced barrier precautions when it first became a requirement. RN A stated hand hygiene should have been performed during glove changes. RN A stated she realized they did not have any sanitizer in the room while performing foley catheter care on Resident #2. RN A stated it was important to ensure hand hygiene was performed during glove changes to keep the resident clean and prevent infection. During an interview on 10/23/2024 beginning at 4:06 PM, CNA B stated she realized she had forgotten to apply enhanced barrier precautions while performing foley catheter care on Resident #1. CNA B stated she was nervous and in a hurry. CNA B stated she normally applied enhanced barrier precautions. CNA B stated it was important to ensure enhanced barrier precautions were applied during foley catheter care for infection control purposes. During an interview on 10/23/2024 beginning at 4:11 PM, the DON stated he should have applied enhanced barrier precautions prior to performing foley catheter care on Resident #1. The DON stated he came into the room in a hurry and just forgot to apply the PPE. The DON stated he expected the facility staff to ensure enhanced barrier precautions were used while providing direct care, such as foley catheter care. The DON stated he expected facility staff to ensure hand hygiene was performed during glove changes. The DON stated the infection control preventionist and the nursing management were responsible for monitoring to ensure staff were implementing enhanced barrier precautions. The DON stated the infection preventionist was at home resting because she had to work the night shift. The DON stated it was important to ensure enhanced barrier precautions were used and hand hygiene was performed during glove changes as an extra step to prevent the spread of infection. During an interview on 10/23/2024 beginning at 5:24 PM, the Administrator stated she expected facility staff to ensure enhanced barrier precautions were used and hand hygiene was performed during glove changes. The Administrator stated the IDT were responsible for monitoring to ensure enhanced barrier precautions were used and hand hygiene was performed at appropriate times. The Administrator stated the IDT included the charge nurse, infection preventionist, and the DON. The Administrator stated it was important to ensure enhanced barrier precautions were used and hand hygiene was performed for infection control purposes. Record review of the Catheter Care policy, revised 02/13/2007, did not address hand hygiene or the use of enhanced barrier precautions. Record review of the Fundamentals of Infection Control Precautions policy, updated 03/2023, reflected 1. Hand Hygiene The following is a list of some situation that require hand hygiene .after removing gloves or aprons .