STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676485	A. Building B. Wing	01/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Princeton Medical Lodge	1401 W. Princeton Dr. Princeton, TX 75407

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** Based on observation, interview, and record review, the facility failed to ensure the comprehensive care plan described the services that were to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being for 3 of 22 (Residents #94, Resident #13, and Resident #18) reviewed for comprehensive care plans. 1. The facility failed to include in Resident #94's comprehensive care plan, revised on 12/16/24, her dental needs and interventions to address the problem. 2. The facility failed to include in Resident #13's comprehensive care plan, revised on 10/21/24, her dental needs and interventions to address the problem. 3. The facility failed to include in Resident #18's comprehensive care plan, revised on 11/20/24, her diagnosis of eczema and her rash and interventions required to address the problem. These failures could affect residents of the facility by not addressing their physical, mental, and psychosocial needs for each to attain or maintain their highest practicable physical, mental, and psychosocial outcome. Findings include: 1. Record review of Resident #94's annual MDS assessment, dated 12/11/24, reflected an [AGE] year-old female who was admitted to the facility on [DATE]. She had a BIMS of 8 which indicated she was moderately cognitively impaired. Her diagnoses included hypertension and coronary artery disease. She had no indication of dental concerns. Record review of Resident #94's care plan, with a review date of 12/16/24, reflected she did not have a care plan for dental concerns or interventions to address those concerns. Record review of Resident #94's progress notes reflected the Social Worker referred the resident to the dental provider per the family's request on 02/13/24. In an interview with Resident #94 on 01/07/25 at 01:20 p.m. she stated the dentist had come and pulled one of her teeth. She stated she needed additional teeth pulled so she could obtain her dentures and had not been told when they were coming back. She stated the dentist had text her some messages, but her family member told her not to worry about them, she was talking with the dentist. (continued on next page)

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	In an interview with the Social Worker on 01/08/25 at 12:07 p.m. she stated there was a financial responsibility the family member was aware of and as far as she knew it had not been met. She stated she had not followed up with the dental provider to determine where they were in the process, but stated she would check today. In a follow up interview with the Social Worker on 01/08/25 at 01:15 p.m. she stated she had reached out to the dental provider. She stated the resident had a tooth extraction on 10/08/24 and was going to need 4 more teeth pulled and then fitted for denture. She stated there was an issue with her applied income and the amount the family was going to have to pay, which was why they had not progressed. She stated the dental provider had told her they had reached an agreement with the facility, and they were going to go forward with the tooth extractions and dentures. She stated the dental provider was coming out next week and assessing Resident #94. In an interview with the Dental Provider Representative on 01/08/25 at 01:27 p.m. she stated the facility had sent them a referral in [DATE]. She stated the resident was wanting dentures but stated there was an applied Income issue and they had communicated with the family about what their responsibility was going to be. She stated the resident later required a tooth extraction which was performed on 10/08/24. She stated the resident was still requesting dentures. She stated the facility's BOM had been working with Medicaid and the family. She stated sometime in December 2024 she, the BOM and the Social Worker met and determined the facility would cover the $1000 dollars needed to for removing 4 additional teeth and fitting the resident with Dentures. She stated they were scheduled to come out to the facility next week. 2. Record review of Resident #13's quarterly MDS assessment, dated 10/11/24, reflected an [AGE] year-old female who was admitted to the facility on [DATE]. She had a BIMS of 12 which indicated she was moderately cognitively impaired. Her diagnoses included hypertension and coronary artery disease. She had no indication of dental concerns. Record review of Resident #13's care plan, with a review date of 10/21/24, reflected she did not have a care plan for dental concerns or interventions to address those concerns. In an interview and observation on 01/07/25 at 09:38 a.m. with Resident #13 she stated she had been at the facility for about a year and half. Resident #13 was observed to have her front teeth missing. She stated she saw the Dentist at the facility about 6 months ago. She stated she needed a new partial. She stated her Medicaid was not approved until July 2024. She stated she asked the Social Worker in November 2024 when the dentist was going to get her partial done. She stated she still had not heard anything. In a follow up interview on 01/08/25 at 12:55 p.m. with Resident #13 she stated she had a partial when she admitted to the facility. She stated it had become bent and she was not able to wear it anymore. She stated it was not the fault of anyone, and was not sure how it bent, but stated she had it for several years. She stated she was seen by the dentist sometime before July 2024. She stated the BOM had told her that when her Medicaid went into effect it would cover a new partial for her, so she opted to wait until her Medicaid went into effect. She stated her Medicaid went into effect in July 2024. She stated she was waiting on was the completion of her dental work. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview with the Social Worker on 01/08/25 at 12:12 p.m. she stated she would have to call the dental office and see what the status was on Resident #13's dental work. She stated the BOM was currently out on medical leave. She stated Resident #13 probably did speak with her in November 2024, but stated she could not remember what the issues was with the dental. In a follow up interview with the Social Worker on 01/08/25 at 01:16 p.m. she stated she had reached out to the dental provider and found out Resident #13 had been seen in November 2024 for a teeth cleaning and again in December 2024 for X Rays. She stated she was on the schedule for this coming Monday (01/13/25) and should have her partial by the end of the month. The Social Worker stated she made all the referrals for ancillary services for the facility. She stated she had not been tracking or following up with each of the providers on where people were in the process. She stated she was doing the best she could do with just getting all the referrals made. In an interview on 01/08/25 at 01:30 p.m. with the Dental provider Representative she stated the facility had sent them a referral in April 2024. She stated they saw Resident #13 in May 2024 and evaluated her for a new partial. She stated the resident was pending Medicaid. She stated they reached out to the resident and family and gave them the option of paying or waiting until the resident was approved for Medicaid. She stated they found out in August 2024 the resident had been approved for Medicaid. She stated they sent the facility the form 1263 B around the third week of October 2024, for the physician to complete and they got that back from the facility around the first of November 2024. She stated she was not sure why it took her company so long to send the facility the form they needed. She stated it was not common for it take as long as had taken for this resident. She stated once they got the completed form back from the facility physician, they saw the resident in November for teeth cleaning and again in December for X-rays. She stated they do that to ensure they were attaching her partial to strong healthy teeth. She stated she should be getting her partial by the end of the month. In a follow interview with the Administrator on 01/08/25 at 02:09 p.m. he stated his expectation was the Social Worker should be documenting the progress of any dental procedures and the timeline of completion of care. He stated they did not have a good system in place to track the process at this time. He stated the facility would approve any necessary dental and pay even if it was not covered by Medicaid. He stated dental care should be in the care plan so they everyone had a clear picture of where the process was for the residents and what necessary intervention needed to be in place to ensure any dental needs were met timely. He stated they had checked to see why the documentation from the dental provider was not uploaded into the electronic record and discovered the dental provider had the wrong E-mail address for their medical records. He stated that had been corrected and they were now receiving the documentation from the dental provider which would help them stay on track on the process and assist in timely interventions and communication amongst the staff. He stated going forward this would be a part of the care planning process. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview with MDS B on 01/08/25 at 02:40 p.m. she stated she was responsible for the long-term care plans. She stated they interview staff and the progress notes for any updates that need to be included into the care plan. She stated any dental procedure should be care planned, because often it required an adjustment to the resident's medication orders. She stated the Social Worker had not communicated any dental procedures. She stated she had not seen anything in the clinical record about any dental procedures for Resident #94 or Resident #13. She stated the care plan was the guide for all the care needs for the resident, so everyone involved in the resident's care were aware of the client's needs and the interventions put into place. She stated not having a comprehensive care plan in place could delay necessary care and not alert them to when additional interventions needed to put into place. 3. Record Review of Resident #18's Quarterly MDS, dated [DATE], reflected the resident was a [AGE] year-old female, admitted to the facility on [DATE] with the diagnoses of hypertension (high blood pressure), dementia (loss of cognition), osteoarthritis (arthritis affecting the joints), and allergic rhinitis (allergies of the nose) and a BIMS score of 7 (severely impaired cognition). Record review of Resident #18's care plan with a revision date of 11/20/24 did not address the resident's eczema or interventions to address the problem. Record review of Resident #18's nurse's progress note revealed an appointment return note, dated 04/23/2024, by Charge Nurse F: .Other comments: Resident's eczema now controlled well and her other treatments will continue as ordered . Review of progress note dated 05/01/2024 by Charge Nurse F revealed Resident #18 received Clotrimazole Cream 1% and Triamcinolone Acetonide Cream 0.1% to her whole body for itching. Review of progress note dated 06/26/2024 by Charge Nurse F revealed Resident #18 had red areas on both upper extremities due to itching. Further review revealed nurse's general assessment progress notes dated 07/24/2024, 08/07/2024, 08/21/2024, 09/04/2024, 10/02/2024, 10/16/2024, 10/30/2024, 11/13/24, 11/27/2024, 12/11/2024, 12/25/2024, and 01/08/2025 by Charge Nurse F, Resident #18 had itchy skin and a rash on her body and was treated with a topical prescription cream. Interview on 01/07/2025 at 1:36 PM with Resident #18 revealed her only concern was her itchy skin. Observation of resident's arm and neck revealed she had red and reddish-brown raised areas of her skin with small scratches and cracks. She stated her skin was itchy all over her body and it made it difficult to sleep at night. She stated she had seen a doctor in the past and the staff were putting a cream on her every night, and she also took Benadryl to help with the itching. She stated her skin had this issue before and it had gotten better, but not fully gone all the way away and it had gotten bad again around Christmas time. Interview on 01/08/2025 at 11:09 AM with CNA D revealed Resident #18 was pretty much independent and had rashes on her back and sides of legs and on her neck and commonly complained of itchy skin and was on medication that helped. CNA D stated when the resident complained about being itchy or she noticed the rash looked worse she informed the charge nurse. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 01/08/25 at 11:44 AM with CNA E revealed Resident #18 had complained her skin itched and stated it had been going on for a while on her arms. She was not sure what was causing the rash. Observation and interview on 01/13/25 at 8:40 AM of Resident #18 with Charge Nurse F revealed Resident #18 had a red rash scattered around her stomach, lower and upper back, around the backs of her arms shoulders, and her neck. Charge Nurse F stated Resident #18's rash was all over her body and included her thighs and front of body. She stated that Resident #18 had seen a dermatologist and did not have a diagnosis yet. She stated she noticed a couple weeks ago Resident #18's skin had gotten worse, and the rash had spread. She documented it in the progress notes, and informed ADON C. She stated ADON C informed the Nurse Practitioner who had prescribed medication and they planned on having the resident see a new dermatologist. She stated there had been discussions during morning meeting and they discussed what possible causes of the rash and ADON C had asked the Nurse practitioner if allergy shots might help. The Nurse Practitioner stated a dermatologist would need to see the resident. Interview and observation on 01/13/25 at 10:45 AM with ADON C revealed Resident #18 had issues with itching. ADON C stated Resident #18 had an appointment scheduled on 01/09/2025 with a new dermatologist but bad weather resulted in it needing to be rescheduled. He stated they were not sure of a cause yet and were focused on symptom management by the Nurse Practitioner and medications like Atarax, Benadryl and topical creams. ADON C stated her rash recently had gotten worse and they planned to have Resident #18 see a different dermatologist. ADON C stated he thought she was seen by a new dermatologist recently and was not aware the resident missed her appointment due to the ice weather on 01/09/25. ADON C reviewed Resident #18's care plan and revealed the resident's eczema diagnosis was care planned on 01/09/2025 ADON C stated he was not aware the resident's skin condition was not care planned before 01/09/25. Interview on 01/13/2025 at 12:53 PM with MDS B revealed Resident #18 had a rash for quite a while, it was on and off and not consistent, she was not sure of exact date the issue started. The MDS Nurse B stated she was notified today (01/13/25) that Resident #18 had a diagnosis of eczema because the paperwork from the dermatologist visits on 04/23/2024 was found on 01/13/2025. She stated when a resident comes back from the doctor office with a new diagnosis or change in care it should be added into the plan of care. She stated she had not received any documentation from Resident's dermatology visit in April 2024. Interview on 01/13/25 at 1:15 PM with the Director of Nurses and Administrator revealed Resident #18's moderate eczema diagnosis from a dermatologist visit on 04/23/24 should had been care planned because it ensured causes and interventions were identified and a plan of care was followed. The Director of Nurses stated the symptoms of eczema can come and go and it was important to care plan the issue because it helped to identify possible causes and interventions. The Administrator stated he was aware that care plans were a work in progress and while they were good about immediately care planning falls and incidents, the chronic conditions were missed because it had gotten better at some point and there was not clear documentation by the nurse practitioner regarding the resident's skin condition. He stated while the interdisciplinary team was responsible for the care plan, ultimately it was the responsibility of MDS to enter in the information from the meetings into the care plan. The Director of Nurses stated staff needed to be trained on documenting skin issues such as eczema. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the facility's undated policy, Comprehensive Person-centered Resident Care Planning, reflected, .The facility will develop and implement a baseline and comprehensive care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality of care .Each resident's plan of care shall be periodically reviewed and revised by an interdisciplinary team after each MDS assessment, including both the comprehensive and quarterly review assessment to reflect the resident's current care needs. The services provided or arranged by the facility, as outlined by the comprehensive person-centered care plan, will meet professional standards of quality; be provided by qualified persons in accordance with each resident's written plan of care .

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure in accordance with accepted professional standards and practices, medical records maintained on each resident were accurately documented for 1 of 8 (Resident #18) residents reviewed for accuracy of records. The facility failed to ensure Resident #18's physician examination record from a dermatologist visit on 04/23/2024 was uploaded into the electronic health chart and failed to update her diagnoses to include moderate eczema. These failures could place residents at risk for delay in care or treatment and appropriate interventions. Record review of Resident #18's face sheet, dated printed 01/12/2025, reflected the resident had no dermatologist listed as a care provider and no diagnosis of eczema or other skin conditions. Record Review of Resident #18's Quarterly MDS, dated [DATE], reflected the resident was a [AGE] year-old female, admitted to the facility on [DATE] with the diagnoses of hypertension (high blood pressure), dementia (loss of cognition), osteoarthritis (arthritis affecting the joints), and allergic rhinitis (allergies of the nose) and a BIMS score of 7 (severely impaired cognition). Record review of Resident #18's care plan revealed she was at risk for skin breakdown, date initiated 03/02/2023 with interventions that included assess skin daily during care and report any redness or irritation, check for incontinent care, apply a moisture barrier every shift and as needed, notify dietary for nutritional assessment, pressure relieving device to bed/chair. Record review of Resident #18's nurse progress notes revealed a dermatology appointment return note, dated 04/23/2024, written by Charge Nurse F: Follow up appt : for 4 month .Other comments : Resident's eczema now controlled well and her other treatments will continue as ordered Further review of Resident #18's medical record revealed no documentation of a follow up visit with the dermatologist after 04/23/2024 and there was no physician examination record for the visit uploaded into the resident's electronic health record. Interview on 01/13/2025 at 9:13 AM with the Transportation CNA G revealed he was not sure where the physician examination record was for Resident #18's visit on 04/23/2024 was located and typically he made a copy for nursing and gave the original to medical records department in a box on their door. He stated he remembered taking Resident #18 to the appointment and she needed a follow up appointment in 4 months but she was better around that time and did not want to go to the dermatologist so a follow up was not scheduled. He stated recently the rash was worse and she had an appointment scheduled on 01/09/2025 that was rescheduled due to bad weather. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview and observation on 01/13/2025 at 12:12 PM with the Director of Nursing reviewed Resident #18's electronic health record and stated she did not see documentation from the dermatologist visit on 04/23/2024. She stated the physician examination record from the dermatology visit should have been provided to staff by the transportation aide and should have been uploaded into the resident's electronic health record. She stated she was going to look for it immediately. Interview on 01/13/25 at 12:17 PM with ADON C revealed Resident #18's physician examination record from her dermatologist visit on 04/23/2024 was found in a drawer at the nurse's station today and he was not sure who placed it there and why it was not found earlier. He stated the transportation aide was supposed to make a copy for themselves and the nurses, and then they placed the original in the box for medical records. Record review of physician examination record for Resident #18 titled Physician Examination Record, dated and signed by Physician H on 04/23/2024, reflected resident had moderate eczema that was controlled, with new orders and instructions for a follow up appointment in 4 months. Interview on 01/13/25 at 12:59 PM with Medical Records revealed Resident #18's paperwork from her dermatology visit on 04/23/2024 was found in a drawer at the nurse's station and her diagnosis of moderate eczema had not been added to the medical record. She stated a situation like this had happened before and there was a box in the front of her door that was for the Transportation Aide to place original physician visit summaries. She stated the transportation aide was responsible to make a copy for themselves and nursing, MDS, and medical records gets the original plus any progress note or order to go with it. She stated if the process was not followed and medical records, they did not receive the appointment return paperwork, they were not able to treat residents properly. Interview on 01/13/25 at 1:15 PM with the Director of Nursing and Administrator revealed they were made aware today of Resident #18's missing dermatology physician examination record from April of 2024. She stated it was found in the drawer at the nurse's station, which was not their process for physician examination records. The Director of Nursing stated Resident #18's physician exam record should have been scanned and added to her electronic chart with an updated diagnosis of moderate eczema. She stated it was important for resident records to have updated diagnoses and after visit summaries in the resident's chart so they can ensure interventions were identified and a plan of care was followed. The Director of Nursing stated Resident #18's physician examination record should have gone from the transportation aide to the nurse, then the nurse placed the document in the medical records box to be scanned and upload to the electronic record and update the MDS or care plan if needed. The Director of Nursing stated they planned to improve the process and were going to discuss in morning meetings any residents with appointments the previous day to ensure the process was followed. The Administrator stated he expected staff to follow the process the Director of Nursing outlined regarding the clinical records and ultimately it was the MDS nurse's responsibility to update the resident's clinical record. The Administrator stated it was important the resident's records were accurate and updated to ensure the plan of care was followed. Review of facility's clinical records policy titled Clinical Records, undated, reflected .Clinical records are maintained on each resident in accordance with accepted professional standards and practices. Clinical records are complete, accurately documented, readily accessible and systematically organized .

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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** 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 1 of 22 residents (Resident #2) observed for infection control. 1. The facility failed to place Resident #2 in enhanced barrier precautions who had a dialysis central venous access device and peritoneal catheter (a tube that is placed through the abdomen into the peritoneum used to clean the blood inside your body). 2. The facility failed to ensure CNA A performed hand hygiene during incontinence care for Resident #2. These failures could place residents at risk of transmission of multidrug-resistant organisms. Findings included: Record review of Resident #2's admission MDS assessment dated [DATE] reflected a [AGE] year-old female admitted to the facility on [DATE]. Resident had a BIMS score of 11 which indicated she was moderately cognitively impaired. Diagnoses included type 2 diabetes mellitus, end stage renal disease (kidney failure) and cerebral vascular accident. Resident #2 had received hemodialysis for the 14 days look back period. Record review of Resident #2's comprehensive care plan initiated on 12/17/24, did not reflect Resident #2 required Enhanced Barrier Precautions. Record Review of Resident #2's Physician Orders Report dated 01/09/25, reflected Dialysis port-(Peritoneal Abdomen) Cleanse with Normal saline, pat dry with gauze, apply skin prep to peri port, apply split gauze, secure/cover and tape every 72 hours .Dialysis-access site check- Check dialysis access site for thrill and bruit, redness, swelling, drainage, temperature of skin surrounding site, peripheral pulses, bleeding and intact every shift The orders did not indicate the resident required Enhanced Barrier Precautions. In an observation on 01/07/25 at 11:04 a.m. revealed no signage posted outside of Resident #2's room for enhanced barrier precautions. CNA A entered Resident 2's room to answer her call light. Resident #2 stated she needed her brief changed. CNA A washed her hands and put on gloves. Upon uncovering the resident, it was revealed Resident #2 had a peritoneal dialysis catheter which was unsecured. CNA A pushed the soiled brief down and cleaned the resident from front to back. CNA A then reached up and repositioned the peritoneal catheter while wearing soiled gloves. CNA A assisted the resident onto her side revealing the Resident had loose bowel movement. CNA A cleaned from front to back, removed gloves and sanitized hands and put on clean gloves and then applied a clean brief. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview with CNA A on 01/07/25 at 11:15 a.m. she stated she was working as a float and was not certain if Resident #2 was on enhanced barrier precautions or not. She stated there were not a sign indicating enhanced barrier precautions and there were no supplies in the room. She stated when someone was on enhanced barrier precautions the facility placed a kit on the wall which contained gloves and gowns. She stated she knew anyone with a G-tube, catheter or wounds were supposed to be on enhanced barrier precautions. She stated she did not realize she had touched the peritoneal catheter with dirty gloves and stated that would have cross contaminated the catheter. In an interview on 01/07/25 at 11:55 a.m. with the DON she stated a sign should be outside of the door of any resident who required enhanced barrier precautions and the required supplies of gloves and gowns should be available. She stated Nurse management and Charge nurses were responsible for ensuring Residents who had significant wound, central lines, catheter, and G-tubes were in enhanced barrier precautions. She stated she did not consider the peritoneal dialysis catheter, or her dialysis access site would require enhanced barrier precautions, since they were not accessing those sites. She stated the Peritoneal catheter was not in use but stated she had only been with the facility for a few weeks and would have to check the policies to determine if the resident should be in enhanced barrier precautions. She stated when the CNA touched the peritoneal catheter with dirty gloves, she had cross contaminated it. She stated the catheter should be secured and she was on her way to secure the catheter. In an interview on 01/08/25 at 04:30 p.m. with the Corporate Nurse she stated any resident with an indwelling medical device should be placed in Enhanced Barrier Precautions. She stated even though the peritoneal dialysis catheter was not in use it was still indwelling which would quality for Enhanced Barrier Precautions. She stated dialysis fistula alone would not put them in isolation, but if a resident had a central hemodialysis line, which Resident # 2 had, then that would also require them to be in Enhanced Barrier Precautions. She stated they had reviewed all the residents in the facility and made sure signage was posted and supplies were in the rooms for those residents who required Enhanced Barrier Precautions and would be doing further training and education to the staff. In an interview on 01/13/25 at 11:03 a.m. with ADON C he stated he was aware upon the Resident #2's admission she had a peritoneal dialysis catheter but stated it was not in use. He stated she had a central venous catheter for her hemodialysis. He stated at the time they did not think it was necessary to place her in Enhance Barrier Precautions. He stated Enhanced Barrier Precautions were new to the facility and they were still learning. He stated he knew residents with catheters, G-tubes, central lines, and wounds had to be in enhanced barrier precautions, but it just did not register that this resident needed it. He stated they had since been educated and had a better understanding of who needed that type of precautions. ADON C stated the risk of not placing someone who needed Enhanced Barrier Precautions were predisposing them to infections. Record review of an E-mail provided by the facility's Director of Corporate Compliance dated 01/08/24, reflected, Residents Requiring EBP, Indwelling Medical Devices (regardless of MDRO) central lines, urinary catheters, feeding tubes, tracheostomies,Duration .discontinuation of indwelling devices .Required PPE (gown/gloves) during High-Contact Resident care .Dressing, Bathing/showering, Transferring, Providing Hygiene, Changing linens, Toileting/Changing Brief, Device Care/Use, Wounds/Skin care & treatment . Implementation .Staff awareness .Update Care profile .Update POC,EBP Signage, PPE set up-Gloves, Gown, Hand Sanitizer (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676485	A. Building B. Wing	01/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Princeton Medical Lodge	1401 W. Princeton Dr. Princeton, TX 75407

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record Review of the facilities undated policy titled, Hand Washing, reflected, Hand washing is required before and after a procedure that involves direct or indirect contact with a resident, after contact with any wastes or contaminated materials .or at any time the hands are soiled .