

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455485	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/18/2024
NAME OF PROVIDER OR SUPPLIER Petal Hill Nursing & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 900 S Baxter Ave Tyler, TX 75701	

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)
<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44637</p> <p>Based on interview and record review the facility failed to provide pharmaceutical services, including the accurate acquiring, administering and receipt of all drugs and biologicals, to meet the needs of 1 of 4 (Resident #2) residents reviewed for pharmacy services.</p> <p>The facility failed to ensure Resident #2 was administered his Ambien (a medication to treat insomnia) for 3 days while he was admitted to the facility for respite care.</p> <p>This failure could place residents who receive medications at risk of not receiving the intended therapeutic benefit of the medications.</p> <p>Findings included:</p> <p>1. Record review of the face sheet dated 4/18/24 indicated Resident #2 was admitted to the facility on [DATE] with diagnoses including weakness, hemiplegia and hemiparesis (one-sided weakness or paralysis) following a stroke affecting the left side, insomnia, and anxiety.</p> <p>Record review of the physician orders dated 4/18/24 indicated Resident #2 was admitted to the facility for respite care on 3/22/24. The physician orders indicated Resident #2 had an order for Ambien 12.5mg at bedtime for insomnia starting 3/23/24.</p> <p>Record review of the MAR dated March 2024 indicated Resident #2 did not receive his Ambien on 3/23/24, 3/24/24, 3/25/24, or 3/26/24.</p> <p>Record review of the MDS dated [DATE] indicated Resident #2 admitted to the facility on [DATE] and discharged on [DATE]. The MDS indicated Resident #2 understood others and was understood by others. The MDS indicated Resident #2 had a BIMS of 12 and was moderately cognitively impaired.</p> <p>(continued on next page)</p>

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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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of the Pharmacy Manifest dated 3/23/24 indicated Resident #2's amlodipine 80mg (medication for elevated blood pressure), aripiprazole 2mg (medication to treat depression and bipolar disorder), atorvastatin 80 mg (medication to treat elevated cholesterol), buspirone 5mg (medication to treat anxiety), desvenlafaxine 100mg (medication to treat depression), Eliquis 5mg (medication to treat and prevent blood clots and prevent stroke), Jardiance 10mg (medication to treat elevated blood sugar), levetiracetam (medication to treat seizures), methocarbamol 500mg (medication to treat muscle spasms and pain), metoprolol 50mg (medication to treat elevated blood pressure), and mirtazapine 30mg (medication to treat depression), phenytoin 100mg (medication to prevent seizures) were delivered to the facility.</p> <p>Record review of the pharmacy manifest dated 3/24/24 indicated Resident #2's Lantus (medication to treat elevated blood sugar) was delivered to the facility.</p> <p>During an interview on 4/12/24 at 1:24 p.m. Resident #2's family said he was admitted to the facility for respite care on 3/22/24. Resident #2's family said when they arrived at the facility to visit Resident #2 on 3/22/24 at approximately 9:40 a.m. his medications from home had been left on the nightstand. Resident #2's family said the went and asked nurse about medications. Resident #2's family said when the asked the nurse they were told Resident #2's home medications would be administered to him. Resident #2's family said his meds were past due and they had to administer the resident's medications on 3/22/24. Resident #2's family said he only received his medications from the facility twice.</p> <p>During an interview on 4/16/24 at 2:20 p.m. the DON said the facility did not have any Ambien for Resident #2 while he was admitted for respite. The DON said Resident #2 was admitted under insurance respite care and not hospice respite care. The DON said this was the first time she had a resident under insurance respite care. The DON said the insurance case manager sends medical records to the facility and then the facility and the family coordinate medications, transportation, etc. The DON said the facility's transportation picked up Resident #2 from home with his medications. The DON said the family had sent his medications. The DON said the medical records they received indicated Resident #2 had an order for Ambien 10mg at bedtime. The DON said the facility did not receive Resident #2's Ambien from his family The DON said she did not follow-up with the family or insurance regarding Resident #2's Ambien.</p> <p>During an interview on 4/17/24 at 11:10 a.m. the DON said the facility did not have a policy for respite care.</p> <p>During an interview on 4/17/24 at 11:53 a.m. the DON said the facility had received Resident #2's clinical information and list of current medication from his insurance company. The DON said the list of current medications provided was how the facility knew what Resident #2's medication orders were. The DON said it was the family's responsibility to supply all Resident #2's medications. The DON said their doctor was not going to order medication for a respite care resident especially if the medication was a narcotic. The DON said there was no documentation of the admitting nurse contacting the family or physician regarding Resident #2's order for Ambien. The DON said without documentation she did not know how it could be proven the nurse contacted anyone regarding the Ambien and its order. The DON said the Medical Director would take responsibility for a respite resident and their care needs while they were in the facility.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 4/17/24 at 1:44 p.m. Resident #2's family said Resident #2 took Ambien at bedtime to help him sleep. Resident #2's family said the facility did not reach out to her regarding any medication. Resident #2's family said they told her they were going to use Resident #2's home medications while he was in the facility.</p> <p>During an interview on 4/17/24 at 2:16 p.m. the DON said the facility's pharmacy delivered all medications for Resident #2 except Ambien. The DON said when orders were put in the facility's electronic medical records for a resident if a box was not checked saying, medications on hand, the order went to the pharmacy. The DON said a designated agent would have needed to call in the Ambien into the pharmacy as it was a narcotic.</p> <p>During an interview on 4/18/24 at 8:58 a.m. RN E said the admitting nurse was responsible for ordering a new resident's medication from the pharmacy. RN E said if a medication did not come (including a narcotic) they should pull it from the electronic dispensing system the facility had for emergencies and when a medication was not yet received from the pharmacy if available. RN E said if a resident admitted for respite care and [NAME] medications from home but did not bring a medication they had an order for the nurse should order it from the pharmacy. RN E said it was important to ensure residents received all their ordered medication was for them to get the therapeutic benefit of the medications.</p> <p>During an interview on 4/18/24 at 10:03 am LVN H said the admitting nurse was responsible for ensuring a newly admitted resident's medications were ordered. LVN H said if a medication did not come in from the pharmacy, then the nurse should reach out to the provider. LVN H said if a newly admitted resident was at the facility for respite and the family was providing their medications and the family did not bring a medication the resident had an order for the nurse should reach out to the family and then the provider if the family cannot supply the medication. LVN H said it was important for residents to receive their ordered medications because of the diagnoses they have.</p> <p>During an interview on 4/18/24 at 10:10 am the DON said if a newly admitted resident's medication did not come from the pharmacy, she expected the nurses to obtain it from the emergency kit if it was available. The DON said if it was a respite care resident, and the family or hospice company did not provide all the medication that were ordered for the resident she expected the nurses to reach out to the family or hospice company. The DON said after reaching out to the family or hospice company for medication if they could not provide the medication, she expected the nurses to reach out to the pharmacy to get the medication. The DON said the importance for a respite care resident continuing to receive all the medications they had orders for and were receiving at home was for continuity of care.</p> <p>Record review of the facility's Medication Reordering policy dated 4/2024 indicated, It is the policy of this facility to accurately and safely provide or obtain pharmaceutical services including the provision of routine and emergency medications and biologicals in a timely manner to meet the needs of each resident .</p>		

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<p>F 0770</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide timely, quality laboratory services/tests to meet the needs of residents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44637</p> <p>Based on interview and record review the facility failed to ensure laboratory services were obtained to meet the needs for 1 of 5 (Resident #1) residents reviewed for laboratory services.</p> <p>The facility did not ensure Resident #1 had a CBC (complete blood count-used to look at overall health and find a wide range of conditions including anemia (condition in which the blood does not have enough healthy red blood cells) and infection) and CMP (complete metabolic panel-test that checks the body's fluid balance and levels of electrolytes) lab tests every 6 months as ordered.</p> <p>This failure could place the residents at risk of not receiving lab services as ordered and suffering from an undetected infection, decreased electrolyte balances, dehydration, and decreased kidney function.</p> <p>Findings included:</p> <p>1. Record review of the face sheet dated 4/18/24 indicated Resident #1 was an [AGE] year-old female, readmitted to the facility on [DATE] with diagnoses including vitamin deficiency, protein-calorie malnutrition (the state of inadequate intake of food occurring in the absence of inflammation, injury, or another condition that elicits a systemic inflammatory response), adult failure to thrive (when an older adult has loss of appetite, eats less than usual, loses weight, and is less active than normal), and anemia (lack of blood).</p> <p>Record review of the physician orders dated 4/18/24 indicated Resident #1 had an order for a CBC and CMP every 6 months in March and September starting 9/14/22. The physician orders indicated Resident #1 had an order for a valproic acid level (measures the amount of valproic acid in the blood) every three months starting 1/9/24. The physician orders indicated Resident #1 had an order for a thyroid stimulating hormone (TSH) level (a blood test that measure the amount of thyroid stimulating hormone) yearly in March starting 3/14/23.</p> <p>Record review of the MDS dated [DATE] did not indicate if Resident #1 was understood by other or understood others. The MDS did not indicate if Resident #1 had a BIMS assessment.</p> <p>Record review of the care plan revised on 2/8/24 indicated Resident #1 was resistive to care and would refuse lab draws, medications, and baths/showers. The care plan indicated Resident #1 had a nutritional problem or potential nutritional problem related to dementia and swallowing.</p> <p>Record review of the lab results dated 4/13/23 indicated Resident #1 had a TSH level drawn.</p> <p>Record review of the lab results dated 5/16/23 indicated Resident #1 had a valproic acid level drawn.</p> <p>Record review of the lab results dated 5/22/23 indicated Resident #1 had a TSH level drawn.</p> <p>Record review of the lab results dated 5/30/23 indicated Resident #1 had a valproic acid level drawn.</p> <p>(continued on next page)</p>		

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<p>F 0770</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of the lab results dated 1/11/24 indicated Resident #1 had a valproic acid level drawn.</p> <p>Record review of the lab results dated 3/14/24 indicated Resident #1 had CBC, TSH, CMP levels drawn.</p> <p>Record review of all lab results for 2023 and 2024 indicated Resident #1 only had a CBS and CMP drawn on 3/14/24.</p> <p>During an interview on 4/16/24 at 9:30 a.m. the DON said Resident #1 sometimes refused labs. The DON said she was reaching out to the lab to obtain their records for Resident #1.</p> <p>During an interview on 4/17/24 at 1:53 p.m. the DON said she had talked to the lab and was informed by the lab they did not have an order for Resident #1's CBC and CMP to be drawn in March and September of 2023. The DON said the lab told her they had requested from the previous DON a lab orders audit of routine labs for 2023 at the end of 2022 and beginning of 2023. The DON said the lab told her they never received the audit, so they did not draw the labs or have an order to draw the labs on Resident #1 in 2023.</p> <p>During an interview on 4/18/24 at 10:03 a.m. LVN H said it was the nurse's responsibility to ensure routine labs were drawn. LVN H said the importance of routine labs was to monitor for certain medication levels, infection, and dehydration.</p> <p>During an interview on 4/18/23 at 10:10 a.m. the DON said every morning in morning meeting they reviewed to ensure labs that were supposed to have been drawn the previous day had been drawn. The DON said if they find a lab was not drawn, they reach out to the lab to find out the reason why and get the lab scheduled to be drawn. The DON said the importance of ensuring routine labs were drawn was because if they had an order for a lab there must be a reason for it.</p> <p>Record review of the facility's Laboratory Services and Reporting policy dated 11/2023 indicated, The facility must provide or obtain laboratory services when ordered by a physician, physician assistant, nurse practitioner, or clinical specialist according with state law .The facility is responsible for the timeliness of the services .</p>

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<p>F 0800</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44637</p> <p>Based on observation, interview, and record review the facility failed to provide each resident with a nourishing, well-balanced diet that meets his or her daily nutritional and special dietary needs, taking into consideration the preferences of each resident for 1 of 3 (Resident #3) residents reviewed for diets.</p> <p>The facility failed to ensure Resident #3 received his health shake or double meat portion at lunch on 4/16/24.</p> <p>This failure could place resident at risk for weight loss, altered nutritional status and diminished quality of life.</p> <p>Findings included:</p> <p>1. Record review of a face sheet dated 4/18/24 indicated Resident #3 was readmitted to the facility on [DATE] with diagnoses including dysphagia (difficulty swallowing), diabetes, hypertension (elevated blood pressure), and pneumonia.</p> <p>Record review of the physician orders dated 4/18/24 indicated Resident #1 had an order med pass (supplement) four times a day and have nurse thicken to honey starting 3/12/24. The physician orders did not indicate what Resident #3's diet was.</p> <p>Record review of the MDS dated [DATE] indicated Resident #3 understood others and was understood by others. The MDS indicated Resident #3 had a BIMS of 14 and was cognitively intact. The MDS indicated Resident #3 required setup or clean-up assistance with eating (the ability to use suitable utensils to bring food and/or liquid to the mouth and swallow food and/or liquid once the meal was placed before the resident). The MDS indicated Resident #3 required a mechanically altered diet (require change in texture of food or liquids (e.g., pureed food, thickened liquids).</p> <p>Record review of the care plan last revised on 2/16/24 indicated Resident #3 was at risk for complications due to non-compliance with physician orders-mechanical soft food with honey thickened liquids. The care plan indicated Resident #3 had a potential nutritional problem related to diet restrictions of mechanical soft food with honey thickened liquids. The care plan indicated Resident #3 was non-compliant with his diet and liquids and would have other residents give him thin liquids and regular textured foods.</p> <p>Record review of the diet type report dated 4/17/24 indicated Resident #3 was on a mechanical soft diet with honey thickened liquids and fortified foods.</p> <p>Record review of a meal ticket dated 4/17/24 indicated Resident #3 was to receive a mechanical soft diet with honey thickened liquids. The meal ticket indicated Resident #3 had special needs including fortified foods, shake with all three meals, and double portions of meat.</p> <p>(continued on next page)</p>		

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<p>F 0800</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an observation and interview on 4/16/24 at 12:19 p.m. Resident #3's meal card indicated he was to receive a health shake with each meal and double portions of meat. Resident #3's lunch tray did not have a health shake or double portion of meat on it. Resident #3 said he drank the health shakes when they put them on his tray, and he liked the extra meat. Resident #3 said he did not always receive health shakes or extra meat.</p> <p>During an interview on 4/18/24 at 8:58 a.m. RN E said the nurses were responsible for checking the meal trays. RN E said nurses checked the meal trays against the meal ticket and were ensuring the residents received the ordered diet, correct consistency of food and drink, any supplements (health shake), and any double portions. RN E said if the meal tray was incorrect, it should be taken back to the kitchen to get the correct meal.</p> <p>During an interview on 4/18/24 at 9:23 a.m. CNA F said it was the nurse's responsibility to check the meal trays to ensure residents were receiving the correct diet, texture, portions, and supplements. CNA F said it was important to ensure resident received the correct texture of food to prevent choking. CNA F said it was important to ensure residents received the correct portion because it was their right to have extra food if requested or to aide in meeting nutritional needs.</p> <p>During an interview on 4/18/24 at 9:25 a.m. CNA G said nurses were responsible for checking meal trays and fluid consistency. CNA G said if a resident received the wrong diet or fluid consistency it could cause them to choke.</p> <p>During an interview on 4/18/24 at 10:03 a.m. LVN H said the nurses were responsible for checking the meal trays for diet consistency. LVN H said meal trays were checked against the meal ticket. LVN H said it was important to check the meal trays to ensure residents were not getting something they were allergic to and to prevent aspiration.</p> <p>During an interview on 4/18/24 at 10:10 a.m. the DON said it was the nurse's responsibility to check the meal trays. The DON said nurses checked the meal trays against the meal ticket for diet and fluid consistency. The DON said the importance of ensuring the residents' meal trays matched their meal tickets was in case a mistake was made because they cannot serve a meal that does not match the ticket.</p> <p>During an interview on 4/18/24 at 1:05 p.m. the Administrator said he expected the dietary staff while preparing the trays and the nursing staff while passing out the trays to ensure residents were receiving the appropriate diets and fluids including consistencies. The Administrator said it was important to ensure residents received the correct diet and fluids for their well-being.</p> <p>Record review of the facility's Nutritional and Dietary Supplements policy dated 4/9/24 indicated, It is the policy of this facility that nutritional and dietary supplements will be used to complement a resident's dietary needs in order to maintain adequate nutritional status and resident's highest practicable level of well-being . Nutritional Supplements refers to products that are used to complement a resident's dietary needs such as calorie or nutrient dense drinks, total parenteral products, enteral products and meal replacement products (e. g., Ensure, Glucerna, Promote) . The facility will provide nutritional and dietary supplements to each resident, consistent with the resident's assessed needs .</p> <p>(continued on next page)</p>		

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<p>F 0800</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of the facility's Liberalized Diets policy dated 4/9/34 indicated, It is the policy of this facility to incorporate individualized, liberalized diets for residents in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' specific goals, needs and preferences . Diet consideration is determined with the resident and in accordance with their informed choices, goals and preferences, rather than exclusively by diagnosis. The facility will work with the resident's practitioner and other members of the IDT team (dietitian, dietary manager, nursing, speech therapists, etc.) to determine the best plan for the resident and accommodate the resident's needs, preferences, and goals and update the care plan accordingly. Unless a medical condition warrants a restricted diet, consider beginning with a regular diet and monitor how the resident and their condition related to their goals regarding nutritional status and their physical, mental and psychosocial well-being .</p>

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<p>F 0805</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44637</p> <p>Based on observation, interview, and record review, the facility failed to ensure honey thickened liquids were prepared in a form designed to meet individual needs for 1 of 3 residents (Resident #3) reviewed for food form and preparation.</p> <p>The facility failed to ensure Resident #3 received honey thickened liquids with his lunch meal on 4/16/24 and 4/17/24.</p> <p>This failure could place residents who received thickened liquids at risk of consuming liquids that could cause choking and aspiration (when something you swallow goes down the wrong way and enters your airway).</p> <p>Findings included:</p> <p>Record review of a face sheet dated 4/18/24 indicated Resident #3 was readmitted to the facility on [DATE] with diagnoses including dysphagia (difficulty swallowing), diabetes, hypertension (elevated blood pressure), and pneumonia.</p> <p>Record review of the physician orders dated 4/18/24 indicated Resident #1 had an order med pass (supplement) four times a day and have nurse thicken to honey starting 3/12/24. The physician orders did not indicate what Resident #3's diet was.</p> <p>Record review of the MDS dated [DATE] indicated Resident #3 understood others and was understood by others. The MDS indicated Resident #3 had a BIMS of 14 and was cognitively intact. The MDS indicated Resident #3 required setup or clean-up assistance with eating (the ability to use suitable utensils to bring food and/or liquid to the mouth and swallow food and/or liquid once the meal was placed before the resident). The MDS indicated Resident #3 required a mechanically altered diet (require change in texture of food or liquids (e.g., pureed food, thickened liquids).</p> <p>Record review of the care plan last revised on 2/16/24 indicated Resident #3 was at risk for complications due to non-compliance with physician orders-mechanical soft food with honey thickened liquids. The care plan indicated Resident #3 had a potential nutritional problem related to diet restrictions of mechanical soft food with honey thickened liquids. The care plan indicated Resident #3 was non-compliant with his diet and liquids and would have other residents give him thin liquids and regular textured foods.</p> <p>Record review of the diet type report dated 4/17/24 indicated Resident #3 was on a mechanical soft diet with honey thickened liquids and fortified foods.</p> <p>Record review of a meal ticket dated 4/17/24 indicated Resident #3 was to receive a mechanical soft diet with honey thickened liquids. The meal ticket indicated Resident #3 had special needs including fortified foods, shake with all three meals, and double portions of meat.</p> <p>(continued on next page)</p>		

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<p>F 0805</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of the swallow screen progress note dated 12/10/23 indicated Resident #3 had a current diet of pureed and honey thick liquids-no straws. The swallow screen progress note indicated the ST had educated Resident #3 on his diet and importance of complying to prevent choking. The swallow screen progress note indicated Resident #3 was educated on aspiration precautions.</p> <p>Record review of a nursing progress note dated 12/10/23 at 1:39 p.m. indicated, While passing [Resident #3's] room another resident was in room giving [Resident #3] a can of peanuts. [Resident #3] was educated on the importance of sticking to his pureed diet. [Resident #3] refused to give me his peanuts .</p> <p>Record review of a nursing progress note dated 12/31/23 at 1:10 p.m. indicated Resident #3 was educated during lunch regarding eating pureed goods and thickened liquids. The progress note indicated the nurse educated Resident #3 on choking precautions and keeping his head elevated.</p> <p>Record review of a nursing progress note dated 12/31/23 at 1:17 p.m. indicated the nurse provided Resident #3 with a cup of honey thickened cranberry juice. The progress note indicated Resident #3 tolerated the first cup well and started coughing while drinking the second cup. The progress note indicated Resident #3's oxygen level was 84% (normal range is 90-100%). The progress note indicated Resident #3 said he would not go to the hospital. The progress note indicated the nurse put oxygen on Resident #3 via nasal cannula (a device that delivers oxygen through a tube and into the nose). The progress note indicated Resident #3 remained non-compliant with keeping the nasal cannula on.</p> <p>Record review of a nursing progress note dated 12/31/23 at 7:22 p.m. indicated the charge nurse was called to Resident #3's room due to him having a whole can of chicken noodle soup in his mouth. The progress note indicated a CNA reported to the nurse Resident #3 was choking and throwing up the contents.</p> <p>Record review of a nursing progress note dated 1/3/24 at 8:30 p.m. indicated Resident #3's roommate went to the vending machine and purchased chips and a honey bun for Resident #3. The progress note indicated Resident #3 became upset with the nurse when she took the items from him and re-educated him regarding his diet.</p> <p>Record review of a nursing progress note dated 1/3/24 at 9:50 p.m. indicated the nurse was notified by a CNA that Resident #3 had a can of chicken noodle soup and was drinking it. The progress note indicated when the nurse enter the room Resident #3 was holding a chicken noodle soup can and had drunk all the liquid out of it. The progress notes indicated the nurse took the can of chicken noodle soup and re-educated Resident #3 regarding his diet and the risk of aspiration.</p> <p>Record review of a nursing progress note dated 1/21/24 at 2:43 p.m. indicated when Resident #3 was transferred by a CNA the CNA found chocolate Butterfinger on his mouth and body. The progress note indicated the nurse advised Resident #3 of his diet.</p> <p>Record review of a nursing progress note dated 2/15/24 at 9:10 p.m. indicated Resident #3 received a new order to upgrade his diet to mechanical soft. The progress note indicated Resident #3 was served a mechanical soft diet for supper and did not have any coughing or choking.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Petal Hill Nursing & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 900 S Baxter Ave Tyler, TX 75701	
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<p>F 0805</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of a nursing progress note dated 3/2/24 at 10:38 a.m. indicated Resident #3 had drank coffee without thickening in it and without notifying the nurse. The progress note indicated Resident #3 was able to drink the coffee without thickening without incident. The progress note indicated when Resident #3's hospice nurse arrived he asked he if he could drink coffee without thickening moving forward. The progress note indicated the hospice nurse told Resident #3 she would check with his weekday nurse.</p> <p>During an observation on 4/16/24 at 12:20 p.m. CNA B obtained thickened liquid from the nurse and took to Resident #3.</p> <p>During an observation and interview with LVN C on 4/16/24 at 12:22 pm revealed the thickened liquid in nurse cart provided to CNA B for Resident #3 was nectar thickened and not honey thickened. LVN C said the nectar thickened liquid in her nurse cart was what was provided to CNA B for Resident #3. LVN C said she was unaware of what Resident #3's liquid order was for as she was not his nurse. LVN C said CNA B did not ask for a specific thickness for Resident #3. LVN C said she did not ask CNA B what specific thickness of liquid Resident #3 had ordered. LVN C said a resident who was given the incorrect thickness of liquid could aspirate.</p> <p>During an interview on 4/16/24 at 12:24 p.m. CNA B said she did not know what thickness of liquid she got for Resident #3. CNA B said the liquid in Resident #3's cup was what the nurse gave her. CNA B said she did not ask for a specific thickness of liquid when she asked the nurse for thickened liquid for Resident #3. CNA B said if a resident received the incorrect thickness of liquid, it could cause them to cough and choke.</p> <p>During an observation 4/16/24 at 12:26 p.m. LVN C came in Resident #3's room and took the nectar thickened liquid away.</p> <p>During an observation on 4/17/24 at 12:00 p.m. Cook D gave Resident #3 thin liquids.</p> <p>During an interview and observation on 4/17/24 at 12:01 p.m. Cook D said she was not checking the resident's meal tickets before providing them with a beverage to know if they required thickened liquids or not. Cook D said she usually prepares the trays and the only reason she was passing them was she did not have anyone in the dining room to pass trays. Cook D said Resident #3 was supposed to get thickened liquids. Cook D was observed taking the thin liquid tea from Resident #3 and giving him honey thickened water.</p> <p>During an interview on 4/18/24 at 8:58 a.m. RN E said the nurses were responsible for ensuring resident received the proper consistency of fluids (thin, nectar thick, honey thick, etc.). RN E said the importance of resident receiving the appropriate fluid consistency was to prevent aspiration.</p> <p>During an interview on 4/18/24 at 9:23 a.m. CNA F said nurses were responsible for checking fluid consistency and ensuring resident were receiving the correct fluid consistency. CNA F said it was important to ensure resident received the correct fluid consistency to prevent aspiration.</p> <p>During an interview on 4/18/24 at 9:25 a.m. CNA G said nurses were responsible for checking meal trays and fluid consistency. CNA G said if a resident received the wrong diet or fluid consistency it could cause them to choke.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Petal Hill Nursing & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 900 S Baxter Ave Tyler, TX 75701	

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<p>F 0805</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 4/18/24 at 10:03 am LVN H said nurses were responsible for checking fluid consistency. LVN H said the importance of checking the resident had the correct fluid consistency was to prevent aspiration.</p> <p>During an interview on 4/18/24 at 10:10 a.m. the DON said it was the nurse's responsibility to check the meal trays. The DON said nurses checked the meal trays against the meal ticket for diet and fluid consistency. The DON said the importance of ensuring the residents' meal trays matched their meal tickets was in case a mistake was made because they cannot serve a meal that does not match the ticket.</p> <p>During an interview on 4/18/24 at 1:05 p.m. the Administrator said he expected the dietary staff while preparing the trays and the nursing staff while passing out the trays to ensure residents were receiving the appropriate diets and fluids including consistencies. The Administrator said it was important to ensure residents received the correct diet and fluids for their well-being.</p> <p>Record review of the facility's Thickened Liquid policy dated 4/9/24 indicated, The facility provides commercially prepared thickened liquids, as prescribed, to residents who require them.</p> <p>Thickened Liquids refer to liquids in which the consistency has been altered to facilitate safe, oral intake .The use of thickened liquids will be based on the resident's individual needs as determined by the resident's assessment, and will be in accordance with the resident's goals and preferences .Residents with swallowing difficulties or orders for thickened liquids are to be referred to speech-language pathologist for screening and evaluated as indicated .Nursing staff are responsible for notifying dietary staff of the need for thickened liquids, including category/consistency. The consistency shall be added to the resident's tray card and medication administration record .</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>44637</p> <p>Based on observation, interview, and record review, the facility failed to store, distribute and serve food in accordance with professional standards for food service safety in the facility's only kitchen.</p> <p>The facility did not ensure dietary staff had their hair restrained while in the kitchen.</p> <p>These failures could place residents at risk of cross-contamination and foodborne illness.</p> <p>Findings included:</p> <p>During an observation and interview on 4/16/24 at 2:42 p.m. Dietary Aide A was observed in the kitchen without his hair secured/restrained. Dietary Aide A said he had just clocked in and had not put on a hair net yet. Dietary Aide A said they were out of hair nets in the kitchen. Two other dietary employees in the kitchen (including the cook) were observed without their hair secured/restrained.</p> <p>During an interview on 4/16/24 at 2:45 p.m. the DM said dietary employees had to get hair nets out of the case in the kitchen to secure/restrain their hair if they were not wearing a cap or bonnet. After checking the DM said the kitchen was out of hair nets. The DM said she needed to get some more hair nets. The DM said the importance in dietary staff to wear hair nets in the kitchen was to keep hair out of the food.</p> <p>During an interview on 4/17/24 at 10:10 am the DON said she expected anyone who entered the kitchen to have their hair secured by a hair net, cap, or bonnet. The DON said if the kitchen staff knew they were out of hair nets they should have told someone. The DON said the importance of ensuring hair was restrained was for hygiene and to keep hair out of the food.</p> <p>During an interview on 4/17/24 at 1:05 p.m. the Administrator said the facility's policy only indicated hair nets had to be worn when handling or preparing food. The Administrator said hair nets were not required when just walking through the kitchen. The Administrator said he would prefer anyone in the kitchen to have a hair net in place. The Administrator said the importance of hair nets/restraints was for hygiene.</p> <p>Record review of the facility's Maintaining Sanitary Tray Line dated 4/9/24 indicated, This facility prioritizes tray assembly to ensure foods are handled safely and held at proper temperatures to prevent the spread of bacteria that may cause food borne illness .During tray assembly, staff shall .Wear hair restraints (bonnets, caps, nets, to cover hair) when preparing or handling food .</p>		

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<p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44637</p> <p>Based on observation, interview, and record review, the facility failed to provide a safe, sanitary, and comfortable environment for residents, staff and the public for 1 of 1 building reviewed for physical environment.</p> <ol style="list-style-type: none"> The facility did not ensure the door to the dining room was not damaged and had thick plastic peeling off it. The facility did not ensure the bathroom in room [ROOM NUMBER] did not have tiles that had fallen off the wall, wallpaper peeling off the wall, the baseboard warped, and a drawer to the vanity with the face peeling off. <p>This failure could place all residents at risk for an unsafe, unsanitary, and uncomfortable environment.</p> <p>Findings included:</p> <ol style="list-style-type: none"> During an observation and interview on 4/16/24 at 10:41 a.m. indicated tiles had fallen off the bottom of the wall, the face of the vanity bottom drawer was peeling off, wallpaper was peeling in 2 different areas under the sink, and the baseboard was warped. The resident residing in room [ROOM NUMBER] said she did not look at it. During an observation on 4/16/24 at 12:03 p.m. the door to dining room was damaged with hard thick plastic peeling off. <p>During an interview on 4/17/24 at 11:42 am the Maintenance Director said he did daily walkthroughs of resident rooms and inspects 5-6 rooms per day. The Maintenance Director said they were aware of renovations that needed to be done throughout the facility and had contacted corporate regarding doing renovations. The Maintenance Director said he had not seen room [ROOM NUMBER] bathroom. The Maintenance Director said when a resident did start complaining about their room or bathroom having issues (missing tiles, peeling wallpaper, etc.) they started renovations on that resident's room.</p> <p>During an interview on 4/17/24 at 2:05 p.m. the Maintenance Director said there was a maintenance logs at the nurse's station where staff could write down things that needed to be done, but once he had completed the task, he threw away the log. The Maintenance Director said he did not keep a log of tasks/repairs performed daily. The Maintenance Director said they did not have documentation of contacting corporate about renovations. The Maintenance Director said corporate does a walk-through approximately 1-2 times a month and they are verbally told about things that need to be done. The Maintenance Director said corporate was last here at the beginning of April 2024.</p> <p>During an interview on 4/17/24 at 1:05 p.m. the Administrator he expected the Maintenance Director to make rounds daily and to see at least every bathroom monthly. The Administrator said the importance of upkeep to the building (tile on walls, wallpaper not peeling, baseboard not warped, etc) was to provide customer service to the residents.</p> <p>(continued on next page)</p>

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<p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of the facility's Safe and Homelike Environment policy dated 11/2023 indicated, In accordance with the residents' rights, the facility will provide a safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible .Environment refers to any environment in the facility that is frequented by residents, including (but not limited to) the residents' rooms, bathrooms, hallways, dining areas, lobby, outdoor patios, therapy areas .Sanitary includes, but is not limited to, preventing the spread of disease-causing organisms by keeping resident care equipment clean and properly stored. Resident care equipment includes, but is not limited to, equipment used in the completion oof activities of daily living .Housekeeping and maintenance services will be provided as necessary to maintain a sanitary, orderly, and comfortable environment .Report any unresolved environmental concerns to the Administrator .</p>		

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<p>F 0925</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Make sure there is a pest control program to prevent/deal with mice, insects, or other pests.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44637</p> <p>Based on observation, record review, and interview the facility failed to have an ongoing and effective pest control program for 1 of 1 building reviewed for pest control.</p> <p>The facility did not have an effective pest control program to eradicate the cockroaches in the facility.</p> <p>The facility failure placed residents at risk for diarrhea, dysentery (infectious diarrhea), salmonella (an infection that can lead to diarrhea, fever, and stomach cramps), and other serious health concerns.</p> <p>Findings included:</p> <p>1. Record review of the Pest Control Report dated 8/8/23 indicated American cockroaches we found in room [ROOM NUMBER] and in the rest rooms and German cockroaches were found in room [ROOM NUMBER].</p> <p>Record review of the Pest Control Report dated 9/14/23 indicated the facility was treated for cockroaches. The Pest Control Report indicated resident room [ROOM NUMBER] was treated for American Cockroaches in the room and inside bathroom drawer. The Pest control report indicated resident room [ROOM NUMBER] had a follow-up for cockroaches.</p> <p>Record review of a grievance dated 10/16/23 indicated resident room [ROOM NUMBER] filed a grievance regarding the facility having a bad problem with water bugs. The grievance indicated maintenance sprayed bug killer around the room and outside area and placed the issues in the pest control book.</p> <p>Record review of the Pest Control Report dated 10/20/23 indicated the facility was treated for cockroaches. The Pest Control Report indicated it was reported that the secondary nurse's station had an issue with cockroaches. The Pest Control Report indicated resident room [ROOM NUMBER] was treated for bed bugs.</p> <p>Record review of a grievance dated 10/30/23 indicated all residents in resident rooms 128-136 complained of a roach problem. The grievance indicated maintenance had sprayed over the counter treatment and notified pest control.</p> <p>Record review of the Pest Control Report dated 11/14/23 indicated the facility was treated for cockroaches. The Pest Control Report indicated The Pest Control Report indicated it was reported that the secondary nurse's station had an issue with cockroaches.</p> <p>Record review of the Pest Control Report dated 12/15/23 did not indicated the facility was treated for cockroaches.</p> <p>Record review of the Pest Control Report dated 12/15/23 did not indicated the facility was treated for cockroaches.</p> <p>(continued on next page)</p>		

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<p>F 0925</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Record review of the Pest Control Report dated 2/28/2024 cockroaches were reported in resident rooms 127-133. The pest control report indicated resident rooms 127, 128, 129, 130, 131, 132, and 133 were treated for cockroaches.</p> <p>Record review of the Pest Control Report dated 3/26/24 indicated resident rooms [ROOM NUMBER] were treated for cockroaches.</p> <p>Record review of the Pest Control Report dated 4/17/24 did not indicated the facility was treated for cockroaches.</p> <p>During an observation on 4/16/24 at 12:08 p.m. when the light was turned on in a resident's bathroom [ROOM NUMBER] large cockroaches roaches scurried to the hole in the wall where tiles had come off.</p> <p>During an interview on 4/17/24 at 10:10 a.m. Resident #4 said she had seen roaches in her room a few days ago. Resident #4 said they really did not bother her too much and if one got close, she would kill it with her shoe.</p> <p>During an interview on 4/17/24 at 11:06 a.m. The Pest Control Company said they had someone on-site at the facility today (4/17/24) performing monthly routine service. The Pest Control Company said the last time they had been at the facility was 3/26/24 for monthly routine service. The Pest Control Company said they did call outs if a facility if they needed additional services beyond their monthly services.</p> <p>During an interview on 4/17/24 at 11:42 a.m. the Maintenance Director said he does daily walkthroughs of resident rooms and inspects 5-6 rooms per day. said he had complaints regarding roaches from residents. The Maintenance Director said when he received a roach or insect complaint, he logged it in the pest control book. The Maintenance Director said when there was a complaint regarding insects, he had the resident leave their room for a couple hours and treated the room with household chemicals. The Maintenance Director said the pest control company comes out monthly and as needed.</p> <p>During an interview on 4/17/24 at 1:41 p.m. Resident #5 said she had seen a roach in her room on 4/16/24.</p> <p>During an interview on 4/18/24 at 10:10 a.m. The DON said she had seen large cockroaches at the exit doors. The DON said she does not deal with pest control, but the facility had pest control out monthly and if there was an issue between the monthly visit, they just had the Maintenance Director take care of the issue.</p> <p>During an interview on 4/18/24 at 1:05 pm the Administrator said he expected to maintain a professional service that could reasonably maintain pest control. The Administrator said they had called the pest control company out between routine visits. The Administrator said he did not know if they gave him a service report for visits made outside the monthly routine visits. The Administrator said the importance of pest control was to protect the residents.</p> <p>(continued on next page)</p>		

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<p>F 0925</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Record review of the facility's Pest Control Program policy dated 1/2024 indicated, It is the policy of this facility to maintain an effective pest control program that eradicates and contains common household pests and rodents. Effective pest control program is defined as measures to eradicate and contain common household pests (e.g., bed bugs, lice, roaches, ants, mosquitos, flies, mice, and rats) .</p>		