STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455485	A. Building B. Wing	12/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Petal Hill Nursing & Rehabilitation Center	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)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42190 Based on observations, interviews, and record reviews, the facility failed to provide maintenance and housekeeping services for 2 (Resident #13 and #54) of 10 resident rooms observed for safe, homelike and sanitary environment. The facility failed to ensure missing and damaged laminate flooring panels were replaced in Resident #13's room (216-B). The facility failed to ensure missing baseboards were replaced in Resident #54's bedroom (#207-B) and bathroom; repair the vanity drawer in the bathroom; clean the toilet and remove trash from the floor of bathroom. These failures could place residents at risk for psychosocial harm and a diminished quality of life and an unsanitary environment. Findings included: 1.A record review of a face sheet dated 12/11/2024 indicated Resident #13 was a [AGE] year-old male who admitted to the facility on [DATE]. He had diagnoses which included dementia (a group of social and thinking symptoms that interferes with daily functioning), mood disorder (a serious mental illness that primarily affects a person's emotional status) , major depressive disorder (a mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment of daily life), and history of falling. A record review of a MDS dated [DATE] indicated Resident #13 had a BIMS score of 9 indicating his cognition to be moderately impaired and required assistance with most ADLs. During an observation on 12/09/2024 at 10:32 AM, Resident #13 was noted to not be in his room. Three (3) approximately 3-3.5 feet long laminate flooring panels were noted be missing from the flooring in the area extending from outside the head of the bed and continuing under the bed. Two (2) more laminate flooring panels underneath the foot of the bed and extending outward into the room were noted to be loose, buckled, and almost completely unattached from the floor beneath them. Another panel of laminate flooring was noted in the same area at the foot of the bed to have a tear in it with the torn area slightly raised and not attached to the floor. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the undated Maintenance Work Log Book at the nurses' desk indicated there were no records of needed repairs in the book. The book contained only blank Maintenance Request Forms. During an interview on 12/09/2024 at 11:01 AM, CNA B said she did not know exactly how long the floor strips at the head and foot of Resident #13's bed had been missing or damaged. She said the staff were supposed to tell the Maintenance Supervisor if something needed to be fixed. She said she had not told anyone about the missing and damaged flooring panels. She said she forgot. During an observation and interview on 12/09/2024 at 11:20 AM in Resident #13's room, the Maintenance Supervisor said the unattached and damaged flooring panels at the foot of the bed were new. He said the staff didn't take time to unlock the bed's wheels and drag the bed over which caused the flooring panels to be pulled away from the floor and damaged. He said he was not made aware of the floor panels at the foot of the bed. The Maintenance Supervisor said the flooring panels at the head of the bed had been missing a while. He said staff were supposed to fill out a Maintenance Request Form and place it in the Maintenance Work Log Book when they saw needed repairs but they didn't. He collected the torn and unattached flooring panels from the floor and said he would see if he had some matching panels and replace them. He said he was going to in-service the staff on communicating repair needs. During an interview on 12/09/2024 at 01:25 PM, Resident #13 said he did not know how long the floor panels had been missing or damaged. He said his room would look better if they were replaced. During an interview with the Administrator on 12/11/2024 at 02:15 PM, he said he was new to the facility and was not aware of the missing and damaged flooring panels in Resident #13's room and would follow up with maintenance. During an interview on 12/11/2024 at 04:00 PM, the Maintenance Supervisor said he did not have any flooring panels, had ordered some, and would replace them when they came in. A record review of a face sheet dated 12/11/2024, indicated Resident #54 was a 41year-old female who admitted to the facility on [DATE]. She had diagnoses which included paranoid schizophrenia (a chronic condition that cause people to lose touch with reality), mood disorder (a serious mental illness that affects a person's emotional state), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), and personal history of traumatic brain injury (brain dysfunction caused by an outside force, usually a violent blow to the head). During an observation of Resident #54's bedroom and bathroom, on 12/09/24 at 11:27AM, a section of the baseboard in the bedroom and two sections of baseboard in the bathroom were missing. The toilet was dirty with brown water stain rings around the bowl of the toilet, brown particles that appeared to be fecal matter was around the inside of the bowl of the toilet and yellow water was in the bowl of the toilet. A separate square piece of sheetrock was in a corner, behind the toilet. Behind the sheetrock was a pile of trash. The middle drawer to vanity was broken. The drawer front was separated from the drawer box, making it inoperable. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation of Resident #54's bedroom and bathroom, on 12/09/24 at 12:59PM, a section of the baseboard in the bedroom and two sections of baseboard in the bathroom were missing. The toilet was dirty with brown water stain rings around the bowl of the toilet, brown particles that appeared to be fecal matter was around the inside of the bowl of the toilet and yellow water was in the bowl of the toilet. A separate square piece of sheetrock was in a corner, behind the toilet. A pile of trash was behind the separate square piece of sheetrock. Behind the sheetrock was a pile of trash. The middle drawer to vanity was broken. The drawer front was separated from the drawer box, making it inoperable. During an observation of Resident #54's bedroom and bathroom, on 12/10/24 at 8:11AM, a section of the baseboard in the bedroom and two sections of baseboard in the bathroom were missing. The toilet was dirty with brown water stain rings around the bowl of the toilet, brown particles that appeared to be fecal matter was around the bowl of the toilet and yellow water was standing in the bowl of the toilet. A separate square piece of sheetrock was in a corner, behind the toilet. Behind the sheetrock was a pile of trash. The middle drawer to vanity was broken. The drawer front was separated from the drawer box, making it inoperable. During an interview and record review on 12/10/24 at 9:05AM, the Director of Maintenance said he was not aware of the missing baseboards, in Resident #54's bedroom or bathroom. He said he was not aware that the vanity drawer was broken and inoperable. He said the sheetrock must have been left in the bathroom, from a previous repair to the sheetrock wall behind the toilet. The pile of trash was revealed when he removed the piece of sheetrock. He said he has asked the staff to use the maintenance logbook to make him aware of repairs that need to be done, but they will not do it. Record review of the maintenance logbook for the December 2024, revealed no documented maintenance request. During an interview, on 12/10/24 at 11:30AM, the Housekeeping Supervisor said she was not aware of the missing baseboards in Resident #54's bedroom or bathroom. She said she was not aware of the broken drawer of the vanity in the bathroom. She said when the housekeeping staff see something that needs repair, they should write down a maintenance request in the maintenance logbook, for the Maintenance Director. She said she was not sure why these things were not written in the maintenance logbook. A record review of the facility's policy dated 07/2022 and titled Work Order Request indicated the following: Policy: It is the policy of this company that all maintenance support requests must be made in writing and submitted into the Maintenance Work Log Book. Policy Explanation and Compliance Guidelines 1.Write your maintenance request and fill out all fields necessary in the Maintenance Work Log book so that the request is easily understood and able to be prioritized. 4. Maintenance will review work log book throughout the day for new work orders. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	5. When orders are completed, maintenance personnel will complete the assignment on the work log in the maintenance book.

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 47204 Based on observations, interviews and record reviews, the facility failed to develop and implement a comprehensive person-centered care plan for each resident that included measurable objectives and time frames to meet a resident's medical, nursing, and mental and psychosocial needs for 1 of 4 residents (Resident #72) reviewed for care plans. The facility failed to ensure Resident #72's comprehensive care plan reflected her positive PASRR Evaluation and the recommended services. The facility failed to ensure Resident #72's comprehensive care plan addressed her smoking status. These failures could place residents at risk for not receiving needed care and services, including care and services to prevent injury. The findings included: A record review of a face sheet dated 12/11/2024 indicated Resident #72 was a [AGE] year-old female who initially admitted to the facility on [DATE] and readmitted on [DATE] after a hospital stay. She had diagnoses which included chronic obstructive pulmonary disease (a group of lung diseases that block airflow and make it difficult to breathe), chronic respiratory failure (a long-term condition that occurs when the lungs cannot exchange oxygen and carbon dioxide properly), mood disorder, anxiety (intense, excessive, and permanent worry and fear about everyday situations), and depression (a serious mental health condition that can impact how a person feels, thinks, and acts). A record review of the admission MDS dated [DATE] reflected Resident #72 had a BIMS score of 15 indicating her cognition was intact and was independently ambulatory, continent of bowel and bladder, and able to voice concerns and needs. The MDS reflected Resident #72 was determined as positive for mental illness according to the PASRR Evaluation process. During observations of the designated smoking area on 12/09/2024 at 11:00 AM and on 12/10/2024 at 01:00 PM and 03:00 PM, Resident #72 was noted sitting in a chair in the area and smoking a cigarette. She was observed to hold the cigarettes safely and use the ashtray appropriately. Facility staff were noted present in the area and controlled the dispensing of cigarettes and use of lighters. A record review of the Admission assessment dated [DATE] indicated Resident #72 smoked cigarettes. A record review of a PCSP Form dated 08/30/2024 indicated Resident #72 was receiving specialized mental illness services which included Routine Case Management and Individual Skills Training. A record review of Resident #72's undated comprehensive care plan did not include any indication of Resident #72's positive PASRR status nor the specialized services to address the needs identified during the PASRR Evaluation. The care plan did not address Resident #72's smoking status nor did it identify any safety actions to prevent injury. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/09/2024 at 11:25 AM, RN A said she had worked at the facility about 3 years. She said Resident #72 was a smoker when she admitted to the facility. She said residents who smoked were assessed for smoking safety upon admission and their care plans would reflect their smoking status with interventions to prevent injury. RN A said the care plan would tell staff how much supervision was needed and if any special devices such as a smoking apron was required. RN A said if the care plan did not address smoking, the staff would not know if the resident required a smoking apron or how much supervision was needed. During an interview on 12/10/2024 at 10:15 AM, the Regional DCO said residents who smoked were assessed for safe smoking on admission and their care plans should reflect their smoking status. She said Resident #72 had not been assessed for safe smoking and her care plan did not address her smoking status. She said she did not know why Resident #72 had not been assessed nor why her care plan did not address it. The DCO said Resident #72 would be assessed immediately. During an interview on 12/10/2024 at 10:20 AM, the MDS Coordinator said she had been at the facility about a week. She said Resident #72's comprehensive care plan should have addressed smoking and PASRR related services to be provided. A record review of the facility's policy dated 06/2023 and titled Resident Smoking indicated the following: Policy: It is the policy of this facility to provide a safe and healthy environment for residents, visitors, and employees, including safety as related to smoking. Policy Explanation and Compliance Guidelines: 9. All safe smoking measures will be documented on each resident's care plan, and communicated to all staff, visitors, and volunteers who will be responsible for supervising while smoking. Supervision will be provided as indicated on each resident's care plan. A record review of the facility's policy dated 07/2022 and titled Comprehensive Care Plans indicated the following: 1. The care planning process will include an assessment of the resident's strengths and needs, and will incorporate the resident's personal and cultural preferences in developing goals of care. 3. The comprehensive care plan will describe, at a minimum, the following: a. The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. c. Any specialized services or special rehabilitation services the nursing facility will provide as a result of PASRR recommendations.

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47204 Based on observation, interview, and record review the facility failed to ensure each resident was provided adequate supervision and preventative measure to prevent injuries for 1 of 4 residents (Resident #72) reviewed for accident hazards. The facility failed to follow the facility's policy to assess Resident #72 for safety when smoking. This failure could place residents at risk for accidents and injuries due to failure to evaluate for risk. Findings included: A record review of a face sheet dated 12/11/2024 indicated Resident #72 was a [AGE] year-old female who initially admitted to the facility on [DATE] and readmitted on [DATE] after a hospital stay. She had diagnoses which included chronic obstructive pulmonary disease, chronic respiratory failure, mood disorder, anxiety, and depression. A record review of the admission MDS dated [DATE] reflected Resident #72 had a BIMS score of 15 indicating her cognition was intact. She was noted as independently ambulatory and able to voice concerns and needs. A record review of the Admission assessment dated [DATE] indicated Resident #72 smoked cigarettes. A record review of physician orders dated 12/11/2024 indicated Resident #72 did not have any orders related to smoking. A record review of Resident #72's undated comprehensive care plan did not address Resident #72's smoking status nor did it identify any safety needs to prevent injury. A record review of Resident #72's medical records did not reflect Resident #72 had been assessed for safe smoking. During observations of the designated smoking area on 12/09/2024 at 11:00 AM and on 12/10/2024 at 01:00 PM and 03:00 PM, Resident #72 was noted sitting in a chair and smoking a cigarette. She was observed to hold the cigarettes safely and use the ashtray appropriately. Facility staff were noted present in the area and controlled the dispensing of cigarettes and use of lighters. During an interview on 12/09/2024 at 11:20 AM, Resident #72 said she had smoked a long time and had never burned herself. She said she was going inside and could not talk anymore. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/09/2024 at 11:25 AM, RN A said she had worked at the facility about 3 years. She said Resident #72 was a smoker when she admitted to the facility. She said residents who smoked were assessed for smoking safety upon admission and their care plans would reflect their smoking status with interventions to prevent injury. RN A said the care plan would tell staff how much supervision was needed and if any special devices such as a smoking apron was required. RN A said if a resident who smoked was not assessed for safe smoking, the staff would not know if the resident required a smoking apron or how much supervision was needed. She said failing to assess a smoker for safe smoking could place residents at risk for burns. During an interview on 12/11/12 at 10:50 AM, CNA-E said the nurse would tell whoever came to get the smoking supplies if a resident needed special supervision or a smoking apron. During an interview on 12/11/2024 at 02:15 PM, DS-C said residents who needed anything, like a smoking apron, brought it with them when they were brought out to smoke. She said if a resident was brought out to smoke who needed a smoking apron but did not have it with them, she had no way of knowing they needed it. During an interview with HKS-D at 03:00 PM, she said the aides made sure residents who needed a smoking apron had it with them when they brought them out to smoke. During an interview on 12/10/2024 at 10:15 AM, the Regional DCO said residents who smoked were assessed for safe smoking on admission and their care plans should reflect their smoking status. She said Resident #72 had not been assessed for safe smoking and her care plan did not address her smoking status. She said she did not know why Resident #72 had not been assessed nor why her care plan did not address it. The DCO said Resident #72 would be assessed and her care plan would be updated immediately. A record review of the facility's policy dated 06/2023 and titled Resident Smoking indicated the following: Policy: It is the policy of this facility to provide a safe and healthy environment for residents, visitors, and employees, including safety as related to smoking. Policy Explanation and Compliance Guidelines: 5. All residents will be asked about tobacco use during the admission process, and during each quarterly or comprehensive assessment process. 6. Residents who smoke will be further assessed, using the Resident Safe Smoking Assessment . 9. All safe smoking measures will be documented on each resident's care plan, and communicated to all staff, visitors, and volunteers who will be responsible for supervising while smoking. Supervision will be provided as indicated on each resident's care plan.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 47723 Based on observation, interview, and record review the facility failed to ensure, in accordance with State and Federal laws, all drugs and biologicals were stored in locked compartments and permitted only authorized personnel to have access to 1 of 3 rooms (DON's office) used for storage of drugs and biologicals. The facility failed to ensure the DON's office door and the metal filing cabinet where discontinued narcotics were stored, was at all times secured under double lock, and unable to be accessed by unauthorized personnel. This failure could place residents at risk for misuse of medication and overdose, drug diversions, and adverse reactions to medications. Findings included: During observation and interview on 12/10/2024 at 11:20 AM, the DON's office door was noted to be unlocked and slightly ajar. The DON, and the ADON joint office were easily push open, upon entering the office it was noted no one was inside. Observed, and noted behind the DON desk in the corner, the metal filing cabinet where discontinued narcotics were stored, the locked device hanging on the metal cabinet were unlocked. A second surveyor coming down the hallway, was asked to come inside the office before opening the drawer to the metal cabinet where the discontinued narcotics were stored. 11:30 AM, the DON, and the ADON entered the office and was informed the office door was left open slightly ajar, and the discontinued narcotics drugs were not secured and were available to anyone who walked into the DON's office. The DON said, the medications were to be processed for destruction, she was called to the front desk, and she did not know why she left the secured cabinet unlocked. The DON did not offer a rationale for not securing the drugs. The ADON did not offer any additional comments. During an interview on 12/10/2024 at 4:05 PM, the DON said, she locked her door when she left her office earlier today, she added the ADON shared the office with her and they both had keys, the ADON had returned and failed to lock the office door. The DON said, she had the only key to the secure metal cabinet and failed to re-lock the secured discontinued narcotics cabinet. Record review of the facility's policy dated 07/2022 and titled Medication Storage indicated the following: Narcotics and Controlled Substances: Scheduled II drugs and back-up stock of Schedule III, IV, and V medications are stored under double-lock and key. When a medication has passed its expiration date or is otherwise deteriorated, or has been discontinued, or for a resident no longer residing at the home, it should be removed from the medication cart as soon as possible, accounted for and kept under double lock and key until time of destruction.

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F 0850 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Hire a qualified full-time social worker in a facility with more than 120 beds. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41695 Based on record review and interview, the facility, with a capacity of more than 120 beds or more less, failed to employ a qualified social worker for the facility reviewed for administration in that: The facility did not have a qualified social worker since [DATE]. This failure could affect any residents in need of social services and place them at risk of psycho-social decline and poor-quality of life. Findings included: Record review of the Facility Summary Report from Tulip dated [DATE] revealed the facility had a maximum capacity of 120. Record review of facility's personnel file accessed on date [DATE], completed by HR indicated there was full time Social Worker on staff but the name listed did not reflect the current social worker that was in place. Record Review [DATE] from the Texas State Board of Social Worker Examiners did not list the facility current Social Worker as a license Social Worker name did not appear on the registry. In an interview with the HR director, on [DATE] at 10:30 AM, she said, the licensed Social Worker's last day at the facility was [DATE] and the Social worker they hired on [DATE] license had expired on [DATE] and his license are in the process of reinstatement. In an interview with the Regional Director of Clinical Operation on [DATE] at 12:00PM, she said they are sharing the Social Worker from a sister facility. In an interview with Administrator on [DATE] at 1:00 pm, he said they do not have a full time Licensed Social Worker. He said he just started work here [DATE] and had no idea that the current Social Worker was not licensed. He didn't know there had to be a full time Social Worker if your building was not at full capacity. He said he thought it was ok to share with the sister facility who has a building of 170. In an interview with facility's non licensed Social Worker on [DATE]@11:00 am he stated that his license was expired, and he had not planned to renew his license then he decided to come back to Social Work., he said he has completed his CEU's to reinstate his license he looked up his license and found license number 21994 was expired and no evidence of reinstatement. Record review of facility's policy Social Services dated 2024 revealed the following: Policy: (continued on next page)

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F 0850 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility, regardless of size, will provide medically related social services to each resident, to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. A facility with more than 120 beds will employ a qualified social worker on a full-time basis. A facility, regardless of size, will provide medically related social services to each resident, to attain or maintain the residents highest practicable physical, mental, and psychosocial well-being. Making referrals and obtaining needed services from outside the facility Assisting residents with financial and legal matters Transitions of care services The facility should provide social services or obtain services from outside entities during situation where there is a lack of an effective family or community support system or legal representative.