STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455522	A. Building B. Wing	09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Tlc West Nursing and Rehabilitation	1700 Marlandwood Rd Temple, TX 76502

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42949 Based on interview and record review the facility failed to ensure based on the comprehensive assessment of a resident, that residents received treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices for one of three residents (Resident #1) reviewed for quality of care. The facility failed to schedule an order to apply TED hose (stockings that prevent blood clots and swelling) to Resident #1's lower extremities while he was at the facility from 09/14/24 - 09/20/24. This failure could place residents at risk of not receiving necessary medical care, harm, and hospitalization . Findings include: Record review of Resident #1's, undated, face sheet reflected a [AGE] year-old male who was admitted to the facility on [DATE] and discharged on [DATE]. Resident #1 had diagnoses which included end-stage renal disease, type II diabetes , morbid obesity, gout (inflammatory arthritis), thrombosis (the formation of a blood clot inside a blood vessel, obstructing the flow of blood through the circulatory system), and dependence on renal dialysis. Record review of Resident #1's discharge MDS assessment, dated 09/23/24, reflected his BIMS was not assessed. Record review of Resident #1's admission care plan, dated 09/14/24, reflected he had diabetes mellitus with an intervention of administering diabetes medication as ordered by the doctor. Record review of Resident #1's physician order, dated 09/14/24, reflected to apply TED hose to lower bilateral extremities daily in the morning and remove at bedtime. Record review of Resident #1's list of physician orders, on 09/26/24, reflected the order to apply/remove TED hose was never scheduled therefore it never triggered on the September TAR. Record review of Resident #1's TAR, September 2024, reflected no order for applying/removing TED hose. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 09/26/24 at 11:35 AM, MA A stated she only worked with Resident #1 one day while he was at the facility and could not remember if he was wearing TED hose. During an interview on 09/26/24 at 12:50 PM, LVN B stated in order for a physician's order to trigger on the TAR, it needed to be scheduled, giving it a start date. She observed Resident #1's orders in his EMR and stated it appeared the order for the TED hose was never scheduled, meaning it would not trigger in the TAR. She stated it was the responsibility of the admitting nurses to schedule physician orders. She stated because it was never scheduled, there would be no proof that it was being done. During an interview on 09/26/24 at 1:22 PM, the ADON stated it was very important to schedule physician orders, so they were active to ensure the orders were being followed. She stated it was the responsibility of the admitting nurses to schedule all orders, but she recently took over the responsibility about two weeks prior. She stated she could not remember if she scheduled the TED hose order for Resident #1 but did remember seeing him wearing his TED hose. She stated a negative outcome of not scheduling this order could be putting the resident at risk for edema or blood clots. A request was made for a policy on physician orders, but only a policy on medication orders was provided. Record review of an in-service conducted by the DON and the ADON, dated 09/10/24, reflected nurses were in-serviced on multiple topics one including completing all QUEUED (pending/in line) orders in resident's orders upon admission/readmission. Record review of the facility's Medication Orders Policy, revised November 2014, reflected there was nothing regarding entering/scheduling/following physician orders.