

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455565	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/03/2025
NAME OF PROVIDER OR SUPPLIER Palestine Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1816 Tile Factory Rd Palestine, TX 75801	

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 0684</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Some</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50818</p> <p>Based on observation, interview and record review, the facility failed to ensure residents received treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the resident's choices for 1 of 4 residents reviewed for quality of care in that:</p> <p>The facility did not prevent the development and worsening of two facility acquired wounds for Resident #1.</p> <p>The facility failed to ensure a bed of appropriate size to prevent the development and worsening of wounds was provided for Resident #1.</p> <p>The facility failed to document weekly skin assessments for Resident #1.</p> <p>The noncompliance was identified as PNC. The past noncompliance began on 12/02/24 and ended on 01/27/25. The facility had corrected the noncompliance before the survey began.</p> <p>These failures could place residents with limited mobility at risk of developing facility acquired pressure injuries.</p> <p>Findings included:</p> <p>Record review of Resident #1's undated face sheet indicated Resident #1 was a [AGE] year-old male admitted on [DATE] with diagnoses of type 2 diabetes, end stage renal (kidney) disease, and chronic ulcers of left and right feet.</p> <p>Record review of an MDS dated [DATE] indicated Resident #1 had a BIMS score of 15 which indicated intact cognition and he required assistance for ADL s. He required total assistance for toileting, hygiene, and bathing; maximal assistance for upper and lower body dressing, putting on/taking off footwear, and personal hygiene; partial assistance with sit to stand and chair/bed-to-chair transfers; touch assist with rolling from left to right, lying to sitting up, and lying to sitting on the side of the bed.</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 0684</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Some</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Record review of an admission observation completed by RN A of Resident #1 on 12/03/2024 at 4:23PM included a skin assessment which indicated Resident #1 was admitted to the facility with no alterations in skin integrity and no pressure injuries to sacrum, heels, hips, ankles, elbows, ears, or any other bony prominence. The same admission observation indicated Resident #1 was assessed for venous ulcers, arterial ulcers, and diabetic ulcers including assessment of lower extremities, upper and lower feet, and upper and lower toes, with no ulcers noted.</p> <p>Record review of a comprehensive care plan revision on 12/11/2024 indicated Resident #1 was at risk for pressure ulcers related to impaired mobility and incontinence. Interventions were put in place including weekly skin assessments with particular attention paid to the bone prominences (areas of the body where the underlying bone is particularly close to the surface of the skin), keeping resident clean and dry, and maintaining the head of the bed at lowest degree of elevation possible.</p> <p>Review of Weekly Skin assessments indicated only two skin assessments had been documented for Resident #1:</p> <p>*01/09/2025 by ADON - Resident with DTI (Deep Tissue Injury) on Right and Left plantar foot;</p> <p>*01/16/2025 by LVN A - DTI TO RT/LT PLANTAR (right and left sole of foot);</p> <p>Record review of Resident #1's comprehensive care plan revisions on 1/09/2025 indicated Resident #1 had developed a diabetic ulcer to his left first toe, and a diabetic ulcer to his right first toe. New interventions were added including avoiding friction and shearing forces during transfer and position change, keep bony prominences from direct contact with one another with pillows, foam wedges, etc., monitor for signs of osteomyelitis (bone infection), cellulitis (soft tissue infection), sepsis (an extreme bodily reaction to infection), and wound treatment orders to clean area with normal saline and apply skin prep daily. The same care plan also included initiation of a planned weight gain program on 1/09/2025 to assist Resident #1's wound healing.</p> <p>Record review of a wound care physicians Initial Wound Evaluation and Management Summary on 1/10/2025 indicated the focused wound exam revealed the presence of two Diabetic Wounds and the following new orders:</p> <ul style="list-style-type: none"> - Site 1: Diabetic wound of the left, first toe, partial thickness. The wound measured 1cm x 1cm x Not Measurable (Length X width X Depth) due to scab covering wound. Treatment plan included applying skin prep daily for 30 days. - Site 2: Diabetic wound of the right, first toe, undetermined thickness. The wound measured 0.5cm x 1cm x Not Measurable due to scab covering wound. Treatment plan included applying skin prep daily for 30 days. - Follow-Up Evaluation by wound care provider weekly, or sooner as needed, with further intervention as indicated based on response to current treatment plan. <p>Record review of Resident #1's comprehensive care plan revision on 1/26/25 indicated Resident #1 had developed a new diabetic wound to his right foot. New interventions were added including using a lift sheet to move resident in bed, resident continued with weekly wound care treatments from wound care provider.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Some</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Record review of Resident #1's the most recent wound care physicians Wound Evaluation and Management Summary dated 1/31/25 indicated the following:</p> <ul style="list-style-type: none"> - Site 1: Diabetic wound of left toe, partial thickness. The wound measured 1cm x 1cm x not measurable due to scab covering wound. Wound healing progress not at goal. Treatment plan included applying skin prep once daily for 16 days. - Site 2: Diabetic wound of the right, first toe, undetermined thickness. The wound measured 1.5cm x 2cm x Not Measurable due to scab covering wound. Healing progress at goal. Treatment plan includes applying skin prep once daily for 16 days. - Site 3: Diabetic wound of right, plantar foot full thickness. The wound measured 3.5cm x 3cm x 0.1cm. Healing progress improved as evidenced by decreased surface area. Treatment includes skin prep once daily for 30 days. No sharp debridement needed due to chronic stable wound with insignificant amount of necrotic tissue and no signs of infection. Monitor closely for now. <p>During an interview on 2/03/25 at 10:10 AM, CNA B said she was familiar with Resident #1. She said his bed was not long enough for him and his feet pressed up against the footboard and hung over the edge of mattress after footboard was removed.</p> <p>During an interview on 2/03/25 at 10:25 AM, LVN A said Resident #1's bed was too small because he is 6ft 8in tall and his feet were pressing and rubbing against the footboard. She said she had reported the concerns to ADM, DON, ADON. She said ADM told her that was the biggest bed available for Resident #1. She said ADON removed the footboard from the bed after Resident #1 developed diabetic wounds on his feet.</p> <p>During an observation and interview on 2/03/25 at 10:30 AM, Resident #1 was observed lying in his bed in his room. His bed had no footboard, and feet were extended beyond the end of the mattress and were resting on a mattress extension attached to bedframe. Wounds to his right great toe, right sole, left great toe, and left sole were observed. The wound beds were covered over by scabbing and not visualized. Resident #1 said he was uncomfortable in the bed when he was admitted to the facility and had voiced this concern to staff, but he could not recall who he spoke to. He said he was comfortable now with the footboard being removed and mattress extension in place. He said he was uncomfortable lying flat in bed and preferred to have his head raised.</p> <p>During an interview on 2/03/25 at 1:00 PM, DON said the facility identified the need for and ordered an extension for Resident #1's bed when he was admitted but they misplaced it and had to order a new one. She said Resident #1 had other interventions in place including frequent rounding and pulling him up in the bed, so his feet don't press on the footboard. She said Resident #1 had weekly skin assessments ordered and all skin assessments should have been charted in his progress notes. She said no staff had ever voiced concerns about Resident #1's feet rubbing against the footboard causing skin breakdown.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Some</p> <p>Note: The nursing home is disputing this citation.</p>	<p>During an interview on 2/03/25 at 12:30 PM, ADM said he measured that mattress with a measuring tape, and it was 81in in length which was sufficient for Resident #1's height of 6ft 8in (80in) and additionally ordered a mattress extension. He said when Resident #1 was pulled up in his bed his feet weren't going to rub on the footboard. He said Resident #1 was mobile and slides down in the bed when he shifts positions. He said no one reported any concerns of skin break down related to resident's feet rubbing against the footboard. He said Resident #1 had a history of chronic diabetic ulcers which were one of his admitting diagnoses. He said following the first reported skin breakdown the facility put interventions in place including ordering a new mattress extension, provided an inservice to all clinical staff in which the topic of timely skin assessments was discussed, and got a referral for specialty wound clinic to assess and treat resident. He said the facility also planned to conduct further inservices and supply resident with a bariatric bed.</p> <p>Review of Facility Wound Summary Report dated 1/03/2025 to 2/03/2025 indicated Resident #1 had two facility acquired Diabetic Ulcers discovered on 1/09/2025. There were no other residents with pressure related injuries in the facility.</p> <p>Review of policy titled Pressure Injury/Skin Breakdown - Clinical Protocol last revised April 2024 indicated:</p> <p>.Within post-acute and long-term care, pressure injuries and other chronic wounds emerge as clinical concerns, heavily influenced by patient immobility, underlying health conditions and nutritional factors. These disruptions in skin integrity can gravely impact a resident's quality of life .</p> <p>And</p> <p>.The licensed nurse will complete a weekly skin assessment in the progress note section of the resident chart .</p> <p>It was determined these failures resulted in Resident #1 being harmed on 01/09/2025.</p> <p>Facility took the following actions to correct the non-compliance:</p> <ul style="list-style-type: none"> - Record review of the facility's In-service binder revealed an in-service titled Mandatory meeting (all clinical staff) was conducted on 1/15/25 topics of in-service topics included Skin assessments need to be done in a timely Manner. They are now schedule by day shift 6-2 and evening shift 2-10 (evening shift are for night shift). - During interviews with 3 CNAs and 2 LVNs on the day shift, all employees indicated they would routinely check for skin concerns. The 3 CNA's said they look at resident's skin during incontinence care and when assisting with showers and would notify their charge nurse of any concerns. The 2 LVN's said they would assess residents as ordered and chart their findings in resident progress notes. - Review of an invoice indicated a mattress extension was purchased on 1/27/2025 and observations of Resident #1 at various times revealed the mattress extension to be in place. - Referral to wound care management with visit frequency of weekly or as needed.

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<p>F 0917</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Some</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Make sure each resident has 1) at least one window to the outside in a room; 2) a room at or above ground level; 3) adequate bedding; 4) furniture that meets the resident's needs; or 5) adequate closet space.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50818</p> <p>Based on observation, interview, and record review, the facility failed to ensure that residents were provided with a separate bed of proper size and height for the safety and convenience of the resident for 1 of 4 residents (Resident #1) reviewed for appropriate functional furniture.</p> <p>The facility failed to ensure Resident #1 had a bed of proper size for his safety to prevent development and worsening of two facility acquired wounds.</p> <p>The noncompliance was identified as PNC. The past noncompliance began on 12/02/24 and ended on 01/27/25. The facility had corrected the noncompliance before the survey began.</p> <p>This failure could place residents at risk for discomfort, skin breakdown and a decreased quality of life.</p> <p>The findings included:</p> <p>Record review of Resident #1's undated face sheet indicated Resident #1 was a [AGE] year-old male admitted on [DATE] with diagnoses of end stage renal (kidney) disease and chronic ulcers of left and right feet, and muscle wasting (atrophy) of lower right and left legs, and chronic diabetic ulcers of both feet.</p> <p>Record review of an MDS dated [DATE] indicated Resident #1 had a BIMS score of 15 which indicated intact cognition and he required assistance for ADLs. He required total assistance for toileting, hygiene, and bathing; maximal assistance for upper and lower body dressing, putting on/taking off footwear, and personal hygiene; partial assistance with sit to stand and chair/bed-to-chair transfers; touch assist with rolling from left to right, lying to sitting up, and lying to sitting on the side of the bed. He was 80 inches tall.</p> <p>Record review of a comprehensive care plan revision on 12/11/2024 indicated Resident #1 had an ADL deficit related to End Stage Renal (kidney) Disease. The same care plan indicated he required the assistance of 2 people for ambulation, transfers, and bed mobility .</p> <p>During an interview on 2/03/25 at 10:10 AM, CNA B said Resident #1's bed was not long enough for him, and his feet were always hanging off the bed.</p> <p>During an observation and interview with Resident #1 on 02/03/25 at 10:30 AM revealed the footboard of his bed had been removed and he was lying on his back in bed with his legs and feet extended beyond the mattress, hanging over the edge. His feet were resting on a mattress extension that was attached to the end of the bed frame. His head was elevated to a semi-Fowler's position (upper body raised to a 30-45-degree angle). Resident #1 said when he was admitted to the facility, he notified staff members that his bed was too small, and it was uncomfortable. He said his feet pressed against the footboard. He said it was uncomfortable to lie flat in bed and he preferred to have his head elevated.</p> <p>(continued on next page)</p>		

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<p>F 0917</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Some</p> <p>Note: The nursing home is disputing this citation.</p>	<p>During an interview on 2/03/25 at 10:25 AM, LVN A said Resident #1's bed is too small because he is 6ft 8in tall and his feet were pressing and rubbing against the footboard. She said she had reported the concerns to ADM, DON, ADON. She said ADM told her that was the biggest bed available for Resident #1. She said ADON removed the footboard from the bed after resident developed diabetic ulcers on both of his feet.</p> <p>During an interview on 2/03/25 at 1:00 PM, DON said the facility identified the need for and ordered a mattress extension for Resident #1's bed when he was admitted but they misplaced it and had to order a new one. She said Resident #1 had other interventions in place for comfort and safety including frequent rounding, maintaining the head of his bed in as low a position as possible to prevent sliding, and pulling him up in the bed so his feet don't press on the footboard.</p> <p>During an interview on 2/03/25 at 12:30 PM, ADM said he measured that mattress with a measuring tape, and it was 81in in length which was sufficient for Resident #1's height of 6ft 8in (80in) and additionally ordered a mattress extension but it was misplaced. He said when Resident #1 is pulled up in his bed his feet aren't going to rub on the footboard. He said resident is mobile and slides down in the bed when he shifts positions. He said Resident #1 had a history of chronic diabetic ulcers which were one of his admitting diagnoses. He said he already ordered a second mattress extension which was in place on resident's bed and the facility held a mandatory in-service for all clinical staff covering bed and chair positioning. He said the facility also planned to conduct further in-services and supply resident with a bariatric bed.</p> <p>Record review of facility policy titled Bed Safety indicated the following:</p> <p>.The resident's sleeping environment shall be assessed by the interdisciplinary team, considering the resident's safety, medical conditions, comfort, and freedom of movement, as well as input from the resident and family regarding previous sleeping habits .</p> <p>.As part of the resident's comprehensive assessment, the following components will be considered when determining the resident's needs .</p> <p>a. Medical diagnoses, conditions, symptoms, and/or behavioral symptoms</p> <p>b. Size and weight .</p> <p>It was determined these failures resulted in Resident #1 being harmed on 1/09/25.</p> <p>Facility took the following actions to correct the non-compliance:</p> <p>- Record review of the facility's In-service binder revealed an in-service titled Mandatory meeting (all clinical staff) was conducted on 1/15/25 topics of in-service topics included positioning residents correctly in chair or bed, positioning devices in beds or chairs, and increasing visual monitoring.</p> <p>(continued on next page)</p>		

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<p>F 0917</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Some</p> <p>Note: The nursing home is disputing this citation.</p>	<p>- During interviews with 3 CNAs and 2 LVNs on the day shift, all employees indicated they would assess resident's comfort and needs when rounding. The 3 CNA's said they reposition residents according to their preference and medical needs and would notify their charge nurse of any concerns. The 2 LVN's said they would ask residents comfort and pain levels during assessments and communicate any concerns.</p> <p>- Review of an invoice indicated a mattress extension was purchased on 1/27/2025 and observations of Resident #1 at various times revealed the mattress extension to be in place.</p>		