

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455579	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/12/2024
NAME OF PROVIDER OR SUPPLIER Sulphur Springs Health and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 411 Airport Rd Sulphur Springs, TX 75482	

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 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41093</p> <p>Based on observations, interviews, and record review the facility failed to treat each resident with respect and dignity and provide care in a manner that promoted maintenance or enhancement of his or her quality of life for 2 of 6 residents (Resident #1 and Resident #2) reviewed for resident rights.</p> <p>CNA B did not treat Resident #1 and Resident #2 with dignity or respect when she spoke to them in a rude tone.</p> <p>This failure could place residents at an increased risk of embarrassment, anger, feelings of worthlessness, sadness, and diminished quality of life.</p> <p>The findings included:</p> <p>1. Record review of Resident #1's face sheet dated 8/8/24 indicated she was [AGE] years old, readmitted to the facility on [DATE] with diagnoses including dementia, COPD (chronic obstructive pulmonary disease is group of lung diseases that block airflow and make it difficult to breathe), age related macular degeneration (macular degeneration causes loss in the center of the field of vision), and poly osteoarthritis (having arthritis that affects five or more joints at the same time).</p> <p>Record review of the MDS for Resident #1 dated 7/3/24 indicated she had clear speech, usually made herself understood, and usually understood others. The MDS indicated Resident #1 had severe cognitive impairment (BIMS score of 04). The MDs indicated Resident #1 had no behavior of physical or verbal aggression directed towards others or herself. The MDS indicated she had no behavior of rejecting care. The MDS indicated Resident #1 required maximal/substantial assistance with the following ADLS, toileting, showering/bathing, dressing of the both the upper/lower body, and personal hygiene. The MDS indicated she was completely dependent on staff to put on/take off footwear. The MDS indicated she was independent with oral hygiene and required set-up/clean up assistance only with eating. The MDS indicated Resident #1 required substantial/maximal assistance with the following aspects of mobility; sit to lying, lying to sitting, sit to stand, transfers to and from toilet, and transfers to and from the shower/tub. The MDS indicated Resident #1 required partial/moderate assistance with turning side to side in bed. The MDS indicated Resident #1 was independent with mobility once in her wheelchair.</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 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of Resident #1's care plan revised on 10/10/23 indicated she was independent with activity choices and to respect Resident #1's right to refuse to attend activities. The care plan did not address Resident #1's right to be treated with dignity and respect by staff.</p> <p>2. Record review of Resident #2' s face sheet dated 8/8/24 indicated she was [AGE] years old, readmitted to the facility on [DATE] with diagnoses including Stage III CKD (in Stage 3 chronic kidney disease, the kidneys have mild to moderate damage, and they are less able to filter waste and fluid out of your blood), dependence on renal dialysis, type 2 diabetes, morbid obesity, anxiety, and depression.</p> <p>Record review of the MDS for Resident #2 dated 5/14/24 indicated she had clear speech, made herself understood, and understood others. The MDS indicated Resident #2 had no cognitive impairment (BIMS score of 15). The MDS indicated Resident #2 had no behavior of physical or verbal aggression directed towards others or herself. The MDS indicated she had no behavior of rejecting care. The MDS indicated Resident #2 required maximal/substantial assistance with the following ADLS, toileting, showering/bathing, dressing of the upper body, personal hygiene. The MDS indicated she was completely dependent on staff to dress the lower body and put on/take off footwear. The MDS indicated she required set-up/clean up assistance only with eating and oral hygiene. The MDS indicated Resident #2 required substantial/maximal assistance with all aspects of mobility; (turning side to side in bed, sit to lying, lying to sitting, sit to stand, transfers to and from toilet, and transfers to and from the shower/tub. The MDS indicated Resident #2 required partial/moderate assistance with turning side to side in bed. The MDS indicated Resident #1 was dependent on staff for mobility in her wheelchair.</p> <p>Record review of Resident #2's care plan revised on 4/25/24 indicated she was independent with activity choices and to respect Resident #2's right to refuse to attend activities. The care plan did not address Resident #2's right to be treated with dignity and respect by staff.</p> <p>During an interview on 8/8/24 at 1:54 p.m., CNA A said she worked the 6:00 a.m. to 2:00 p.m. shift and had worked at the facility for about a year. CNA A said CNA B usually worked the 2:00 p.m. to 10:00 p.m. shift and usually took care of the residents she cared for on the earlier shift. CNA A said Resident #1 had told her last week that CNA B had spoken rudely to Resident #1 and told her (Resident #1) she was a big girl and could do it herself (in reference to going to the bathroom). CNA A said Resident #2 was Resident #1's roommate and witnessed the incident. CNA A said she could not remember the exact date. CNA A said CNA B should not have spoken rudely to Resident #1 and the incident made Resident #1 angry.</p> <p>During an interview on 8/8/24 at 2:12 p.m., Resident #1 was sitting in her wheelchair in her room. When asked if anyone was mean or rude to her, Resident #1 said well, maybe ya. When asked if whomever was mean to her was male or female she said ya, I think. When asked if anyone was rude to her Resident #1 said I don't know, I can't remember. Resident #1 then pointed at the paper in the state surveyors' hand and said, it should be on the paper.</p> <p>(continued on next page)</p>		

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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 8/8/24 at 2:20 p.m., Resident #2 said some staff were very rude. When asked if she could tell me who was rude, she named CNA B. Resident #2 said it was not what CNA B said but rather how she would say things. Resident #2 said CNA B would yell at her (Resident #2) You need to raise the head of the bed up! Instead of asking her nicely to raise the head of the bed up. Resident #2 said CNA B was very disrespectful. Resident #2 said CNA B was really rude to Resident #1 because she was cognitively impaired. Resident #2 said CNA B would yell at Resident #1 while she was in the bathroom to come out of the bathroom and yell that she did not need that she did not need to just be sittin' in there in that bathroom! Resident #2 said she could not say an exact date and that CNA B yelled/ was rude most of the time.</p> <p>During an interview on 8/8/24 at 3:15 p.m., CNA B said she had worked at the facility for 3 years. CNA B said she had not been rude nor yelled at any residents. CNA B said if some residents thought she came off mean or rude it was probably just a personality conflict. CNA B said she did not have any personality conflicts with any residents. CNA B said she was unaware any residents thought she was rude to them.</p> <p>During an interview on 8/12/24 at 1:00 p.m., the DON said staff should treat residents with respect and dignity. The DON said all staff communication with residents should be respectful and said in a way to promote dignity. The DON said in-services had been conducted over resident rights in June and July .</p> <p>During an interview on 8/12/24 at 1:23 p.m., the Administrator said staff should treat residents with respect and dignity.</p> <p>Record review of the facility policy and procedure titled Resident Rights, dated 2/20/21 stated .The resident has the right to a dignified existence .The resident has the right to be treated with respect and dignity .</p>		