STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455579	A. Building B. Wing	12/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sulphur Springs Health and Rehabilitation	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)
F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33249 Based on observation, interview, and record review the facility failed to ensure the promote resident had the right and the facility promoted and facilitated resident self-determination through support of resident choice for 1 of 6 residents (Resident #51) reviewed for resident rights . The facility failed to ensure Resident #51 was assisted out of bed per his preference on 12/09/2024 . This failure could place dependent residents at risk for feelings of depression, lack self-determination, and decreased quality of life. Findings include: Record review of Resident #51's face sheet, dated 12/11/2024, indicated an [AGE] year-old male who admitted to the facility on [DATE], readmitted on [DATE] and most recently readmitted on [DATE]. Resident #51 had diagnoses which included Parkinsonism (a syndrome characterized by tremor, bradykinesia, rigidity, and postural instability), Major Depressive Disorder (persistent feelings of sadness and loss of interest) and dementia (loss of memory). Record review of Resident #51's Admission MDS, dated [DATE], indicated Resident #51 was understood and usually understood others. Resident #51's BIMS score was 10, which indicated moderate cognitive impairment. Section F0800 Staff Assessment of Daily and Activity Preferences indicated the resident preferred choosing clothes to wear, caring for personal belongings, the type of bath received, snacks, staying up late, use of the phone in private, reading, listening to music, spending time outdoors and doing things groups of people. Resident #51 required substantial/maximal assistance with transfers. Record review of the Comprehensive care plan, dated 8/18/2024 and revised on 9/12/2024, indicated Resident #51 had an ADL self-care deficit and was at risk of not having his needs met in a timely manner. The goal of the care plan was Resident #51 would have a sense of dignity by being clean, dry, odor free and well groomed. Resident #51 was independent in making activity choices and attending activities of preference. The goal of the care plan was Resident #51 would remain independent in activity choices and participation. The care plan interventions included spending time outdoors, watching television, watching movies, talking/conversing and keeping up with the news. (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

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 12/12/2024
NAME OF PROVIDER OR SUPPLIER: Sulphur Springs Health and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE: 411 Airport Rd Sulphur Springs, TX 75482	

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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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and interview on 12/09/2024 at 10:29 a.m., revealed Resident #51 was lying in his bed. Resident #51 had his call light activated and he said he was waiting for the staff to help get him up. Resident #51 said he needed to get out of the bed and enjoy the day. The transport aide entered the room, turned off Resident #51's light, and asked Resident #51 what was his need. Resident #51 told the transport aide he would like to get out of bed. The transport aide indicated she would inform his nurse aide. During an observation and interview on 12/09/2024 at 11:09 a.m., Resident #51 remained in bed. Resident #51 said no one had come to assist him up or offer for him to get up. During an observation and interview on 12/09/2024 at 2:34 p.m., Resident #51 remained lying in bed. Resident #51 said he really needed to get up out of the bed. During a telephone interview on 12/09/2024 at 2:42 p.m., the transport aide said she told CNA Q Resident #51's desire to get up out of bed. The transport aide said she left on transports and was not in the facility to follow up on Resident #51's desire to get up out of bed. interview on 12/10/2024 at 8:29 a.m., CNA Q said the transport aide never relayed the information to her on 12/09/2024 concerning Resident #51 wanting to be assisted up out of bed. CNA Q said she was responsible for answering call lights, and ensuring the residents needs were fulfilled. During an interview on 12/11/2024 at 2:44 p.m., the Treatment nurse said she expected the call light to be answered and the resident's need be met. The Treatment nurse said the staff should never turn the light off and not return. The Treatment nurse said a resident had the right to choose to get up out of bed. During an interview on 12/11/2024 at 2:58 p.m., the DON said she expected when a resident wanted to get up, they should be assisted up in a reasonable amount of time. The DON said she had been a charge nurse on the floor recently and knew Resident #51's preferences. The DON said the nursing management monitored the resident choice to be out of bed by making rounds often throughout the day. The DON said when a resident was not allowed to get up, they could become unhappy, disgruntled, and cause increased depression. During an interview on 12/12/2024 at 9:57 a.m., the Administrator said her expectations were to follow through with all procedures to ensure the resident task was completed. The Administrator said when a resident's needs were not met the resident could be unhappy and affect their quality of life. The Administrator said this was monitored by making rounds, asking questions, and answering questions to ensure needs were met. Record review of the Resident Rights policy, dated 2/23/2016 and reviewed on 2/20/2021, indicated . Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of the resident choice, including but not limited to: a. The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part.

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F 0573 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Let each resident or the resident's legal representative access or purchase copies of all the resident's records. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46928 Based on interview and record review the facility failed to provide the resident access personal and medical records pertaining to him or herself, upon an oral or written request, in the form and format requested by the individual, if it is readily producible in such form and format (including in an electronic form or format when such records are maintained electronically, or, if not, in a readable hard copy from such other form and format as agreed to by the facility and the individual, within 24 hours (excluding weekends and holidays) and allow the resident to obtain a copy of the records or any portions thereof upon request and 2 working days advance notice to the facility for 1 of 2 residents (Resident #16) reviewed for access of records. The facility failed to provide Resident #16's legal representative copies of medical records after a request was submitted to the facility on [DATE]. This failure could place residents at risk of violation of their rights by not receiving copies of their medical records. Findings include: Record review of Resident #16's face sheet, dated 12/11/24, indicated an [AGE] year-old male who admitted to the facility on [DATE] with diagnoses which included parkinsonism (a chronic and progressive movement disorder that initially causes tremor in one hand, stiffness or slowing of movement), dementia (memory loss), essential hypertension (high blood pressure), cirrhosis of liver (permanent scarring that damages the liver and interferes with its functioning), and cerebrovascular disease (condition that affect blood flow to the brain). Record review of Resident #16's quarterly MDS assessment, dated 10/23/24, indicated Resident #16 was usually understood and usually understood others. Resident #16 had a BIMS score of 8, which indicated his cognition was severely impaired. Resident #16 required substantial/maximal assistance with toileting hygiene, showers, upper/lower body dressing and personal hygiene. Record review of Resident #16's comprehensive care plan, revised and cancelled on 11/25/24, indicated Resident #16 had impaired cognition and was at risk for a further decline in cognitive and functional abilities related to dementia. The care plan interventions included to monitor/document/report to physician any changes in cognitive function, specifically changes in decision making ability, memory, recall, and general awareness, difficulty expressing self, difficulty understanding others, level of consciousness, and mental status changes. Record review of Authorization to Disclose Health Information dated 12/02/24, indicated any and all records for [Resident #16's name] was to be disclosed to Resident #16's legal representative. The form was signed by Resident #16's legal representative. Record review of Claim/Incident Reporting Form dated 12/03/24, indicated a request for records for Resident #16. The form was signed by the Administrator. (continued on next page)

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F 0573 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/09/24 at 10:25 AM, Resident #16's family member said they requested records from the facility last week and still had not received them. During an interview on 12/11/24 at 4:34 PM, the Administrator said the process for obtaining medical records was as follows: a form was filled out by medical records which indicated the request for copies of the medical records, the form was then sent to the regional director, the regional director reviewed the form and sent it back with approval, and then the facility printed and gathered all requested records. The Administrator said Resident #16's family requested records and they were still working on them since the family had requested Resident #16's whole file since admission . The Administrator said there was a lot of records to print. The Administrator said she did not know the specific timeframe as to when the medical records should have been released to the family but said once approval was received from the corporate office then the Medical Records Staff printed them as quickly as possible. During an interview on 12/12/24 at 12:04 PM, the Medical Records Staff said when someone requested records, they filled out an authorization to disclose health information form. The form then was sent to the corporate office. The corporate office reviewed the form, and they instructed them for when the medical records could be released. The Medical Records Staff said Resident #16's family member requested the medical records a week ago on 12/02/24 and the form was sent on 12/03/24 to the corporate office. The Medical Records Staff said she received approval on Tuesday, 12/10/24, she could start printing Resident #16's medical records and had been working on it since then. She said she planned on having Resident #16's medical records completed either by that afternoon (12/12/24) or the next morning (12/13/24). During an interview on 12/12/24 at 12:08 PM, the DON said she did not know the exact process for when medical records were requested but knew a written release of records was to be submitted. The DON said the Medical Records Staff was responsible for obtaining the requested medical record copies. The DON said it was the residents or legal representatives right to obtain copies of their medical records and know the care and services they received. During an interview on 12/12/24 at 12:10 PM, the Administrator said it was the resident or resident legal representative right to receive copies of their medical records. The Administrator said the Medical Records Staff was responsible for ensuring the requested medical records were obtained . Record review of the facility's policy titled Release of Medical Records revised on 09/09/19, indicated . Medical records will be released with a valid request in accordance with state and federal laws . 5. Upon request to access or obtain copies of the medical record, the facility's Privacy Officer should review the authorization to ascertain access rights of that person. Authority to access or release records is only granted by the resident or the resident's legal medical representative . 7. Upon receipt of a request for medical records copies, the facility should notify the requesting party, in writing, of the cost for obtaining records and that the records are available 2 days after receipt of payment for the copies.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46928 Based on interview and record review the facility failed to immediately inform the resident, consult with the resident's physician, and notify, consistent with his or her authority, the resident's representative when there was a significant change in the resident's physical, mental, or psychosocial status, that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications for 1 of 2 residents (Resident #16) reviewed for notification of changes. The facility failed to notify Resident #16's physician when Resident #16 had a change in condition on 11/22/24. This failure could place residents' at risk of a delay in treatment and decline in the residents' health and well-being. Findings include: Record review of Resident #16's face sheet, dated 12/11/24, indicated an [AGE] year-old male who admitted to the facility on [DATE] with diagnoses which included parkinsonism (a chronic and progressive movement disorder that initially causes tremor in one hand, stiffness or slowing of movement), dementia (memory loss), essential hypertension (high blood pressure), cirrhosis of liver (permanent scarring that damages the liver and interferes with its functioning), and cerebrovascular disease (conditions that affect blood flow to the brain). Record review of Resident #16's quarterly MDS assessment, dated 10/23/24, indicated Resident #16 was usually understood and usually understood others. Resident #16 had a BIMS score of 8, which indicated his cognition was severely impaired. Resident #16 required substantial/maximal assistance with toileting hygiene, showers, upper/lower body dressing, and personal hygiene. Resident #16 received scheduled pain medication. Record review of Resident #16's comprehensive care plan, revised and cancelled on 11/25/24, indicated Resident #16 had impaired cognition and was at risk for a further decline in cognitive and functional abilities related to dementia. The care plan interventions included to monitor/document/report to physician any changes in cognitive function, specifically changes in decision making ability, memory, recall, and general awareness, difficulty expressing self, difficulty understanding others, level of consciousness, and mental status changes. Record review of Resident #16's order summary report, dated 12/11/24, indicated Resident #16 had an order for tramadol 50mg give 2 tablets by mouth every 6 hours for pain with an order start date of 11/05/24. Record review of Resident #16's progress note, dated 11/22/24 at 12:24 PM and signed by RN B, indicated . res (resident) confused could not hold head up and kind of drowsy at this time held tramadol called [physician name] 0 answer called [nurse practitioner name] 0 answer left message to call facility back at this time. (continued on next page)

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F 0580

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Record review of Resident #16's progress notes, dated 11/22/24, did not indicate if the oncoming nurses tried to reach out to Resident #16's physician again or if he had returned the call.

Record review of Resident #16's progress note dated 11/23/24 at 11:00 AM and signed by RN M, indicated . upon assessment pt (patient) noted with slightly altered mental status slurred speech, tachycardia (fast heart rate), hypotension (low blood pressure) and admits to dysuria (discomfort with urination). Vitals b/p 80/50, p 133, resp 20 even and not labored, lungs cta, abdomen wnl. 98.2 temp . called [Resident #16's Physician] left message, gave resident water and got him back in bed, denies pain .

Record review of Resident #16's progress note dated 11/23/24 at 11:30 AM and signed by RN M, indicated, Resident #16's mental status still mildly confused, slurred speech, medications reviewed and resident receiving tramadol 100mg every 6 hours routine. Telehealth physician was notified with orders for cbc, cmp, ua stat, frequent vitals q hour times 2 hours.

Record review of Resident #16's progress note dated 11/23/24 at 12:30 PM and signed by RN M, indicated Resident #16's physician returned previous phone call and orders given to send Resident #16 to the ER for evaluation.

Record review of the 24-hour report worksheet dated 11/22/24, did not indicate Resident #16 was on the report to be monitored for increase drowsiness, confusion or that his tramadol was held. The report did not indicate Resident #16's Physician was called and awaiting call back due to his change from his baseline.

Record review of Resident #16's medication administration record dated 11/1/24-11/30/24, indicated Resident #16 tramadol 50 mg 2 tablets was held on 11/22/24 at 12:00 PM and 6:00 PM.

During an interview on 12/10/24 at 11:46 AM, LVN DD said she remembered Resident #16 very well and usually took care of him. LVN DD said on 11/22/24, RN B did not notify her of Resident #16 having a change in condition. LVN DD said on 11/22/24, Resident #16 was fine and had no complaints regarding anything. LVN DD said if she had noticed a change in condition in Resident #16, she would have assessed the resident, notified the physician and family and if Resident #16 was not doing well she would have sent him to the hospital. LVN DD said anything out of the resident normal was considered a change in condition. LVN DD said if she was unable to reach Resident #16's physician she would have called the facility's medical director.

During an interview on 12/10/24 at 2:46 PM, RN B said Resident #16 stayed in bed a lot of the times. RN B said Resident #16 got really sleepy like after he took his medication on 11/22/24. RN B said she thought it was medication related because Resident #16 was a bit drowsy but was talking. RN B said she did not think it was an emergency. RN B said she called the physician because it was a change from his baseline. RN B said she reported Resident #16's status to oncoming nurse, LVN DD. RN B said Resident #16's physician sometimes took a little while to return the phone call. RN B said if she had felt it was an emergency, she would have sent Resident #16 out to the hospital . RN B said if the Resident #16's physician did not return the call she could have called the Medical Director.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/10/24 at 3:26 PM, Resident #16's Physician said he had been out of the country twice. Resident #16's Physician said they contacted him on 11/23/24 when he instructed the facility nurse to send Resident #16 out. Resident #16's Physician said if the nurse had been able to reach him on 11/22/24 with the findings of being drowsy but everything else was fine, he would have instructed them to monitor him and if he worsened to send him out to the hospital, which the facility did. Resident #16's Physician said if they were not able to reach him, the nurse should have called the facility's Medical Director. During an interview on 12/10/24 at 4:57 PM, the DON said if the physician was not answering the phone, the nurse was responsible to use the telehealth program or contact the medical director. The DON said she expected the nurse to have placed Resident #16 name on the 24-hour report so oncoming nurses could have monitored him for continuity of care. The DON said when a resident had a change in condition the nurses and management were to follow up . The DON said it was important to recognize changes in condition because it could be lifesaving to ensure the resident got proper care timely and for the best patient outcome. During an interview on 12/12/24 at 2:44 PM, the Administrator said when a resident had a change in condition the nurse was to notify the physician. The Administrator said she was not clinical, and she would have to refer to the DON to answer expectations on when the physician was unable to be reached, or the risks of not contacting the physician. Record review of the facility's policy titled, Notification of Changes revised 02/10/29, indicated . To provide guidance on when to communicate acute changes in status to the MD, NP and/responsible party. The facility will immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or appropriate family member(s) of the following: . 3. A significant change in the physical, mental, or psychosocial status of the resident. a. Immediate Physician Notification- the physician is notified immediately and should respond timely (within minutes), the Medical Director will be contacted before the resident will be sent for emergency room evaluation. b. Non immediate physician notification- the physician is notified and there should be a return call within the same day 46892

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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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45879 Based on observation, interview, and record review the facility failed to ensure residents had a right to personal privacy and confidentiality of his or her personal and medical records for 1 of 4 residents (Resident #17) reviewed for privacy and confidentiality. The facility failed to ensure LVN BB logged out of her computer and protected Resident#17's Medication Administration Record. This failure could place residents at risk for low self-esteem, loss of dignity, and decreased quality of life due to medication administration records being accessible to others. Findings include: Record review of Resident #17's face sheet, dated 12/11/24, indicated a [AGE] year-old female who was admitted to the facility on [DATE] and readmitted on [DATE]. Resident #17 had diagnoses which included diabetes (a disease that occurs when your blood glucose, also called blood sugar, is too high), anxiety (a feeling of fear, dread, and uneasiness), depression (sadness), and high blood pressure. Record review of Resident #17's 5-day MDS assessment, dated 11/01/24, indicated Resident #17 sometimes understood and was sometimes understood by others. Resident #17's BIMS score was 07, which meant she was moderately cognitively impaired. Resident #17 required help with toileting bed mobility, dressing, transfers, personal hygiene, and eating. The MDS indicated she took insulin medication during the 7-day look-back period. During an observation and interview on 12/09/24 at 11:00 a.m., RN BB stepped away from the medication cart and entered Resident #17's room to check her blood sugar. RN BB left the computer screen (on top of the medication cart) unlocked where the medication administration record of Resident#17 was clearly displayed. While RN BB was in the room staff and residents were observed walking by the unlocked computer screen. RN BB said she left the computer screen open for Resident #17 because she was in a hurry. She said she should have closed the MAR before she entered Resident #17's room. She said it was a HIPPA (stands for Health Insurance Portability and Accountability Act, a federal law that protects the privacy and security of patients' health information) violation to keep the MAR open where others could see Resident #17's personal information, such as diagnosis and medication orders. During an interview on 12/11/24 at 12:08 p.m., the DON said she expected the nurses and med aides to provide full visual privacy and confidentiality of information for all residents. She said if the staff left the MAR open anyone could walk up to it and see personal information or change orders under the logged-in person's name. The DON said failure not to protect the resident's information could cause poor self-esteem and embarrassment for the resident. During an interview on 12/11/24 at 3:32 p.m., the Administrator said she expected the MAR to always be closed when unattended because of resident information and privacy. (continued on next page)

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the facility's policy titled Residents Rights, revised February 20, 2021, indicated, Policy: #7. Privacy and confidentiality: The resident has a right to personal privacy and confidentiality of his or her personal and medical records. a. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. b. The resident has a right to secure and confidential personal and medical records. i. The resident has the right to refuse the release of personal and medical records except as provided at S483.70(i)(2) or other applicable federal or state laws.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33249 Based on interview and record review the facility failed to develop and implement a baseline care plan each residnet that included the instructions needed to provide effective and person-centered care of the resident that met professional standards of quality of care for 1 of 2 resident's (Resident #108) reviewed for baseline care plans. The facility failed to ensure Resident #108's weight bearing status to her fractured right arm was addressed on the baseline care plan. This failure could place residents at risk of increased pain, and worsening of fractures. Findings include: Record review of Resident #108's face sheet, dated 12/11/2024, indicated a [AGE] year-old female who admitted to the facility on [DATE]. Resident #108 had diagnoses which included fracture of the right humerus (right upper arm), muscle weakness, unsteadiness on feet and the lack of coordination. Record review of Resident #108's Baseline Care Plan, dated 11/26/2024, indicated Resident #108 desired to discharge back home, advance directive status was a full code status, had a risk for ADL/mobility performance impairment due to a fracture, used a wheelchair as an assistive device, required physical assistance with bed mobility, transfers, toileting, locomotion, was independent with eating, and was totally dependent with bathing. The Baseline Care Plan Indicated Resident #108 had risk factors for falls due to severe weakness/deconditioning and had the potential to fall. The Baseline Care Plan did not indicate Resident #108's weight bearing status to the fractured right arm. Record review of Resident #108's hospital discharge orders, dated 11/26/2024, indicated continue shoulder restraints, work with physical therapy, and follow up with the orthopedic physician within 1-2 weeks. Record review of Resident #108's Admission MDS, dated [DATE], indicated Resident #108 understood and was understood by others. Resident #108's BIMS score was 14, which indicated she was not cognitively impaired. Resident #108 required partial/moderate assistance with toileting hygiene and bathing, and substantial/maximal assistance with bathing, personal hygiene and dressing. Record review of Resident #108's consolidated physician's orders, dated 12/11/2024, indicated on 11/27/2024 the physician ordered occupational therapy services 5 times a week for 12 weeks for self-care, ADL retraining, therapeutic activities, therapeutic exercises, neuromuscular re-education, safety education and modalities as needed. During an interview on 12/11/2024 at 8:45 a.m., RN B said she was unaware of Resident #108's right arm weight bearing status. RN B said nursing should know Resident #108's weight bearing status to her right arm because not knowing could be dangerous. RN B said bearing weight on a fracture bone could cause more injury. RN B said the baseline care plan, and/or the comprehensive care plan should indicate Resident #108's weight bearing status to her arm. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Sulphur Springs Health and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 411 Airport Rd Sulphur Springs, TX 75482	

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/11/2024 at 8:53 a.m., the OTA stated she believed Resident #108 was non-weight bearing. The OTA said she would find the weight bearing status of Resident #108 and provide to the State Surveyor. During an interview on 12/11/2024 at 2:52 p.m., the Treatment Nurse said she had been a charge nurse recently and provided care to the residents. The Treatment Nurse said she provided care to Resident #108. The treatment nurse said she was not aware of Resident #108's weight bearing status to the right arm fracture. The treatment nurse said the care plan should reflect a weight bearing status to prevent further injury. The treatment nurse said the baseline care plan should indicate the care a resident required and was on-going. During an interview on 12/11/2024 at 3:12 p.m., the DON said the process was when an admission came therapy evaluated the needs of the resident and provided recommendations. The DON said if therapy failed to make recommendations, then the physician should be notified for weight bearing orders. The DON said the baseline care plan would implement safety and prevention of injury or re-injury. The DON said she had not formulated a process for reviewing the baseline care plans since she was newly appointed to her position. The DON said she was responsible for ensuring the baseline care plan was completed and accurately reflected the resident's needs. During an interview on 12/12/2024 at 10:04 a.m., the Administrator said Resident #108's weight bearing status should be part of the baseline care plan. The baseline care plan would direct Resident #108's care and would especially direct the care of her fractured arm. The Administrator said she expected therapy, after the evaluation to address weight bearing restrictions. The Administrator said it should be reviewed by nursing and again in the management morning meeting. During an interview on 12/12/2024 at 10:30 a.m., the OTA said she was unable to local the weight bearing status for Resident #108. The OTA said staff should be aware of the weight bearing status to prevent further complications. Record review of a Baseline Care Plans policy, dated 5/13/2021 and revised on 4/02/2024, indicated Resident person-centered baseline care plans are developed and implemented for new admission residents. The baseline care plans will be developed and implemented from minimum healthcare information necessary to properly care for a resident including, but not limited to initial goals based on admission orders, admission evaluation/assessments, physician orders, dietary orders, therapy services, social services, and resident choices.

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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** 45810 Based on interviews and record reviews the facility failed to develop and implement a comprehensive person-centered care plan for each resident, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment for1 of 2 residents (Resident #37) reviewed for Care Plans. The facility failed to update Resident #37's Care Plan to reflect a history of Staph dermatitis (an infection caused by staphylococcus bacteria) with interventions for the antibiotic use and the staff to monitor the resident for possible Staph symptoms. This deficient practice could place residents at risk of not receiving the care and services they needed. Findings include: Record review of Resident #37's face sheet, dated 10/10/24, indicated a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #37 had diagnoses which included cerebral infarction (a stroke resulting from disrupted blood flow in the brain), hemiplegia (paralysis of one side of the body), chronic respiratory failure (condition in which the lungs cannot get enough oxygen in the blodd stream) and diabetes mellitus type 2 (a disease that results in problems controlling blood sugar levels). Record review of Resident #37's care plan, last revised 07/08/24, indicated he had an ADL self-care deficit and required total assistance from 2 staff for bed mobility, toileting, transfers, bathing and set up assistance for eating. The care plan did not indicate a diagnosis of staph dermatitis or interventions. Record review of Resident #37's quarterly MDS, dated [DATE], indicated he could make himself understood and he usually understood others. Resident #37 had a BIMS score of 9, which meant he had moderately impaired cognition. Record review of Resident #37's order summary report, dated 12/10/24, indicated he had an order for Bactrim DS Oral tablet 800-160mg (Sulfamethoxazole-Trimethoprim) Give 1 tablet by mouth two times a day for staph dermatitis 14 days. During an interview on 12/11/24 at 02:20 PM, the Medical Director for the facility said he expected the facility to be aware of Resident #37's diagnosis for staph dermatitis as well as the antibiotic Bactrim DS while in use. He said he cultured Resident #37 in the past for the infection and did not feel he needed to do so again because it did not completely go away. The Medical Director said the staff should have been made aware of the diagnosis when he gave orders for the antibiotic used for staph dermatitis. (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 12/11/24 at 02:47 PM, the DON said Resident #37 should have had the antibiotic and the staph dermatitis infection on his care plan. She said the MDS nurse was responsible for updating the care but had been in the hospital. The DON said the failure placed Resident #37 at risk, impeded resident care, decrease in quality of care, and the nurses not knowing the proper diagnosis and treatments to care for him. During an interview on 12/11/24 at 02:54 PM, the Administrator said her expectation was for Resident #37's diagnosis of staph dermatitis and antibiotic use to be included in the resident's care plan. She said the IDT was responsible for ensuring the care plans were accurate and ultimately the MDS nurse should have included it in the care plan. The Administrator said the DON and ADON added acute care plans and MDS completed the comprehensive care plans. The Administrator said the failure placed risk for the staff not knowing what was going on with Resident #37 and how to care for him. Record review of the facility's policy Comprehensive Care Plan, dated 9/2/24, indicated: Policy: It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment . 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.

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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 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33249 Based on observation, interview and record review the facility failed to provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities both facility sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interation in the community for 3 of 3 residents (Residents #13, #42 and #48) reviewed for activities. The facility failed to provide their scheduled activities on December 9th, 10th and 11th for all residents which included Residents #12, #42 and #48. This failure could place residents at risk for not having activities to meet their interests or needs and a decline in their physical, mental, and psychosocial well-being. Findings include: 1. Record review of Resident #13's face sheet, dated 12/11/2024, indicated Resident #13 was an [AGE] year-old female who admitted to the facility on [DATE] and readmitted on [DATE]. Resident #13 had diagnoses which included heart failure, and multiple sclerosis (an autoimmune disease attacking the brain, spinal cord, and optic nerves). Record review of Resident #13's Comprehensive Care Plan, dated 4/08/2024, indicated Resident #13 was independent in making activity choices and attending activities of preference. Resident #13 attended meals in the dining room and activities as she wished. The goal of the care plan was Resident #13 would remain independent in activity choices and participation. The interventions included provide a program of activities that was of interest and empowered the resident by encouraging/allowing choice, self-expression, and responsibility and to provide the resident with material for individual activities as desired. Record review of Resident #13's Quarterly MDS, dated [DATE], indicated Resident #13 was able to understand and was understood by others. Resident #13 was not cognitively impaired with a BIMS score of 15. Record review of Resident #13's Activity Participation Review, dated 11/27/2024, was completed by the AD, indicated Resident #13 enjoyed group activities such as bingo, dominos, arts and crafts, social events and socializing with others. During an interview on 12/11/2024 at 11:16 a.m., Resident #13 said last Thursday (12/5/2024) a week ago was the last activity they had. Resident #13 said they had bingo, and the residents love bingo. Resident #13 said she wanted to finish painting her Christmas art and went to go to the AD office for more brown paint, but the AD was not at work. 2. Record review of Resident #42's face sheet, dated 12/11/2024, indicated a [AGE] year-old female who admitted to the facility on [DATE] and readmitted on [DATE]. Resident #42 had diagnoses which included heart failure and dementia (memory loss). (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #42's Quarterly MDS, dated [DATE], indicated Resident #42 usually understands and was usually understood. Resident #42's BIMS score was 8, which indicated Resident #42 had moderate cognitive impairment. Record review of Resident #42's Comprehensive Care Plan, dated 3/06/2024, indicated Resident #42 was independent in making activity choices and attending activities of preference. Resident #42 attended meals in the dining room and activities as she wished. The goal of the care plan was Resident #42 would remain independent in activity choices and participation. The interventions included provide a program of activities that was of interest and empowered the resident by encouraging/allowing choice, self-expression, and responsibility and to provide the resident with material for individual activities as desired. Record review of Resident #42's AHS-Activity Participation Review, dated 12/03/2024, indicated Resident #42's activity preferences were to attend group activities such as bingo, socialization with others, and family visits. 3. Record review of Resident #48's face sheet, dated 12/11/2024, indicated the resident was admitted to the facility on [DATE] and readmitted on [DATE]. Resident #48 had diagnoses which included acute and chronic respiratory failure, heart failure, and bipolar disorder (chronic mood disorder that causes intense shifts in mood, energy levels and behaviors). Record review of Resident #48's Quarterly MDS, dated [DATE], indicated Resident #48's usually understands and was usually understood. Resident #48's BIMS was a 10, which indicated moderate cognitive impairment. In Section D0700 indicated Resident #48 sometimes felt lonely or isolated from others around her. Record review of Resident #48's Comprehensive Care Plan, dated 11/22/2023 and updated on 11/14/2024, indicated Resident #48 was independent in making activity choices and attended activities of preference. Resident #48 ate in the dining room and sat in the lobby visiting with others most days. The goal of the care plan was Resident #48 would remain independent in activity of choices and participate. The interventions included to introduce the resident to residents with similar backgrounds, interests, and encourage and facilitate interactions, provide the activity calendar, provide materials for individual activities, and provide a program of activities that is of interest and empowers the resident by encouraging/allowing choice, self-expression and responsibility. Record review of Resident #48's AHS-Activity Evaluation, dated 11/15/2024, indicated it was very important for Resident #48 to do things with groups of people and did her favorite activities. The evaluation indicated Resident #48's interests included cards, games, puzzle, arts, crafts, hobbies, exercises, sports, music and reading. Record review of the Activity Calendar, for December 2024 dated 12/09/2024 at 11:54 a.m., Monday 12/09/2024 scheduled activities were: 8:30 a.m. Daily Delight; 10:00 a.m. Manicure Monday, and 2:00 p.m. bingo. Tuesday 12/10/2024 scheduled activities were: 8:30 a.m. Daily Delight; 10:00 a.m. exercise with, and 2:00 p.m. dominoes. Wednesday 12/11/2024 scheduled activities were: 8:30 a.m. Daily Delight, 10:00 a.m. volleyball, and 1:30 p.m. Bible study. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation and interview on 12/09/2024 at 2:00 p.m., MR said she shared an office with the AD. MR said the AD was not there today. MR said she was unsure where the resident group activities were held. During an observation on 12/9/2024 at 2:05 p.m., in both dining room areas revealed no activity of bingo occurred. During an observation on 12/10/2024 at 8:25 a.m. - 8:35 a.m. revealed the small dining room was being cleaned by housekeeping, and the large dining room had no activity occurring. The activity of Daily Delight did not occur in either activity area. During an interview on 12/10/2024 at 8:35 a.m., MR said the AD was not there today. During an observation on 12/10/2024 at 10:05 a.m., there was no exercise group with occurring in the small dining room, the large dining room, or the AD office area. During an interview on 12/10/2024 at 12:05 a.m., CNA AA said she was unaware of the activity of Daily Delight. CNA AA said she had not assisted any residents to Daily Delight or Exercising with today. During an observation on 12/11/2024 at 8:30 a.m., both dining rooms were observed and there was not any activity which occurred including the scheduled activity of Daily Delight. During an observation and interview on 12/11/2024 at 10:22 a.m., both activity areas were observed and there was not an activity of volleyball. The Social Worker was standing at the nurse's desk, and she said she had not seen the activity of volleyball this morning and the Social Worker said the AD was not at work today. During an interview on 12/11/2024 at 11:21 a.m., Residents #42 and #48 were lying in their beds awake, lights were out, and watching television. Residents #42 and #48 said they had not had any activities since last Thursday (12/5/2024) when a group of high school kids came to help them with bingo. Resident #42 said can you image how bored it gets here with no activities? Resident #48 said we are bored, and activities are important to us. During an interview on 12/11/2024 at 2:46 p.m., the Treatment Nurse said the staff provide and then should ensure residents attended activities if they desired. The Treatment Nurse said the residents could experience boredom, and increased depression. The Treatment Nurse said activities could prevent falls, and pressuring injuries by keeping the resident active. During an interview on 12/11/2024 at 3:06 p.m., the DON said she expected the residents to be provided an activity program. The DON said when the AD was not present then she expected someone to be assigned to the activity program. The DON said the AD reported to the Administrator. The DON said when residents were not provided activities, they could become bored, stagnant, and depressed with nothing to look forward to. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 12/12/2024 at 10:01 a.m., the Administrator said the AD was responsible for ensuring the residents were provided an activity program. The Administrator said there was not an activity assistant who could provide activities when the AD was out. The Administrator said when the residents were not provided activities this could affect their quality of life. The Administrator said she monitored the activity program by hearing the announcements of activities. Record review of a Recreation Services policy, dated 1/2015, indicated, A program calendar will be developed that reflects planned programming based on the current assessed needs and interests of the facility population. The purpose of the calendar is to inform residents, family, staff, and volunteers of the current month's programs.

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F 0689

Level of Harm - Immediate jeopardy to resident health or safety

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 46892

Based on observation, interview and record review the facility failed to ensure the resident environment remained as free of accident hazards as was possible and failed to ensure each resident received supervision and assistance devices to prevent accidents for 1 of 3 residents (Resident #14) reviewed for accidents and supervision.

1. The facility failed to ensure 2-person assistance was used while providing Resident #14 a bed bath on 06/09/2024. This resulted in Resident #14 falling out of bed and fracturing her right distal tibia (right lower end of the leg).

2. The facility failed to ensure staff knew where to find resident information on the required level of assistance each resident needed.

An Immediate Jeopardy (IJ) situation was identified on 12/11/2024 at 4:25 PM. While the IJ was removed on 12/12/2024 at 3:59 PM, the facility remained out of compliance at a scope of isolated with the potential for minimal harm that is not immediate jeopardy, due to the facility's need to evaluate the effectiveness of the corrective systems that were put into place.

This failure could place residents at risk for falls, injuries and hospitalization s.

Findings include:

Record review of Resident #14's face sheet, dated 12/12/2024, indicated Resident #14 was an [AGE] year-old female initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident #14 had diagnoses which included chronic obstructive pulmonary disease (chronic inflammatory lung condition that affects the respiratory system) and rheumatoid arthritis (chronic disease that causes inflammation of the joints and pain and can also affect other body systems).

Record review of Resident #14's quarterly MDS assessment dated [DATE], indicated Resident #14 was dependent on staff for toileting hygiene, showering/bathing self, and personal hygiene.

Record review of Resident #14's Quarterly MDS Assessment, dated 10/25/2024, indicated Resident #14 usually understood others and was usually able to make herself understood. Resident #14 had a BIMS score of 8, which indicated her cognition was moderately impaired. Resident #14 was dependent on staff for toileting hygiene, showering/bathing self, and personal hygiene. Resident #14 required substantial to maximum assistance with rolling left and right. T Resident #14 was always incontinent.

Record review of Resident #14's care plan, revised 11/06/2024, indicated she had an ADL self-care performance deficit and was at risk for not having her needs met in a timely manner related to weakness, immobility, poor balance, and forgetfulness. Resident #14 indicated she required for bed mobility maximum assistance of 2 staff, transfers total assistance of 2 staff using a lift, toileting maximum assistance of 2 staff, and bathing total assistance of 1. 2 staff for transfers in and out of the shower.

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of Resident #14's progress note, dated 06/09/2024 at 11:48 AM, indicated, Called to resident room by aide resident sitting in floor beside bed. Aid [sic] was giving resident a bed bath and asked resident roll onto her left side. Resident rolled to [sic] fast and to [sic] far and slid out of bed aid [sic] was able to partially catch resident before her whole body hit the floor resident did not hit her head full assessment done no deformity or shortening noted Resident assisted back into bed resident has bruise to right ankle resident can move foot with no pain. MD, RP and Admin notified signed by LVN Z. Record review of Resident #14's progress note dated 06/09/24 at 9:25 PM and signed by LVN Z, indicated . received x-ray results resident has FX (fracture) of distal tibia called [telehealth] got order to send to ER. Record review of Resident #14's progress note dated 06/10/24 at 2:32 AM and signed by LVN FF, indicated . Resident returned from ER at approx. (approximately) 0030 (12:30 AM) hrs (hours) via ambulance. Splint to RLE (right lower extremity) to immobilize r/t (related to) fx to distal tibia . Record review of Resident #14's progress note dated 06/11/24 at 11:57 AM signed by RN B, indicated . Res (resident) back from ortho (orthopedic) apt. (appointment) with new cast to r/t lower leg circulation cont. (continues) . Record review of Resident #14's radiology (medical imaging) Patient Report for the right ankle, dated 06/09/2024, indicated, .Findings: there is a fracture of the distal tibia (fracture of the lower leg). Record review of Resident #14's Post Fall Evaluation, with an effective date of 06/09/2024, signed 07/18/2024 by the previous DON, indicated position at the time of the fall lying in bed, activity at the time of the fall was a bed bath, range of motion was limited per the resident's norm, the resident had no falls in the past 6 months, immediate intervention implemented to prevent further falls was education. The root cause or causes of the fall was bed positioning during bed bath. Intervention/system change was assist rails. Record review of an undated witness statement signed by CNA A indicated, On Sunday June 9, 2024 I, [CNA A], was working west hall when [Resident #14] got on her call light needing to be changed when I [CNA A] went to change [Resident #14] I notice [sic] she had BM all up and down her from head to toe. I told her would she like a shower to get all the BM off her she said no I [CNA A] than told [Resident #14] she needed and [sic] bed bath to remove all the BM. [Resident #14] wasn't happy but turned to the side saying she don't want anything done to her I [CNA A] told [Resident #14] I can't not [sic] leave her in that condition I [CNA A] turned my back to get everything I needed to clean [Resident #14] up when I notice [sic] she had throwed [sic] her legs off the side of the bed and started to go down on her knees I [CNA A] ran over to the other side to help her to the floor when ask [sic] [Resident #14] why did she throw her legs off the bed she look [sic] at me and cut [sic] her eyes. During an observation on 12/11/2024 at 12:41 PM, revealed Resident #14 had assist bars on both sides of the bed. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 12/09/2024 at 11:49 AM, Resident #14 said a CNA was changing her and the CNA let me fall. Resident #14 said the CNA was talking on her phone and the CNA turned her back to her. Resident #14 said she told the CNA I'm going to fall and she fell . Resident #14 said she broke her ankle, and this happened about 3-4 months ago and they got rid of her the same day she was a black girl. Resident #14 said she did not know the CNAs name. During an attempted phone interview on 12/11/24 at 12:14 PM, LVN Z did not answer the phone. During an attempted phone interview on 12/11/2024 at 12:17 PM, the previous DON did not answer the phone. During an interview on 12/11/2024 at 12:58 PM, CNA C said she worked on 06/09/2024, but was not the CNA who provided care to Resident #14. CNA C said she remembered the CNA who cared for Resident #14 the day of the fall, but she could not remember her name. CNA C said Resident #14 required 2-person assistance for bed baths and mobility. During an interview on 12/11/2024 at 1:59 PM, CNA E said Resident #14 required 2-person assistance for her bed baths and repositioning. CNA E said whenever it was hard to turn the residents, she would use 2 people to provide care. CNA E said she did not have her log in to the electronic system. CNA E said sometimes when they reported at the end of the shift the other CNAs reported to her the level of assistance the residents required with their ADLs. During an interview on 12/11/2024 at 2:01 PM, CNA F said Resident #14 required 2-person assistance for her bed baths. CNA F said Resident #14 required one person on one side and one person on the other because she was totally dependent for mobility. CNA F said if she did not know the level of assistance a resident required, she would ask the nurse. CNA F said she relied on the nurse to tell her. CNA F said the level of assistance required by a resident for ADLs should be in the computer. CNA F attempted to demonstrate where to locate the information but was unable to find it. During an interview on 12/11/2024 at 2:04 PM, RN B said she had been a nurse at the facility for [AGE] years, and Resident #14 had always required 2-person assistance with all her ADLs for safety because of the air bed she had. RN B said most of the time the CNAs could ask the nurses and they could tell them the type of assistance the residents required. RN B said the information might be in the computer where the CNAs documented that they used to have a binder with the level of assistance required for the residents ADLS at the nurses' station, but it was no longer there. RN B said she was not working on 06/09/2024 when Resident #14 fell . During an interview on 12/11/2024 at 2:08 PM, CNA C said she remembered it was CNA A who provided care to Resident #14 on 06/09/2024. CNA C said if she was not familiar with a resident, she would ask the nurse what type of assistance they required for their ADLs. CNA C said there used to be a book at the nurses' station with the information, but it was no longer there. CNA C said she did not know where in the electronic system she could find the information regarding the level of assistance a resident required with their ADLs. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER: Sulphur Springs Health and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE: 411 Airport Rd Sulphur Springs, TX 75482	

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 12/11/2024 at 2:13 PM, CNA G said she was PRN, and Resident #14 required 2-person total assistance for changing her. CNA G said she usually asked the other CNAs the level of assistance required by the residents. CNA G said she did not know if there was anywhere they could look, and they did not have time to look in the electronic system when they started their shift. CNA G said it was important to know the level of assistance a resident required for their ADLs so they knew what the residents needed, and they could properly care for them. During an interview on 12/11/2024 at 2:23 PM, the ADON said Resident #14 required 2-person assistance for her ADLs. The ADON said the staff could look in the Kardex (electronic system they chart on) for the information regarding how much assistance the residents required for their ADLs. The ADON said the CNAs should be aware they could find the information in the Kardex. The ADON said if the CNAs did not know where to find this information it was a safety issue. During an interview on 12/11/2024 at 2:26 PM, the DON said Resident #14 required 2-person assistance for ADLS which included bed mobility and bathing. The DON said the MDS Coordinator was responsible for ensuring the care plans were updated. The DON said she thought where the care plan indicated bathing total assistance of 1. 2 staff for transfers in and out of the shower it was saying 1-to-2-person assistance, but she had only known for Resident #14 to require 2-person assistance. The DON said the care plan should indicate 2-person assistance. The DON said she did not know what happened on 06/09/2024. The DON said the MDS Coordinator should have revised Resident #14's care plan after the fall. The DON said the CNAs should be checking the Kardex for the level of assistance required, and they should have access to it. The DON said in the past she verbally provided the CNAs education regarding using the Kardex, but she had not done an official in-service. The DON said it was important for the staff to know the level of assistance a resident required for the resident's safety and to prevent injuries to themselves or to the residents. During an interview on 12/11/2024 at 3:24 PM, the Administrator said when Resident #14 had the fall on 06/09/2024, she had only been at the facility for four days, and she did not remember much about the incident. The Administrator said she remembered the CNA, the bed bath, and she thought Resident #14 was too close to the edge of the bed. The Administrator said she only remembered the CNA was in the room and was trying to change the bed and Resident #14 rolled off the bed. The Administrator said the CNA did not work there anymore, and she could not recall the CNAs name. During an attempted phone interview on 12/11/2024 at 3:40 PM, CNA A did not answer the phone. During an attempted phone interview on 12/12/2024 at 10:08 AM, CNA A did not answer the phone. Record review of the facility's Fall Management System, reviewed 02/19/2021, indicated It is the policy of this facility that each resident will be assessed to determine his/her risk for falls, and a plan of care implemented based on the resident's assessed needs . The licensed nurse will assess and document the condition of the resident at least once per shift for at least 72 hours post fall. 4. Documentation in the nurse's notes and/or care plan will reflect interventions attempted . An Administrative nurse will ensure that the resident's plan of care is revised to reflect each fall and interventions that were implemented . interventions will be implemented in an attempt to prevent the resident from sustaining further falls. Based on the investigation results, the licensed nurse will initiate intervention measures as soon as practicable (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	This was determined to be an Immediate Jeopardy (IJ) was identified on 12/11/2024 at 4:25 PM. The Administrator and the Corporate Nurse were notified. The Administrator was provided with the IJ template on 12/11/2024 at 4:39 PM. The following Plan of Removal submitted by the facility was accepted on 12/12/2024 at 1:41 PM: Issue Cited: Failure to use 2 staff transfer assistance while providing Resident #14 a bed bath. The Facility failed to ensure staff knew where to find resident information on the required assistance needed. 1. Immediate Action Taken: A. On 6/9/2024 Resident #14 was assessed by charge nurse, notification to physician and X-rays obtained after the fall. Resident #14 was monitored every shift. B. On 6/10/2024 the Nurse Assistance was suspended pending investigation where she was subsequently terminated due to failure to report back to work. C. On 6/10/2024 the DON/Designee completed an investigation into an incident involving Resident #14. D. On 6/10/2024 the DON provided in-service education to all staff on Abuse and neglect. This education was completed on 6/10/2024. E. On 6/14/2024 the DON/Designee in-service education with license nurses and Nurse aide on use of PCC Kardex that determines type and amount of care residents required for all ADL's. This was completed on 6/15/2024. All clinical staff are provided with training and access upon hire. F. On 12/11/2024 DON/Therapy assessed all residents to determine the type and number of staff assistance required for ADL's and validated that all Kardex have been updated. This was completed on 12/11/2024. F. On 12/11/2024 the DON/Designee provided in-service education with all license nurses and Nurse aide on use of PCC Kardex that determines type and amount of care residents required for all ADL's. This was completed on 12/12/2024 at 6:30 am, and no licensed nurse or Nurse Aide will be allowed to work until this education has been provided. 2. Identification of Residents Affected or Likely to be Affected: On 6/14/2024 the DON/Designee reviewed all residents requiring 2 persons bed mobility and bathing to verify that care plan and C.N.A. Kardex reflected the type of care residents require. 3. Actions to Prevent Occurrence/Recurrence: A. DON/Designee will review 24-hour nurse report daily in the morning meeting to validate that the care plan and Kardex has been reviewed/revised for any resident that has a change in bed mobility or bed bath. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	B. The DON/Designee will review all Incident/Accidents daily in the morning meeting to validate those residents with falls that involved bed mobility or falls during bed baths, had the appropriate number of staff needed during the transfer. C. The Regional Nurse Consultant will provide oversight into this process weekly x 4 weeks. D. The facility will continue to provide training to all license nurse and Nurse Aides upon hire and as need on documentation procedures for the Kardex system on PCC to identify type and amount of care a resident requires. On 12/11/2024 the facility's Administrator notified the Medical Director regarding the Immediate Jeopardy the facility received related to and reviewed plan to sustain compliance Date Facility Asserts Likelihood for Serious Harm No Longer Exists: 12/12/24 Monitoring of the POR included the following: During an interview on 12/12/2024 at 1:50 p.m., the DON and the Corporate Nurse said the In-service on ADL care was verbal and there was not any handouts or policy to review. The DON said she in-serviced on positioning a resident in bed during care, and in-serviced verbally on Finding the information on the amount of assistance each resident for bathing, and bed mobility required on the Kardex. The DON said the staff not only verbalized understanding but also demonstrated understanding of the use of the Kardex. The DON and Corporate nurse said the post incident/fall protocol policy was not an actual policy but an assessment in the computerized system required completion after a fall. During an interview on 12/12/2024 at 2:46 PM, the DON said she would review the 24-hour report daily in the morning meetings and verify that all the necessary assessments and updates were completed for any incidents that occurred the day before. During an interview on 12/12/2024 at 2:20 PM, the Medical Director said he had been contacted regarding the immediate jeopardy and plan of removal. During interviews conducted on 12/12/2024 between 2:29 PM and 3:57 PM, MA N, LVN O, CNA P, the ADON, CNA F, LVN K, CNA H, CNA Q, LVN R, CNA E, CNA G, the Treatment Nurse, MA D, MA S, CNA T, CNA U, CNA V, LVN W, MA X, and CNA Y were able to verbalize they were provided in-service education on the use of the Kardex and where to find the type and amount of care residents required for all ADL's. Record review of Resident #14's progress notes indicated on 06/09/2024 she was assessed by the charge nurse; the physician was notified and an x-ray obtained. Resident #14's progress notes indicated she was monitored every shift from 6/9/2024-6/11/2024. Record review of a facility document titled, Associate Discplinary [sic] Memorandum, indicated CNA A was suspended pending investigation beginning on 06/10/24. After the investigation was completed, discharge was effective 06/13/24. The document indicated, During f/u (follow up) call for investigation employee quit on the spot w/ (with) no notice via phone-hung up on the Admin/DON signed by the Administrator and the previous DON on 06/13/2024. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review completed of Resident #14's Witnessed Fall Incident Report, dated 06/09/2024 indicated, Nursing Description: called to residents room by aid [sic] resident sitting in the floor beside bed; Resident Description: I rolled out; Witnessed: Yes . Injuries observed at time of incident bruise right ankle (outer) . Other info rolled out of bed while getting bed bath . Record review of an In-Service Program Attendance Record with the topic Abuse and Neglect, dated 06/10/2024, indicated 23 staff signatures. Record review of an In-Service Program Attendance Record, dated 06/14/2024, with the topic Incontinent Care: Rotating and changing residents in a timely manner, completing showers as scheduled and upon request, know your residents and check for Kardex changes, and taking your time and letting the resident know what is happening with their care indicated 14 staff signatures. Record review of the CNA job description indicated Essential job Duties and Responsibilities: Assists residents with activities of daily living including bathing, dressing, grooming, toileting, changing of bed linens, and positioning in and out of bed, chair, etc. Assists with resident recreation programs. Prepares residents for meals and snacks, assists residents in eating where needed and records food intake. Reads and follows daily care plans; performs assigned restorative and rehabilitative procedures; reports changes in resident condition to nurse in charge; documents care provision on resident record/flowsheets as required and reports accidents and incidents; and provides nursing functions as directed by supervisor. Record review completed of the Kardex and care plans for 60 residents to verify they included the type and number of staff assistance required for ADLs and the Kardex and care plans matched. The Administrator was notified the Immediate Jeopardy was removed on 12/12/2024 at 3:59 PM. The facility remained out of compliance at a severity level of no actual harm, with the potential for minimal harm that is not immediate jeopardy, a scope of isolated due to the facility's need to evaluate the effectiveness of the corrective systems that were put into place.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47708 Based on observations, interviews, and record review the facility failed to ensure that residents requiring respiratory care were provided such care, consistent with professional standards of practices for 2 of 57 residents (Resident #14 and Resident #31) reviewed for respiratory care. 1. The facility failed to ensure Resident #14's oxygen was administered at 3 liters per minute via nasal cannula as prescribed by the physician. 2. The facility failed to ensure Resident #31's oxygen was administered at 4 liters per minute via nasal cannula as prescribed by the physician. This failure could place residents who receive respiratory care at risk for developing respiratory complications. The findings included: 1. Record review of the face sheet, dated on 12/10/24, indicated that Resident #14 was an [AGE] year-old female who admitted to the facility on initial admitted d 11/20/16, with diagnoses of COPD (chronic obstructive pulmonary disease with (acute) exacerbation (chronic inflammatory lung disease that causes obstructed airflow from the lungs, muscle weakness (a lack of muscle strength, meaning the muscles may not contract or move as easily as they used to), polyneuropathy (a type of neuropathy, or nerve disease, that affects many nerves), and essential hypertension (high blood pressure). Record Review of Resident #14's quarterly MDS assessment, dated 10/25/24 indicated that Resident #14 had clear speech and was usually understood by staff. The MDS revealed Resident #14 was usually able to understand others. The MDS revealed Resident #14 had a BIMS score of 08, which indicated moderately impaired cognition. The MDS revealed Resident #14 had no behaviors or refusal of care. The MDS revealed Resident #14 received oxygen therapy while a resident. Record Review of the comprehensive care plan, dated on 11/21/24, indicated that Resident #14 used oxygen therapy routinely and was at risk for ineffective gas exchange. The interventions included: Administer oxygen therapy per physician's orders, monitor for signs and symptoms of respiratory distress, and report to the physician as needed. Respiratory distress could include an increased respiratory rate, tachycardia, diaphoresis, lethargy, confusion, persistent cough, pleuritic pain, accessory muscle use, decreased oxygen saturation, or changes in skin color such as a bluish or grey tint and encourage resident to change position at least every two hours to promote lung expansion and to facilitate secretion movement and drainage. Record review of the oxygen order report, reviewed on 12/10/24 at 01:47 PM for Resident #14 indicated, Oxygen: O2 continuous @ 3LPM via Nasal Cannula, monitor Oxygen saturation notify physician if <92%. During observation on 12/09/24 at 11:48 a.m., Resident #14's oxygen concentrator was set at 2 liters per minute. Resident #14 was wearing a nasal cannula in her nose. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During observation on 12/10/24 8:32 a.m., Resident #14 oxygen concentrator was set at 2 liters per minute. Resident #14 was wearing a nasal cannula in her nose. 2. Record review of the face sheet, dated on 12/10/24, indicated that Resident #31 was a [AGE] year-old female who admitted to the facility on initial admitted d 10/18/23, with a diagnosis of acute respiratory failure with hypoxia (not enough oxygen in blood), COPD-chronic obstructive pulmonary disease with (acute) exacerbation (chronic inflammatory lung disease that causes obstructed airflow from the lungs), diastolic (congestive) heart failure (heart unable to relax normally between beats) and respiratory failure with hypoxia (not enough oxygen in blood). Record Review of Resident #31 MDS assessment, dated 10/23/24 indicated that Resident #31 had clear speech and was understood by staff. The MDS revealed Resident #31 was usually able to understand others. The MDS revealed Resident #31 had a BIMS score of 10, which indicated moderately impaired cognition. The MDS revealed Resident #31 had no behaviors or refusal of care. The MDS revealed Resident #31 received oxygen therapy while a resident. Record Review of the comprehensive care plan, dated on 6/26/24, indicated that Resident #31 used oxygen therapy routinely and was at risk for ineffective gas exchange; This was related to COPD, Chronic Respiratory Failure. The interventions included: Administer medications as ordered by the physician. Monitor/document any side effects and effectiveness; Administer oxygen therapy per physician's orders; Monitor for signs and symptoms of respiratory distress and report to the physician as needed. Record review of the oxygen order report, reviewed on 12/10/24 at 4:08 p.m., revealed Resident #31 physician's order, indicated oxygen on via nasal cannula @ 4 liters per minute as the need arises. During an observation on 12/09/24 at 10:54 a.m., Resident # 31 was set on 4 1/2 liters per minute of oxygen. Resident #31 was wearing a nasal cannula in her nose. During observation on 12/10/24 at 08:32 a.m., Resident # 31 was set on 4 1/2 liters per minute. Resident #31 was wearing a nasal cannula in her nose. During an interview on 12/11/24 at 9:22 a.m., Resident #14 stated she wore her oxygen cannula all the time. Resident #14 stated her oxygen was to be set on 4 liters per minute. During an interview on 12/11/24 at 9:22 a.m., Resident #31 stated she wore her oxygen cannula most of the time. Resident #31 stated her oxygen was to be set on 4 liters per minute. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/11/24 at 9:34 a.m., RN B stated she had been the charge nurse for [AGE] years at the facility. RN B stated she, and another RN oversaw one aide on the 300 hall. RN B stated when she arrived to work that she had noticed the oxygen concentrators were not set on the prescribed liters per minute as prescribed by the doctor. RN B stated she was off on Monday (12/9/24) and Tuesday (12/10/24) and had just returned back to work on today (12/11/24). RN B stated in-services on oxygen concentrators were completed last year. RN B stated her process for making the oxygen concentrator was set at the right liter per minute was to first check the physician order for the oxygen concentrator, then she would go in each room and check the oxygen concentrator to ensure the concentrator was set at the prescribed liters per minute. RN B stated during her time with setting the correct liters per minute on the oxygen concentrators that she also made sure the concentrators filters were clean. RN B stated, It was important to ensure the oxygen concentrator was set to the correct liters per minute because it could hurt someone, overextend the lungs, and you could kill someone that's why you have to be real accurate when setting the oxygen concentrator. During an interview on 12/11/24 at 9:25 a.m., the DON stated nursing staff were responsible for making sure the residents were set at the correct liters per minute on the oxygen concentrators. The DON stated she had been employed at the facility a year but only had been the DON for 30 days at the facility. The DON stated she oversaw the nursing department. The DON stated she was not aware that the residents were not set at the correct liters per minute. The DON stated in-services on the oxygen concentrator had been completed a few months ago. The DON stated every morning the facility had clinical meetings and she had spoken to staff about making sure the oxygen concentrators were set at the correct liter per minute as prescribed by the physician. The DON stated she conducted random rounds daily and sometimes twice a day once in the morning and once in the afternoon. It was important to prevent hospitalization and to ensure that the residents were breathing at their optimal rate to prevent blow out especially for the residents with COPD, you want to be extra careful as possible. During an interview on 12/11/24 at 11:25 a.m. the Administrator stated she had been employed since June 3rd ,2024. The Administrator stated she oversaw the nursing department. The Administrator stated she was not aware that Resident #14 and Resident #31 were not set on the correct liters per minute per physician orders. The Administrator stated she did not know when staff last completed in-services on the oxygen concentrators. The Administrator stated the nursing staff were to sign off on the concentration at least once a day verifying the oxygen concentrators were set at the prescribed liters per minute. The Administrator stated it was important to ensure staff were following the physician orders for the oxygen concentrators so the residents can get the right amount of oxygen to breath. Record Review of oxygen therapy policy titled Oxygen Administration review dated 1/5/20 indicated, Policy: To describe methods for delivering oxygen to improve tissue oxygenation; Procedure:(1) Verify Physician Order, (2) Order should have when to call the physician parameters (3) Assemble equipment (4) Explain procedure and provide privacy (5) Wash hands (6) Place No Smoking Oxygen in sign on the doorway (7) Evaluate/assess respiratory status, breathing pattern, and pulse oximeter reading (8) If a resident has a pulse oximeter reading is less than 90% , notify physician of pulse oximeter results and obtain further orders (9) Set up oxygen source.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45879 Based on observations, interviews, and record review the facility failed to ensure all drugs were only accessible by authorized personnel, for 1 of 6 medication carts (400 hall medication cart) observed for medication storage. The facility did not ensure the 400-hall medication cart was secured and unable to be accessed by unauthorized personnel. This deficient practice could place residents at risk for harm due to improper storage and drug diversion. Findings included: Record review of Resident #17's face sheet, dated 12/11/24, indicated a [AGE] year-old female who was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included diabetes, anxiety (a feeling of fear, dread, and uneasiness), depression (sadness), and high blood pressure. Record review of Resident #17's 5-day MDS assessment, dated 11/01/24, indicated Resident #17 sometimes understood and was sometimes understood by others. Resident #17's BIMS score was 07, which meant she was moderately cognitively impaired. The MDS indicated Resident #17 required help with toileting bed mobility, dressing, transfers, personal hygiene, and eating. The MDS indicated she took insulin medication during the 7-day look-back period. Record review of Resident #17's physician's order dated 11/01/24 indicated: Lyumjev (rapid-acting insulins for lowering blood sugar levels) Kwik Pen 100 Unit/ML Solution. Inject as per sliding scale: if 0 - 69 >70 notify MD; 70 -150 = 0; 151 - 200 = 1 units; 201 - 250 = 2 units; 251 -300 = 4 units; 301 - 350 = 6 units; 351 - 400 = 8 units; 401 - 999 >400 notify MD, subcutaneously before meals related to diagnosis of Diabetes. If glucose was below 70 or above 400 notify the physician. Record review of Resident #17's comprehensive care plan, dated 08/21/24, indicated Resident #17 had a diagnosis of diabetes and was at risk for unstable blood sugars and abnormal lab results. The interventions were to administer diabetic medication as ordered by the physician, monitor for adverse reactions, and report abnormalities as detected. During an observation and interview on 12/09/24 at 11:00 a.m., RN BB went into Resident #17's room to check her blood sugar. While in Resident #17's room, the medication cart was unlocked and pushed away from Resident #17's door. Observed staff and residents passing by the unlocked medication cart. RN BB came out of Resident #17's room and said she left the cart unlocked. She said it was her responsibility to lock the cart when left unattended. RN BB said it was a HIPPA violation and safety issue by leaving the cart unlocked and unattended. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/11/24 at 12:08 p.m., the DON said she expected the medication aides/nurses to always keep the carts locked for the security of the medications. She said failure to lock the medication cart(s) could lead to someone stealing medication, or a resident or visitor opening the cart, and taking some medication. During an interview on 12/11/24 at 3:32 p.m., the Administrator said the nurses were responsible for ensuring the carts were locked when not in use. She said if carts were left open anyone could obtain anything off the carts without authorization. The Administrator said she expected the nurse's carts to be locked to ensure the safety of others. Record review of the facility policy titled, Medication Storage, dated 01/20/21, indicated, Policy: It is the policy of this facility to ensure all medications housed on our premises will be stored, dated, and labeled according to the manufacturer's recommendations and sufficient to ensure proper sanitation, temperature, light, ventilation, moisture control, segregation, and security. Policy Explanation and Compliance Guidelines: 1. General Guidelines: a. All drugs and biologicals will be stored in locked compartments (i.e., medication carts, cabinets, drawers, refrigerators, medication rooms) under proper temperature controls. b. Only authorized personnel will have access to the keys to locked compartments c. During a medication pass, medications must be under the direct observation of the person administering medications or locked in the medication storage area/cart.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sulphur Springs Health and Rehabilitation	411 Airport Rd Sulphur Springs, TX 75482

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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 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, quality laboratory services/tests to meet the needs of residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45879 Based on interviews and record review, the facility failed to ensure laboratory services were obtained to meet the needs of 2 of 7 residents (Resident #48 and Resident #12) reviewed for laboratory services. 1. The facility failed to ensure Resident #48's lipid level (a blood test that measures the levels of different fats in your blood. The test can help identify abnormalities in your blood lipids and determine your risk for certain diseases, including heart disease and stroke) was drawn on 08/14/24. 2. The facility failed to obtain Resident #12's ordered Hgb A1C (hemoglobin A1C measures blood glucose level). These failures could place residents at risk of not receiving lab services as ordered, not receiving timely diagnosis and treatment, and not receiving appropriate monitoring for certain diseases. Findings included: 1)Record review of Resident #48's face sheet dated 12/11/24, indicated a [AGE] year-old female who was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included chronic obstructive pulmonary disease also known as COPD (a progressive lung disease that makes it difficult to breathe), heart failure (a serious condition that occurs when the heart is unable to pump enough blood and oxygen to the body's organs), and high blood pressure. Record review of Resident #48's annual MDS assessment dated [DATE], indicated Resident #48 understood and understood others. The MDS assessment indicated Resident #48 had a BIMS score of 15 indicating she was cognitively intact. The MDS assessment indicated she required assistance with her ADLs. Record review of Resident #48's comprehensive care plan last reviewed on 12/05/22 indicated Resident #48 had high blood pressure. The interventions were to obtain and monitor lab/diagnostic studies as ordered. Report results when available to the physician and follow up as needed. Record review of Resident #48's physician orders dated 08/07/24 indicated a lipid panel to be drawn in 1 week and then annually. Record review of Resident #48's lab requisition dated 08/14/24 indicated a lipid panel was to be drawn annually. The lab requisition did not indicate the lipid panel was to be drawn on 08/14/24. Record review of Resident #48's electronic health record did not indicate a lipid panel was drawn on 08/14/24. During an interview on 12/12/24 at 12:34 p.m., the Administrator said the lab requisition was not filled out correctly by the nurse and was not followed up by the nurse managers. She said they were aware of the missed lab after being questioned by the state surveyor and the DON would order the lab for tomorrow (12/13/24). (continued on next page)

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	33249 2)Record review of a face sheet dated 12/11/2024 indicated Resident #12 was an [AGE] year-old male who admitted on [DATE] with a diagnosis of diabetes (a chronic condition where the body cannot effectively use or produce enough insulin, leading to elevated blood glucose levels). Record review of an Admission MDS dated [DATE] indicated Resident #12 was understood, and usually understood others. The MDS indicated Resident #12's BIMs score was 13 indicating he had no cognitive deficits. Record review of the Consolidated Physician's Orders dated December 11, 2024, indicated on 11/15/2024 the physician ordered a Hgb A1C now and every three months for the diagnosis of diabetes. Record review of the Comprehensive Care Plan dated 11/11/2024 failed to address Resident #12's diagnosis of diabetes. Record review of Resident #12's electronic medical record failed to indicate the facility had obtained the ordered Hgb A1C. Record review of a QA form after state surveyor intervention from the laboratory provider dated 12/11/2024 indicated a requestion was received by the lab for Resident #12's Hgb A1C on 11/18/2024. The QA form indicated upon investigation A1C was missed as a clerical error on the part of the laboratory provider. During an interview on 12/11/2024 at 3:20 p.m., the DON said she had a lab tracking system but had not put this tracker in place. The DON said the process was once the nurse received the order, the nurse completed a requisition for ordered labs, the requisition was placed in the lab binder under the date the lab that it was expected to be obtained, and then the lab obtained the sample, processed, and provided the results. The DON said when the resident labs were missed the nursing staff were unaware of needed care delivery and could cause medication level problems. During an interview on 12/12/2024 at 10:10 a.m., the Administrator said she expected labs to be completed as ordered. The Administrator said obtaining lab results ensured the continuity of care. The Administrator said the nursing department was responsible and the orders should be reviewed in the morning meetings. Record review of a Radiology and other Diagnostic Services and Reporting policy dated 8/2012 and revised on 7/26/2022 indicated the facility must provide or obtain radiology and other diagnostic services when ordered by a physician, physician assistant, nurse practitioner, or clinical nurse specialist in accordance with state law State Diagnostic Tests 4)Routine orders and those orders for testing that are not ordered STAT will be communicated to the appropriate services to be performed/collected at the time specified by the physician.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47708 Based on observations, interviews, and record review, the facility failed to store, prepare, distribute and serve food in accordance with professional standards for food service safety in (1 of 1) kitchen reviewed for dietary services. 1) The facility failed to date all food items. 2) The dietary staff failed to properly seal refrigerated food items. These failures could place residents at risk for food contamination and foodborne illness. The findings included: During observation in the kitchen Refrigerator 1 of 3 on 12/09/24 at 10:02 a.m., the following were observed: -(1) zip lock bag of flour tortilla was not sealed closed. -(1) boiled egg had a prep date of 12/7/24 and had no expiration date. During an interview and observation of the kitchen on 12/11/24 at 10:03 a.m., the Dietary Manager stated the flour tortilla should have been sealed closed. The Dietary Manager stated boiled egg found in a zip lock bag should have had a use by date. The Dietary Manager disposed of the hard-boiled egg found in the refrigerator. During an interview on 12/11/24 at 11:07 a.m., the Dietary Manager stated she had been employed at the facility since February of 2024. The Dietary Manager stated she oversaw the dietary staff. The Dietary Manager stated, Yes, all food items in the refrigerator were to be labeled, dated with receive date, open date, and expiration date. The Dietary Manager stated Yes, staff completed in-services on labeling and dating a few weeks ago. The Dietary Manager stated she conducted walk thrus every morning in the kitchen. The Dietary Manager stated the Administrator conducted walk thrus once or twice a month in the kitchen. The Dietary Manager stated it was important to ensure staff were labeling, dating, and resealing refrigerator and frozen food items to make sure the residents did not get sick and to prevent salmonella. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 12/11/24 at 11:20 a.m., the Administrator stated she had been employed since June 3rd, 2024. She stated she oversaw the dietary staff. The Administrator stated, Yes, all food items in the refrigerator were to be labeled, dated with receive date, open date, and expiration date. The Administrator stated in-services on resealing refrigerated and frozen food items was completed this month. The Administrator stated she conducted walk thrus weekly in the kitchen and sometimes two times a week. The Administrator stated, No I was not aware of the dietary staff not dating, and resealing refrigerated food items in the refrigerator. The Administrator stated, Yes I do expect staff to follow policies and procedures. The Administrator stated, It was important for staff to label, date, and reseal refrigerated items because staff got to know when you can and cannot feed it to the residents. Record review of the kitchen policy titled Frozen and Refrigerated Foods Storage with review dated on 7/22/22, indicated, (7) Refrigerate cooked foods in shallow containers to speed the cooling process. Proper labeling of cooked foods includes the date placed in the refrigerator, and an expiration or use by date. Refrigerated products that are opened must be labeled with an opened on date. The use by date is 7 days from when the product was opened, unless there is a manufacturer's use by, expiration or sell by date. For all foods that have a manufacturer use by, sell by or expirations dates this date will be used. Examples of foods that typically have manufacturer, use by, sell by or expirations dates are cottage cheese, milk, sour cream, pre-pared refrigerated salads etc. Foods prepared in the building and properly cooled will be dated as to the date prepared and Use by date which will be 7 days from the date prepared; (9) Items stored in the refrigerator must be dated upon receipt, unless they contain a manufacturer use by, sell by, best by date, or a date delivered. Most pick stickers do have the delivery date on the sticker. They must also be dated with an expiration date unless they have one from the manufacturer (i.e., milk cartons, eggs). (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record Review of FDA Food code dated 2022 indicated, 3-602.11 Food Labels. (A) FOOD PACKAGED in a FOOD ESTABLISHMENT, shall be labeled as specified in LAW, including 21 CFR 101 - Food labeling, and 9 CFR 317 Labeling, marking devices, and containers. (B) Label information shall include: (1) The common name of the FOOD, or absent a common name, an adequately descriptive identity statement; (2) If made from two or more ingredients, a list of ingredients and sub-ingredients in descending order of predominance by weight, including a declaration of artificial colors, artificial flavors and chemical preservatives, if contained in the FOOD; (3) An accurate declaration of the net quantity of contents. (4) The name and place of business of the manufacturer, [NAME], or distributor; and (5) The name of the FOOD source for each MAJOR FOOD ALLERGEN contained in the FOOD unless the FOOD source is already part of the common or usual name of the respective ingredient. (6) Except as exempted in the Federal Food, Drug, and Cosmetic Act S 403(q)(3) - (5), nutrition labeling as specified in 21 CFR 101 - Food Labeling and 9 CFR 317 Subpart B Nutrition Labeling. (7) For any salmonid FISH containing canthaxanthin or astaxanthin as a COLOR ADDITIVE, the labeling of the bulk FISH container, including a list of ingredients, displayed on the retail container or by other written means, such as a counter card, that discloses the use of canthaxanthin or astaxanthin. Commercially processed food Open and hold cold (B) Except as specified in (E) - (G) of this section, refrigerated, READY-TO-EAT TIME/TEMPERATURE CONTROL FOR SAFETY FOOD prepared and PACKAGED by a FOOD PROCESSING PLANT shall be clearly marked, at the time the original container is opened in a FOOD ESTABLISHMENT and if the FOOD is held for more than 24 hours, to indicate the date or day by which the FOOD shall be consumed on the FDA Food Code 2022 Chapter 3. Food Chapter 3 - 29 PREMISES, sold, or discarded, based on the temperature and time combinations specified in (A) of this section and: (1) The day the original container is opened in the FOOD ESTABLISHMENT shall be counted as Day 1; (2) The day or date marked by the FOOD ESTABLISHMENT may not exceed a manufacturer's use-by date if the manufacturer determined the use-by date based on FOOD safety. (C) A refrigerated, READY-TO-EAT TIME/TEMPERATURE CONTROL FOR SAFETY FOOD ingredient or a portion of a refrigerated, READY-TO-EAT, TIME/TEMPERATURE CONTROL FOR SAFETY FOOD that is subsequently combined with additional ingredients or portions of FOOD shall retain the date marking of the earliest-prepared or first-prepared ingredient. (D) A date marking system that meets the criteria stated in (A) and (B) of this section may include: (1) Using a method approved by the regulatory authority for refrigerated, ready-to-eat time/temperature control for safety food that is frequently rewrapped, such as lunchmeat or a roast, or for which date marking is impractical, such as soft serve mix or milk in a dispensing machine; (2) Marking the date or day of preparation, with a procedure to discard the food on or before the last date or day by which the food must be consumed on the premises, sold, or discarded as specified under (A) of this section; (3) Marking the date or day the original container is opened in a food establishment, with a procedure to discard the food on or before the last date or day by which the food must be consumed on the premises, sold, or discarded as specified under (B) of this section; or (4) Using calendar dates, days of the week, color-coded marks, or other effective marking methods, provided that the marking system is disclosed to the REGULATORY AUTHORITY upon request.

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F 0839 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Employ staff that are licensed, certified, or registered in accordance with state laws. 45810 Based on interviews, and record review, the facility failed to ensure professional staff were certified in accordance with applicable State laws for 1 (NA EE) of 15 personnel reviewed for licensed nursing. The facility failed to ensure NA EE had become a Certified Nurse Aide by passing her certification test. This failure could place residents at risk of being provided care by staff who were not qualified per state law. Findings included: Record review of NA EE's employee file indicated she was hired on 4/1/24 as a full-time nursing staff trainee and had no evidence of CNA certification. The employee file indicated NA EE had completed the CNA training course on 04/26/24 but no evidence of the certification. During an interview on 12/12/24 at 11:00 AM NA EE said she had been working at the facility from 4/1/24 up until last week on 12/07/24 providing care for residents to include bathing, transfers, incontinent care, and repositioning. She said the facility notified her on 12/07/24 that she could no longer work as a CNA until she passed her clinical portion of the CNA course which was scheduled for January 17, 2025. During an interview on 12/12/24 at 12:43 PM the DON said NA EE was supposed to be working as a hospitality aide and thought the hospitality aide could work together with a certified CNA, but she said she found the hospitality aides were not allowed to do so. The DON said she was only aware that she was observing showers and incontinent care and not performing incontinent care and showers. The DON said her expectation was for the staff to know if they were uncertified, and they were supposed to grab a certified staff when residents needed the hands-on care completed. The DON said the failure placed a risk for resident safety issues and risk for physical harm. The DON said the Human Resources Director monitored the CNA certifications and the individuals were responsible for ensuring that they were certified. She said she had a conversation with NA EE and other NAS that had completed the CNA course and notified them that they could not provide any personal care for residents. The DON said NA EE failed the skills part of her course on 12/6/24 and she was notified on that day that she could not provide any care. During an interview on 12/12/24 at 12:54 PM The Administrator said she had a phone conversation with the aide to ensure she did not provide care on 12/1/24. She said the Human Resource Director was involved and responsible for monitoring and ensuring the CNAs had their certifications. The expectation was for the aide to not be providing care for residents as she was told. The Administrator said she did not just let her go from the position because it was Christmas time and she needed her hours, but she expected her to be completing hospitality duties. The Administrator said the failure placed risks to the residents' safety and continuity of care to ensure they were providing proper services. (continued on next page)

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F 0839 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the Job Description for Hospitality Aide revised 2/12/05 indicated: GENERAL PURPOSES: Responsible for providing resident related (non-hands-on) care in accordance with quality standards under the direction of a licensed charge nurse. The position is applicable prior to successfully receiving certification as a nursing assistant. Performs host/hostess type duties in accordance with accepted standards of non-hands-on resident care. Uses daily task assignment.

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F 0840 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Employ or obtain outside professional resources to provide services in the nursing home when the facility does not employ a qualified professional to furnish a required service. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33249 Based on interviews and record review the facility failed to arrange an appointment with an outside resource for 1 of 1 resident (Resident #108) reviewed for the use of outside resources. The facility failed to ensure Resident #108's appointment for the orthopedic specialist (specialty for prevention, diagnosis, and treatment of disorders, conditions, and injuries of the skeleton and its associated structures, including muscles, ligaments, joints, and tendons) was made for her right arm fracture. This failure could place residents at risk of not receiving needed medical care. Findings included: Record review of a face sheet dated 12/11/2024 indicated Resident #108 was a [AGE] year-old female who admitted on [DATE] with the diagnoses of a fracture of the right humerus (right upper arm), muscle weakness, unsteadiness on feet, and the lack of coordination. Record review of the AHS-Baseline Care Plan dated 11/26/2024 indicated Resident #108 desired to discharge back home, advance directive status was a full code status, had a risk for ADL/mobility performance impairment due to a fracture, used a wheelchair as an assistive device, required physical assistance with bed mobility, transfers, toileting, locomotion, was independent with eating, and was totally dependent with bathing. The Baseline Care Plan Indicated Resident #108 had risk factors for falls due to severe weakness/deconditioning and had the potential to fall. The Baseline Care Plan failed to indicate Resident #108's weight bearing status to the fractured right arm. Record review of the hospital discharge orders dated 11/26/2024 indicated continue shoulder restraints, work with physical therapy, and follow up with the orthopedic physician within 1-2 weeks. Record review of an Admission MDS dated [DATE] indicated Resident #108 understood and was understood by others. The MDS indicated Resident #108's BIMS score was 14 indicating she was not cognitively impaired. The MDS indicated Resident #108 required partial/moderate assistance with toileting hygiene and bathing, and substantial/maximal assistance with bathing, personal hygiene, and dressing. During an observation and interview on 12/09/2024 at 3:00 p.m., Resident #108 was sitting in her room. Resident #108 was wearing an arm sling to her right arm. Resident #108 said she had a fall at the assisted living facility and fractured her arm. Resident #108 said she had not seen an orthopedic physician since she admitted and was unsure if an appointment was made. During a telephone interview on 12/11/2024 at 8:50 a.m., the receptionist at Resident #108's orthopedic physician's office said a follow up appointment had not been made for Resident #108. The receptionist said the physician's expectation was the resident should have a follow up appointment within 7-14 days from the time of the injury. (continued on next page)

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F 0840 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/11/2024 at 2:49 p.m., the Treatment Nurse said she provided care to Resident #108 daily. The Treatment Nurse said it was important for Resident #108 to have a follow up appointment with the orthopedic specialist to determine the healing process of the current right arm fracture ensuring the best of care. The Treatment Nurse said the admitting nurse was responsible for ensuring the order was completed for the appointment. The Treatment Nurse said without a follow up appointment nursing and therapy would not know how the bone was healing. During an interview on 12/11/2024 at 3:09 p.m., the DON said her expectations were when a resident came in with an appointment, transportation was provided the date to ensure the resident got to the appointment. The DON said when a resident missed a physician specialist follow up it could cause quality of care issues when missing care. The DON said in this instance with Resident #108, the nursing staff would be unaware of how the right arm fracture was healing or not healing. The DON said nursing was responsible for ensuring a resident's follow up appointments were scheduled. During an interview on 12/12/2024 at 10:03 a.m., the Administrator said she expected the hospital discharge appointments to be followed up on to ensure continuity of care. The Administrator said nursing was responsible for ensuring the appointments were obtained. The Administrator said the admission audit tool was a tracker tool used to ensure hospital discharge orders were followed. Record review of the Resident Rights policy dated 2/23/2016 and reviewed on 2/20/2021 indicated the facility will inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility .2.b.(iv) The right to receive the services and or items included in the plan of care. 2.e. The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. g. Nothing in this paragraph should be construed as the right of the resident or receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate.

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45879 Based on interviews and record review, the facility failed to collaborate with hospice representatives and coordinate the hospice care planning process for each resident receiving hospice services, to ensure the quality of care for the resident, ensuring communication with the hospice medical director, the resident's attending physician, and others participating in the provision of care for 1 of 7 residents (Resident #38) reviewed for hospice services. The facility failed to maintain Resident #38's hospice binder containing information related to hospice services provided for the resident such as the most recent plan of care, hospice election form, and physician recertification. These deficient practices could place residents who receive hospice services at risk of receiving inadequate end-of-life care due to a lack of documentation, coordination of care, and communication of resident needs. The findings included: Record review of Resident #38's face sheet, dated 12/11/24 indicated Resident #38 was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses which included dementia (the loss of cognitive functioning - thinking, remembering, and reasoning), depression (sadness), anxiety (uneasiness or fear), and high blood pressure. Record review of Resident #38's quarterly MDS assessment, dated 11/23/24, indicated Resident #38 rarely understood and was rarely understood by others. Resident #38 had short and long-term memory loss indicating she was cognitively impaired. The MDS indicated Resident #38 required total or extensive assistance with his ADL's. The MDS indicated Resident #38 was on hospice services. Record review of Resident #38's comprehensive care plan dated 06/25/24 indicated Resident #38 had a terminal prognosis and was on hospice services. The intervention was to work cooperatively with the hospice team to ensure the resident's spiritual, emotional, intellectual, physical, and social needs were met, assist with ADLs, and provide comfort measures as needed. Record review of Resident #38's physician orders dated 06/06/24 indicated an order for {name} hospice. Record review of Resident #38's hospice binder revealed it did not have the Physician certification of the terminal illness, care plan, or Hospice election form. The last IDG (Interdisciplinary Group) meeting was dated 10/25/24. The last recertification was dated 09/04/24-12/02/24. During an attempted phone interview on 12/10/24 at 12:21 p.m., unable to reach the primary hospice nurse for Resident #38, a message was left. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a phone interview on 12/10/24 at 2:14 p.m., the hospice Office Manager said the binders at the facility should contain a face sheet, the do not resuscitate copy, the IDG meetings, 3074 certifications of hospice, and any supporting notes or documentation needed for Resident #38. She said they met every two weeks for the IDG meetings and said the documentation should be updated at least every 2 weeks after the IDG meetings. She said she printed the IDG meetings, and the nurse's and aide's notes, and gave them to the nurse to bring to the facility. She said it was important to have the binders at the facility to help the facility know the care and services they were providing. During an interview on 12/11/24 at 11:58 a.m., LVN W said the hospice book should include the code status, bath schedules, sign-in sheet for the nurses and aides, the medication list with their orders, diets, and face sheets. She said any information the hospice company had for Resident #38 should be at the facility because our care was combined, and we needed to ensure we were meeting the needs of our residents. During an interview on 12/11/24 at 12:08 p.m., the DON said she expected the hospice documents to be at the facility. The DON said it was the responsibility of the hospice company to ensure their documents were at the facility timely and then it was the nurse manager's responsibility to ensure that was being completed. The DON said the failure to ensure those documents were at the facility was due to a lack of communication with the facility and the hospice company. She said all information done by hospice should be at the facility for care coordination. During an interview on 12/11/24 at 3:32 p.m., the Administrator said it was the facility's responsibility to ensure all hospice documents were up to date. She said the nurse managers were the overseers of the process. She said the books should be updated because they reflect the care the resident should be receiving. Record review of the facility policy titled, Coordination of Hospice Services, dated 03/12/22, indicated, Policy: When a resident chooses to receive hospice care and services, the facility will coordinate and provide care in cooperation with hospice staff in order to promote the resident's highest practicable physical, mental, and psychosocial well-being. Policy Explanation and Compliance Guidelines:1. The facility maintains written agreements with hospice providers that specify the care and services to be provided and the process for hospice and nursing home communication of necessary information regarding the resident's care. 2. The facility and hospice provider will coordinate a plan of care and will implement interventions in accordance with the resident's needs, goals, and recognized standards of practice in consultation with the resident's attending physician/practitioner and resident's representative, to the extent possible. 3. The plan of care will identify the care and services that each entity will provide in order to meet the needs of the resident and his/her expressed desire for hospice care. a. The hospice provider retains primary responsibility for the provision of hospice care and services that are necessary for the care of the resident's terminal illness and related conditions. b. The facility retains primary responsibility for implementing those aspects of care that are not related to the duties of the hospice.

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 12/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sulphur Springs Health and Rehabilitation	411 Airport Rd Sulphur Springs, TX 75482

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45810 Based on observations, interviews, and record review, the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment, and to help prevent the development and transmission of communicable diseases and infections for 2 of 4 residents (Residents #47 and Resident #3) reviewed for infection control practices. 1. The facility failed to ensure CNA Q used proper hand hygiene between glove changes while she provided incontinent care for Resident #47. 2. The facility failed to ensure CNA P and LVN R complied with Enhanced Barrier Precautions when providing incontinence care for Resident #3 These failures could place residents at risk of exposure to communicable diseases, cross-contamination, and infections. Findings included: 1.Record review of Resident #47's face sheet dated 12/11/24 indicated she was a [AGE] year-old female who admitted to the facility on [DATE] with diagnoses of chronic obstructive pulmonary disease (disease of the lungs that causes chronic respiratory symptoms and decreased airflow), bipolar disorder (mental disease characterized by periods of deep depression and elevated moods), thrombocytopenia (abnormally low levels of blood platelets), and high blood pressure. Record review of Resident #47's quarterly MDS dated [DATE] indicated she was able to make herself understood and usually understood others. The MDS also indicated she had a BIMS score of 8 which meant she had moderate cognitive impairment. The MDS also indicated she was frequently incontinent of bowel and bladder. Record review of Resident #47's care plan dated 09/22/22 indicated she had an ADL self-care deficit and required maximal assistance of 1 staff for incontinent care. During an observation on 12/11/24 at 01:44 PM CNA Q provided incontinent care for Resident #47. During the procedure CNA Q changed gloves between clean and dirty correctly but failed to use proper hand hygiene prior to donning new gloves. During an interview on 12/11/24 at 01:58 PM CNA Q said she should have used hand sanitizer each time she changed her gloves as they were supposed to. CNA Q said she thought about her needing her hand sanitizer during care, but she had left it in the dining room. CNA Q said the purpose of using the hand sanitizer was to prevent infection between the clean and the dirty surfaces. (continued on next page)

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 12/12/2024
NAME OF PROVIDER OR SUPPLIER: Sulphur Springs Health and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE: 411 Airport Rd, Sulphur Springs, TX 75482	

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 12/11/24 at 02:44 PM the DON said her expectation was for the staff to wear the proper PPE and to follow the policy for incontinent care. She said all CNAs should always use hand sanitizer between glove changes as well as before and after care. The DON said the failure placed Resident #47 at risk for cross contamination or infection. The DON said the DON or the ADON may be responsible for ensuring the CNAs provide proper incontinent care but she was unsure because she had only been employed in her position for about a month. During an interview on 12/11/24 at 02:58 PM the Administrator said she expected the CNAs to perform hand hygiene between glove changes. The Administrator said the DON or designee were responsible for insuring CNAs were providing incontinent care properly. The Administrator said the failure placed a risk for possibility of germs being exchanged and infection. During an interview on 12/12/24 at 11:35 AM the Administrator stated the facility currently did not have any incontinent care proficiency check offs for any CNA. 45879 2.Record review of Resident #3's face sheet, dated 12/11/24 indicated he was an [AGE] year-old male admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included Moisture Associated Skin Damage also known as MASD (e.g., incontinence-associated dermatitis also known as IAD, is the general term for inflammation or skin erosion caused by prolonged exposure to a source of moisture such as urine, stool, sweat, wound drainage), stroke, and glaucoma (a group of eye diseases that can cause vision loss and blindness by damaging a nerve in the back of your eye called the optic nerve). Record review of Resident #3's quarterly MDS assessment, dated 12/05/24, indicated Resident #3 usually understood and was usually understood by others. Resident #3's BIMS score was a 05 indicating he was severely cognitively impaired. The MDS indicated he required assistance with his ADLs such as toileting and hygiene. The MDS indicated Resident #3 was always incontinent of bowel and bladder. The MDS indicated Resident #3 had a wound. Record review of Resident #3's Physician order dated 11/04/24 indicated: Cleanse wound to the penis with normal saline, pat dry, apply Silver Sulfadiazine daily, and monitor for any signs of infection. Record review of Resident #3's comprehensive care plan dated 10/31/24 indicated, that he required Enhanced Barrier Precautions related to a non-pressure wound. The interventions were for staff to ensure EBP signage was posted outside the resident's room and above the head of the resident's bed. Ensure PPE was available for use on the resident and wear a gown and gloves during high-contact resident care activities. During an observation on 12/11/24 at 1:32 p.m., Resident #3 had a sign for Enhanced Barrier Precautions also known as EBP which indicated they recommended staff to wear gowns and gloves while providing care for any resident who had any of the following: 1) infection or 2) a wound or indwelling medical device, even if the resident is not known to be infected) outside his door. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation and interview on 12/11/24 at 1:33 p.m., CNA P and LVN R entered Resident #3's room to provide incontinent care. Resident #3 had a sign above his bed revealing his EBP status. CNA P nor LVN R wore a gown while providing care to Resident #3 during incontinent care. CNA P and LVN R said they were unaware of Resident #3's EBP status. They said after the state surveyor pointed out the sign above his head that they should have worn a gown and gloves during incontinent care to protect the resident. They said they were aware of the precautions they should use when a resident was on EBP but did not realize Resident #3 was on EBP. They said the sign was on the door and the PPE equipment was hanging on the door. During an interview on 12/03/24 at 12:08 p.m., the DON said she expected staff to follow the precautions for EBP. She said they had yellow signs outside the door letting staff know that a resident was on EBP. She said they should wear gloves and gowns when providing care and wash their hands before and afterward. She said she expected the EBP precautions to be on the care plan, but they did not have to have an order. She said the staff had been educated on infection control and was last in-serviced on 10/23/24. She said staff should wear gowns and gloves during high-contact resident care activities for residents to prevent infection. During an interview on 12/11/24 at 3:32 p.m., the Administrator said all staff was responsible for following infection control practices. She said she expected staff to look at the sign on the door to tell them what they should do, and she expected them to do that. Record review of the facility policy titled, Infection Prevention and Control Program, revised 03/26/24, indicated, Policy: This facility has established and maintains an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections as per accepted national standards and guidelines #2. All staff are responsible for following all policies and procedures related to the program .#4. Standard Precautions: a. All staff shall assume that all residents are potentially infected or colonized with an organism that could be transmitted during the course of providing resident care services. b. Hand hygiene shall be performed in accordance with our facility's established hand hygiene procedures. c. All staff shall use personal protective equipment (PPE) according to established facility policy #6. Enhanced Barrier Precautions: EBP are used in conjunction with standard precautions and expand the use of PPE to donning of gown and gloves during high-contact resident care activities that provide opportunities for transfer of MDRO s(multidrug-resistant organisms) to staff hands and clothing. EBP are indicated for residents with any of the following: a. Infection or colonization with an MDRO when Contact Precautions do not otherwise apply. b. Wounds and/or indwelling medical devices (e.g., central lines, urinary catheter, feeding tube, tracheostomy/ventilator) regardless of MDRO colonization status. During high-contact resident care activities: dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs, or assisting with toileting, Device care or use: central line, urinary catheter, feeding tube, tracheostomy/ventilator. Wound care: any skin opening requiring a dressing #16. Staff Education: b. All staff are expected to provide care consistent with infection control practices. c. Direct care staff shall demonstrate competence in resident care procedures established by our facility.