STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455642	A. Building B. Wing	08/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Dayton Nursing and Rehabilitation	310 E Lawrence St Dayton, TX 77535

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41057 Based on observation, interview, and record review, the facility failed to ensure residents received an accurate assessment, reflective of the resident's status for 2 of 12 residents reviewed for accuracy of assessments. (Resident #'s 4 and 12) The facility did not accurately complete the MDS assessment to indicate Resident #4 was not receiving an anticoagulant and no longer received an antidepressant medication. The facility did not accurately complete the MDS assessment to indicate Resident #12 smoked. This failure could place the residents at risk of not receiving the appropriate care and services to maintain their highest level of well-being. Findings included: 1. Record review of a face sheet dated August 2024 indicated Resident #4 was a [AGE] year-old-female readmitted [DATE] with diagnoses of dementia (a group of thinking disorders that interfere with daily functioning), anxiety (intense, excessive and persistent worry and fear about everyday situations) and depression (a mood disorder that causes a persistent feeling of sadness and loss of interest). Record review of the quarterly MDS assessment dated [DATE] indicated Resident #4 had a BIMS score of 3 indicating severely impaired cognition. The assessment indicated the resident received an anti-coagulant (e. g. warfarin, heparin, or low-molecular weight heparin (a class of anticoagulants used for treatment of blood clots) and received an antidepressant medication (medication to treat depression). Record review of physician orders dated August 2024 indicated Resident #4 did not receive an anticoagulant or antidepressant medication. Record review of a care plan updated 07/07/24 indicated Resident #4 had a history of depression. Record review of the MAR dated 07/06/21 through 07/03/24 indicated Resident #4 received an antidepressant medication duloxetine 30 mg every other day from 03/01/24 with an end date of 03/25/24 and received no anticoagulant medication, only aspirin (a blood thinning medication) 81 mg daily, that cannot be coded as an anticoagulant medication on the MDS. (continued on next page)

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

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

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 08/05/24 at 09:45 a.m., Resident #4 said she was treated well and denied pain. She was oriented to self but was confused and unsure of what medication she was prescribed. 2. Record review of a face sheet dated August 2024 indicated Resident #12 was a [AGE] year-old-male readmitted [DATE] with diagnosis of chronic obstructive pulmonary disease (COPD- a group of lung diseases that block airflow and make it difficult to breathe). The face sheet indicated Resident #12 was a current everyday smoker. Record review of a significant change in status MDS assessment dated [DATE] indicated Resident #12 had a BIMS score of 15 indicating intact cognition. The assessment indicated Resident #12 had a diagnosis of COPD and did not indicate current tobacco use. Record review of a Smoking Risk assessment with an observation date of 10/09/23 indicated Resident #12 smoked cigarettes every few hours and was a safe smoker. Record review of a care plan updated 05/15/24 indicated Resident #12 was a smoker and required supervision while smoking. During an observation and interview on 08/05/24 at 11:09 a.m., Resident #12 was observed smoking safely during the smoking time. Staff were observed providing his smoking supplies and monitoring during the smoking time. Resident #12 said he smoked every day and the staff kept his supplies and monitored him while smoking. During an interview and record review on 08/06/24 at 3:25 p.m., the Regional MDS nurse said he was responsible for all the MDS assessments in this facility as of July 2024. He said he completed Resident #4's quarterly MDS that captured an anticoagulant and antidepressant medication and after medical record review, they should not have been captured due to the resident no longer receiving the medication. The Regional MDS nurse said aspirin should not have been captured on the MDS. He said it was captured by the system from a previous MDS and should have been removed. The Regional MDS nurse said Resident #12's Significant change MDS that was completed by a previous MDS nurse, did not capture Resident #12 's smoking and should have captured it. He said it was overlooked. He said Resident #12 smoked daily since admission. The Regional MDS nurse said the Regional Consultant was his backup for double checking for MDS completeness and accuracy. The Regional MDS nurse said he was educated on MDS completion and accuracy. He said the risk of items not being captured correctly on the MDS was state inspectors and staff could be misinformed of the resident's status and not get a correct picture of the resident which could lead to a nurse not following the plan of care. During an interview on 08/06/24 at 3:50 p.m., the DON said the Regional MDS nurse was responsible for all MDSs in the facility and the Regional Consultant was his back up to check MDSs for accuracy. The DON said he was unsure why Resident #4's MDS was not captured correctly. The DON said his expectation was for all MDSs to be completed accurately and completely. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 08/07/24 at 8:17 a.m., the Administrator said the Regional MDS nurse was responsible for all MDSs in the facility and the Corporate MDS nurse was his back up and double checked MDSs for accuracy. She said Resident #4's MDS captured an anticoagulant and antidepressant medication that Resident #4 was not receiving and they should not have been captured. The Administrator said Resident #12 smoked daily and smoking should have been captured on his MDS. She said all items on the MDS should be correct. The Administrator said the Regional MDS nurse was educated on MDS completeness and accuracy. She said her expectation was to capture everything accurately on the MDS. The Administrator said the risk of incorrectly captured items on a MDS was the resident may not receive needed care. During an interview on 08/07/24 at 11:37 a.m., the Regional Consultant said the Regional MDS Nurse was responsible for the MDSs in the facility. He said he was not the back up and did not audit MDSs for accuracy. The Regional Consultant said he monitored MDSs for timeliness and provided training and new guidance. He said the Regional MDS nurse was educated on MDS completeness and accuracy. The Regional Consultant said the risk to a resident of items captured inaccurately was the MDS was a data collection tool that drives the care plan that drives resident care and observations. Record review of the facility policy revised November 2019, titled, Electronic Transmission of the MDS indicated, . All MDS assessments . are completed and electronically encoded into our facility's MDS information system and transmitted to CMS' QIES Assessment Submission and Processing system in accordance with current OBRA regulations governing the transmission of MDS data Record review of Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual dated October 2023 indicated, . N0415: High-Risk Drug Classes: Use and Indication 1. Is taking: Check if the resident is taking any medication by pharmacological classification, not how it is used during the last 7 days or since admission/ reentry or reentry if less than 7 days. N0415C1. Antidepressant: check if there is an indication noted for all antidepressant medications taken by the resident any time during the observation period N0415E1. Anticoagulant (eg., warfarin, heparin, or low-molecular weight heparin): Check if an anticoagulant medication was taken by the resident at anytime during the 7- day look back period.Coding Tips and Special Populations . Do not code antiplatelet medication such as aspirin/ extended release, dipyridamole, or clopidogrel as N0415 E, Anticoagulant. Record review of, Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual dated October 2023 indicated, . J1300: Current Tobacco Use. 0. No 1.0 Yes 1. Ask the resident if they used tobacco in any form during the look back period. 2. If the resident states that they used tobacco in some form during the 7-day look back period code 1. Yes .

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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** 25779 Based on interview and record review, 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 for 2 of 18 residents reviewed for care plans. (Resident #s 2 and 3) The facility did not develop a care plan for Resident #2's trauma induced wound to her right heel. The facility did not develop a care plan for Resident #3's Hospice services. These failures could place the residents at risk of not receiving the care and services to maintain their highest level of well-being. Findings included: 1.Record review of a face sheet dated 08/06/24 indicated Resident #2, readmitted [DATE] was an [AGE] year-old female with diagnosis of hemiplegia and hemiparesis (muscle weakness or partial paralysis on one side of the body that can affect the arms, legs, and facial muscles) following cerebral infarction (occurs when blood flow to the brain is blocked) affecting right dominant side. Record review of a quarterly MDS assessment, dated 06/17/24 indicated Resident #2 was cognitively intact, was independent with bed mobility and required partial/moderate assistance with transfers. Record review of physician orders for Resident #2 dated 07/26/24 indicated: clean wound to right posterior heel with wound cleaner, apply betadine around the wound, wound dres to the wound bed, cover with collagen and a dry dressing daily. Record review of the care plans indicated Resident #2 did not have a care plan for the wound on her right posterior heel. During an interview on 08/07/24 at 10:50 a.m., Resident #2 said the Treatment Nurse was taking care of her wound every day. During an interview on 08/07/24 at 10:55 a.m., the Treatment Nurse said she was responsible for writing care plans for new wounds, and she had never written a care plan for Resident #2 right posterior heel wound. She said the wound was discovered on 07/26/24 and during that time the Corporate MDS Nurse was her direct supervisor. She said not writing a care plan for a new wound could result in inconsistencies in care and deterioration of the wound. (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 08/07/24 at 11:14 a.m., the Regional MDS Nurse said he had been the Treatment Nurse's direct supervisor when Resident #2's wound was discovered on 07/26/24 and a care plan was not written. He said the treatment nurse was responsible for writing care plans for new wounds, but he was ultimately responsible because it was his responsibility to ensure care plans were complete and accurate for all residents. He said his expectation was for residents to have a person-centered care plan which addressed all of the resident's current care and treatments. He said not having a care plan to address a new wound could result in the resident not receiving care as ordered by the physician. 2. Record review of a face sheet dated 08/07/24 indicated Resident #3, readmitted [DATE] was a [AGE] year-old male with a diagnosis of cerebral infarction due to embolism (a stroke that occurs when a blood clot or plaque debris blocks the blood flow to the brain). Record review of physician orders dated 8/7/24 indicated Resident #3 was admitted to hospice services on 10/30/23. Record review of the quarterly MDS assessment dated [DATE] indicated Resident#3 was on hospice services. Record review of the care plans indicated Resident #3 did not have a care plan for Hospice services. During an interview and record review on 08/06/24 at 3:55 p.m., the Corporate MDS nurse said he was responsible for ensuring the comprehensive care plans were accurate for each resident. During record review of Resident #3's clinical record, he said Resident #3 did not have a hospice care plan and should have because he was receiving hospice services. He said the possible negative outcome of not having a hospice care plan would be the resident may not receive coordination of services and not receive the appropriate care they needed. During an interview on 08/07/24 at 12:05 p.m., the Administrator said every resident should have a person centered care plan. She said the DON was ultimately responsible that care plans addressed all care and treatments of the residents. She said the Regional MDS Nurse was the interim DON during the time these care plans were not written. Record review of a Care Plans, Comprehensive Person-Centered policy revised March 2022 indicated: Policy Statement-A comprehensive person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental and psychosocial well-being. 36214

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41057 Based on observation, interview, and record review the facility failed to ensure each resident's drug regimen was free of unnecessary medication for 1 of 12 residents reviewed for unnecessary medication (Resident #5) The facility did not monitor Resident #5 for side effects of the anticoagulation medication Eliquis (a blood thinning medication). This failure could place the residents at risk for adverse consequences of the anticoagulant medication. Findings included: Record review of a face sheet indicated Resident #5 was a [AGE] year-old male readmitted [DATE] with a diagnosis of DVT (deep vein thrombosis- a blood clot in a deep vein, usually the legs). Record review of an annual MDS assessment dated [DATE] indicated Resident #5 had a BIMS score of 15, indicating intact cognition. Record review of a care plan revised 08/07/24 indicated Resident #5 was prescribed anticoagulant therapy. An approach indicated to observe for signs of active bleeding, nose bleeds, bleeding gums, petechiae (tiny round brown-purple spots due to bleeding under the skin), blood in urine, blood in stool, elevated temperature and abdominal pain. Record review of a MAR dated 07/31/24 indicated Resident #5 received Eliquis 5 mg two times a day for DVT with a start date of 07/17/24. Record review of the physician orders dated August 2024 indicated Resident #5 was prescribed Eliquis (a blood thinning medication) 5 mg two times a day for DVT with a start date of 07/17/24. The orders did not address monitoring the anticoagulant medication. Record review of the electronic record for Resident #5 did not indicate the nurses documented monitoring of side effects of anticoagulant daily with medication administration. During an observation and interview on 08/05/24 at 10:00 a.m., Resident # 5 was lying in bed with no observed bruised areas. He said he received a blood thinner but was unsure which one or if he was monitored for bleeding. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview and record review on 08/06/24 at 3:30 p.m., the ADON said she was providing care for Resident #5 today. She said his Eliquis did not have monitoring in the computer system and should have monitoring for side effects of the anticoagulant medication in the computer system. She said the nurse putting the order in was responsible for adding the monitoring into the system. She said LVN A was the nurse that put the order into the computer system. The ADON said the monitoring was overlooked. She said the DON was responsible for a double check of the orders for accuracy, but the DON started 08/05/24. She said she was educated on putting side effect monitoring in the computer system for all anticoagulants. The ADON said the risk of anticoagulant monitoring not being in the computer system was the anticoagulant not being monitored for side effects and the resident could have excessive bleeding. She said she would add the monitoring into the computer system now, after surveyor intervention. During an interview on 08/06/24 at 3:42 p.m., the DON said Resident #5's Eliquis should have been monitored for side effects but was not. The DON said the ADON was responsible for adding the monitoring cues to the computer system and to ensure all anticoagulant medication was monitored for side effects. He said today was his second day and he was now responsible for double checking the physician orders for monitoring. He said he was unsure why the anticoagulant monitoring was not in the computer system. The DON said the risk of anticoagulant medication monitoring not being in the computer system was the resident bleeding. He said his expectation was for staff to monitor all anticoagulant medication for side effects. During an interview on 08/07/24 at 8:25 a.m., the Administrator said the ADON was responsible for ensuring the monitoring of anticoagulant medication was put in the computer system and the DON was to double check to ensure the monitoring was in the computer system. She said all the nurses were educated to monitor anticoagulants for side effects and to add monitoring in the computer system. The Administrator said the risk to residents of monitoring not being in the computer system was a decline in resident's care and the resident could have side effects. The Administrator said her expectation was all anticoagulants were monitored, monitoring was put in the computer system correctly and the resident was monitored for side effects and documented in the computer system. During an interview and record review on 08/07/24 at 10:00 a.m., LVN A said she was responsible for writing the order for Resident #5's Eliquis. She said she should have added monitoring when she wrote the order but missed it. LVN A said the nurse writing the order was responsible for adding the monitoring into the computer system and the ADON was responsible for double checking to ensure the monitoring was added into the computer system. She said she was educated on anticoagulant medication required monitoring added into the computer system. LVN A said the risk of monitoring for an anticoagulant medication not being added into the computer system was a resident could have bleeding issues. Record review of a policy titled, Anticoagulant - Clinical Protocol revised November 2018, indicated, . The staff and physician will monitor for possible complications in individuals who are being anticoagulated and will manage related problems. a. If an individual on anticoagulant therapy shows signs of excessive bruising, hematuria (blood in urine), hemoptysis (coughing up blood), or other evidence of bleeding, the nurse will discuss the situation with the physician before giving the next scheduled dose of anticoagulant.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. 36214 Based on interview and record review, the facility failed to ensure an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and help prevent the development and transmission of communicable diseases and infections was established and maintained to prevent the spread of infections for all residents in the facility. The facility did not maintain a system of trending infections within the facility for the months of July 2023 through July 2024. This failure could place residents at risk of cross contamination and the development of infections. Findings included: Record review of a facility census sheet dated 08/05/24 indicated facility census was 31. Record review of the facility's infection control tracking and trending binder did not include any documentation of infection trending for the months of July 2023 through July 2024. During an interview on 08/06/24 at 3:20 p.m., the Administrator said that the Regional MDS Nurse was the Infection Control Nurse for the facility. During an interview on 08/07/24 at 12:39 p.m., the Regional MDS Nurse said the previous DON had left the facility in July 2024 and had deleted facility computer records before she left. He said he believed the trending of infections records had been deleted. He said he took over the position of DON and Infection Control Nurse after the DON left, but he did not complete any trending of infections. He said trending was done to document the type of infection, possible common bacteria, and the area of the facility in which the infection occurred. He said the possible negative outcome of not trending infections was increased and continuous infections and the spread of infection among the residents. During an interview on 08/07/24 at 12:46 p.m. the Administrator said she thought to previous DON had deleted the files that recorded the trending of infections in the facility. She said the previous DON left on 07/19/24. She said she expected all infections in the facility to be tracked and trended to make the facility staff aware of what infections were occurring and develop an ongoing and effective infection prevention program. She said the possible negative outcome of not trending infections could be the rise of infections in the facility. Record review of a facility policy titled Surveillance for infections revised September 2017 indicated .The purpose of the surveillance of infections is to identify both individual cases and trends of epidemiologically significant organisms and healthcare-associated infections, to guide appropriate interventions, and to prevent future infections .