STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455643	A. Building B. Wing	09/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Matagorda House Healthcare Center	700 12th St Bay City, TX 77414

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 45604 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 the resident's medical, nursing, mental, and psychosocial needs and describes the services to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being for 1 of 6 residents (Resident #1) reviewed for comprehensive care plans. The facility failed to develop a comprehensive person-centered care plan for Resident #1 as identified in the Care Area Assessment of the Admission MDS assessment. This failure could place residents at risk of not having personalized plans developed to address their specific care needs. Findings included: Record review of Resident 1#'s undated face sheet revealed an [AGE] year-old male admitted on [DATE] with a readmission on 09/02/2024 and primary diagnosis of Chronic diastolic congestive heart failure (a condition that occurs when the left ventricle of the heart becomes stiff and can't relax properly between heartbeats.) Record review of Resident 1's Admission MDS assessment, dated 06/21/2024, reflected the resident was assessed in section C with a BIMS score of 05 that indicated severe cognitive impairment. Section V for CAA summary reflected additional care areas of cognitive loss/dementia, visual function, communication, ADL Functional/Rehabilitation Potential, Urinary Incontinence, Falls, Nutritional Status, Pressure Ulcer, Psychotropic Drug Use, and Pain. Record review of Resident #1's undated Care Plan reflected a plan of care only for the category Nutritional Status: Problem Start Date: 06/19/2024 Resident is at risk for weight loss due to new admit to facility. Resident is currently on Dys (Dysphagia) advanced diet, thin liquids. Created: 06/19/2024 (continued on next page)

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

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Long Term Goal Target Date: 09/16/2024 Resident weight will be stable through the next review date Created: 06/19/2024 Approach Start Date: 06/19/2024 Honor Resident's food preferences to the best of our ability. Notify MD, RD and RP of any significant weight changes. Honor Resident's diet as ordered. RD will assess resident quarterly or as needed. Created: 06/19/2024 In an interview and observation on 09/12/2024 at 1:20 pm, of Resident#1 in his room at the facility. He said that he did not have any care concerns. In an interview on 09/12/2024 at 2:25 p.m. with the MDS Coordinator, she said that she was an LVN, and started at the facility in May of 2021. She said that she was tasked to complete all MDS assessments and comprehensive care plans for the facility. She said that the comprehensive care plan is due within 21 days of admission and the care plan was based on what is triggered on the CAAs of the MDS. She said that anything that is on the CAAs summary should be on the comprehensive care plan. She said that the purpose of the comprehensive person-centered care plan was to have a plan of care for the resident with goals and interventions based on the care areas. She said that if a resident does not have a comprehensive person centered care plan there could be an issue treating the resident, and care could be missed by nursing staff. She said that no one reviews her work to ensure that care plans are completed with accuracy. She said that on 09/11/2024 the administrator told her to update the care plan of Resident #1 as instructed by the facility's corporate nurse (RNC). She said that she completed the Admission MDS and comprehensive care plan for Resident #1. She said that when she went to review the care plan there was only a focus for nutritional status. She said that the IDT participants are the DON, ADON, Activities, Dietary Manager, Director of Rehabilitation and Social Worker. She said that the focus of each department is addressed during the IDT, and she is responsible for putting the information provided from each department in the care plan. She said that she did not complete the careplan for Resident #1 and it was an oversight. She said that the DON is oversight for the care plans, and the DON at the time of Resident #1's admission was the corporate nurse (RNC). She said that it was no one's job but hers, and it was on her that Resident #1 did not have a comprehensive care plan after the MDS was completed on 06/21/2024. (continued on next page)

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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 - Some	In an interview on 09/12/2024 at 3:07pm with the Administrator, he said that he started on 08/26/2024. He said that the MDS Coordinator completes all comprehensive care plans for the facility. He said that Resident #1 did not have a care plan as of yesterday (9/11/24) that was comprehensive and person centered and it was an oversight. He said that it was brought to his attention by RNC who told him to have the MDS Coordinator update the care plan. He said that the DON has oversight for care plans, and at the time of Resident #1's admission it would have been RNC. He said that he was not the Administrator at the time that Resident #1 admitted to the facility. He said that he was the Administrator when Resident #1 discharged to the hospital from 08/30/2024-09/01/2024. He said that if a resident has a change of condition or goes out to the hospital the care plan should be updated and reviewed in the morning stand up meeting attended by each department head upon readmission. He said that Resident #1 had a readmission and the error should have been caught during the clinical review of the records of Resident #1 at the time of his re-admission that Resident#1 did not have a comprehensive careplan completed after the admission MDS was finalized. He said that the purpose of a comprehensive, person-centered care plan is to ensure measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs are developed and implemented for each resident. He said that the risk to a resident without a comprehensive person-centered care plan is that the resident may not receive care that is tailored to their needs. Interview on 09/12/2024 at 3:09pm with the RNC, who said that she was a registered nurse and has worked for the facility's corporate entity for 9 years. She was the interim DON until the current DON started on 09/10/2024. She said that she noticed that Resident #1 did not have comprehensive care plan on 09/11/2024, that addressed all his care areas. She said that she told the MDS Coordinator to complete it, and it was an oversight. She said that she was the oversight to ensure that the MDS Coordinator was completing the care plans, she should have been auditing the care plans, and she would start auditing. She said that the error with the care plan of Resident #1 should have been corrected when reviewed at the weekly quality of care meeting with all department heads present. She said that the purpose of a comprehensive person-centered care plan was to provide accurate care to the resident. She said that the risk to the resident would be that the nurses would not have a readily accessible plan of care for the resident's care areas but there would not be a delay in care. Record review of the Policies and Procedures titled, Care Plans, Comprehensive Person-Centered dated March 2022 read in part .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. Policy Interpretation and Implementation 1. The interdisciplinary team (IDT), in conjunction with the resident and his/her family or legal representative, develops and implements a comprehensive, person-centered care plan for each resident 2. The comprehensive, person-centered care plan is developed within seven (7) days of the completion of the required MDS assessment (Admission, Annual or Significant Change in Status), and no more than 21days after admission. 7. The comprehensive, person-centered care plan: a. includes measurable objectives and timeframes; b. describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, 12. The interdisciplinary team reviews and updates the care plan: a. when there has been a significant change in the resident's condition; .c. when the resident has been readmitted to the facility from a hospital stay; .

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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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45604 Based on interview, observation, and record review, the facility failed to develop a comprehensive care plan within seven days after completion of the comprehensive assessment, for 1 of 6 residents (Resident #1) reviewed for comprehensive care plans. The facility failed to develop a comprehensive person-centered care plan for Resident #1 within 7 days of the completed Admission MDS assessment and no more than 21 days after admission. This failure could place residents at risk for not receiving the required person-centered care. The findings were: In an interview and observation on 09/12/2024 at 1:20 pm, of Resident#1 in his room at the facility. He said that he did not have any care concerns. In an interview on 09/12/2024 at 2:25 p.m. with the MDS Coordinator, she said that she was an LVN, and started at the facility in May of 2021. She said that she was tasked to complete all MDS assessments and comprehensive care plans for the facility. She said that the comprehensive care plan is due within 21 days of admission. She said that the purpose of the comprehensive person-centered care plan was to have a plan of care for the resident with goals and interventions based on the care areas. She said that if a resident does not have a comprehensive person centered care plan there could be an issue treating the resident, and care could be missed by nursing staff. She said that no one reviews her work to ensure that care plans are completed with accuracy. She said that on 09/11/2024 the administrator told her to update the care plan of Resident #1 as instructed by the facility's corporate nurse (RNC). She said that she completed the Admission MDS and comprehensive care plan for Resident #1. She said that Resident#1 admitted on [DATE], the admission MDS was completed on 6/21/2024, and she did not complete the careplan until 09/11/2024 to include all the areas from the CAA. She said that she did not complete the careplan for Resident #1 and it was an oversight. She said that the DON is oversight for the care plans, and the DON at the time of Resident #1's admission was the corporate nurse (RNC). She said that it was no one's job but hers, and it was on her that Resident #1 did not have a comprehensive care plan after the MDS was completed on 06/21/2024. (continued on next page)

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