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	12/05/2024

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 0645

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

PASARR screening for Mental disorders or Intellectual Disabilities

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 46678

Based on observation, interview and record review, the facility failed to ensure the coordination of assessments with the Pre-Admission Screening and Resident Review (PASRR) program was provided for 1 of 4 residents reviewed for PASRR screenings (Resident #49).

The facility did not correctly identify Resident #49 as having mental illness in his PASRR Level 1 Screening.

This failure could place residents with documented mental illness diagnoses at risk of not receiving needed care and services in the appropriate setting.

Findings included:

Record review of Resident #49's face sheet, not dated revealed a [AGE] year-old male admitted to the facility on [DATE] with diagnoses of Parkinson's disease (a disorder of the central nervous system that affects movement), psychosis (a mental disorder characterized by a disconnection from reality), scabies (a contagious skin condition caused by microscopic mites), muscle weakness, Dementia (a group of thinking and social symptoms that interferes with daily functioning), traumatic brain injury, chronic kidney disease, Rheumatoid arthritis (a chronic inflammatory disorder usually affecting small joints in the hands and feet) and anemia.

Record review of physician orders dated 3/21/24 indicated Resident #49 was prescribed Sertraline 100 mg once daily and Trazadone 50 mg once daily for depression.

Record review of quarterly MDS dated [DATE] indicated Resident #49 had a BIMS of 2 which indicated severe cognitive impairment. Resident #49 had active diagnoses of depression and psychotic disorder and was taking an antidepressant.

Record review of Resident #49's care plan dated 9/13/24 indicated Resident #49 received antidepressant medication r/t dx depression. Approaches included: assess/record effectiveness of drug treatment, monitor and report signs of sedation, hypotension, or anticholinergic symptoms, and pharmacy consultant review.

Record review of the PASRR level1 screening from the hospital dated 3/20/2024 indicated Resident #49 was negative for mental illness, intellectual disability, and developmental disability.

(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: 455643	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/05/2024
NAME OF PROVIDER OR SUPPLIER Matagorda House Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 700 12th St Bay City, TX 77414	

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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 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the PASRR level 1 screening dated 12/5/24 indicated Resident #49 was negative for mental illness, intellectual disability, and developmental disability. Observation and interview with Resident #49 on 12/3/24 at 10:15 am, he was sitting on a chair in the activity room, watching an aide pass out jig saw puzzles to other residents. This surveyor asked how he was, Resident #49 said he was fine. He did not answer any more questions, he sat at the chair observing other residents. Interview with the MDS Coordinator on 12/5/24 at 11:41 am, she said the PASRR Level 1 form for Resident #49 was copied from the PASRR form that came from the hospital . The MDS Coordinator said the process for PASRR assessments was to look at the clinicals from where the resident came from and use the diagnoses from the resident's face sheet. She said she was solely responsible for PASRR assessments. She said the risk to the resident when not assessed correctly would be they could miss out on services provided by the state. Interview with the Regional Reimbursement Consultant on 12/5/24 at 3:10 pm, she said when a new resident comes into the facility, the PASRR assessment should be conducted that first day. She said staff should look at the referral packet and supporting diagnoses as well. If the resident triggered a positive PASRR this would get submitted to the appropriate agency. She said the risk to the resident would be they would not qualify for services they may need. The Regional Reimbursement Consultant said MDS Coordinator is responsible for the PASRR assessments, and the Administrator looks behind the MDS Coordinator for completed assessments. A policy for Resident Assessments was requested from the Administrator on 12/5/24 at 10:05 am but was not provided.

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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 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. 46678 Based on interview and record review, the facility failed to use the services of a registered nurse for at least 8 consecutive hours 7 days a week reviewed for RN coverage for 5 of 30 days reviewed for nursing services. (11/9/24, 11/10/24, 11/23/24, 11/24/24 and 11/30/24). The facility failed to have an RN for 8 consecutive hours 7 days a week for 5 days from November 9, 2024, through November 10, 2024, November 23, 2024, through November 24, 2024, and November 30, 2024. This failure could place residents at risk of lack of nursing oversight and a higher level of care. Findings included: Record review of a Detailed Calculated Time form from 11/1/24 through 11/30/24 indicating RN hours worked indicated no RN hours for 11/9/24, 11/10/24, 11/23/24, and 11/24/24. The report indicated less than 8 hours a day worked on 11/30/24- 2.25 hours. Further review of the report indicated the DON did not work any hours on 11/9/24, 11/10/24, 11/23/24, 11/24/24, and 11/30/2024. Record Review of the facility's Civil Rights form (3761) (Texas Health and Human Services form that list the facility staff to ensure the facility is not violating the Civil Rights of staff hired) not dated, indicated the following: 4 RNs 9 LVNs 34 Direct Care Staff 14 Dietary 11 Housekeeping & Laundry 12 All Others Interview with ADON A on 12/5/24 at 3:30 PM she said if there was a last minute call-in, the facility will call their own staff first and if their on-call staff cannot come in, they would call an agency for nurses. Interview with DON on 12/5/24 at 4:50 pm, she said the facility has one full-time RN and a PRN RN that works nights. The DON said she would come in and assist if there was no RN on duty. The DON said the facility also used an agency for RN staff if needed. The DON said she did not think there was a risk to the resident if a nurse was not on duty. She said some of their LVNs were better workers than their RNs. (continued on next page)

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A policy for RN coverage was requested on 12/5/24 at 4:27 PM, the Administrator stated in an email the facility does not have a policy on RN staffing, they followed the state rules and regulations. Record review of Centers for Medicare & Medicaid Services. State Operations Manual, Appendix PP Guidance to Surveyors for Long Term Care Facilities (February 2023 Revision). F727: RN 8 Hrs./7days/Wk., Full Time DON . Policy read in part . Except when waived . the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week .

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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45581 Based on interview, and record review, the facility failed to provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident for 2 (Resident #11 and Resident #45) of 25 residents reviewed for pharmacy services. The facility failed to ensure Resident #11's medications were reordered timely to prevent the medications being unavailable for administration to the resident. The facility failed to administer two doses of Hydrocodone-acetaminophen- Schedule II tablet; 10-325 mg; oral on 12/04/2024 at 1 AM and 7 AM for Resident #11. The facility failed to monitor the blood pressure and pulse before administering Diltiazem (a blood pressure (BP) medication given to control high blood pressure and chest pain) and Amiodarone (prevents fast or irregular heartbeat) to Resident #45 as ordered by the physician. The facility failed to monitor the blood pressure and pulse before administering Losartan (a blood pressure (BP) medication given to control high blood pressure and chest pain) and Metoprolol (prevents fast or irregular heartbeat and relax blood vessels) to Resident #11 as ordered by the physician. These failures could place residents at risk for adverse effects of pain, discomfort, increase side effects, not receiving the therapeutic effects of the medication, and a decline in health. The findings were: Record review of Resident #11's Admission Record revealed Resident #11 was a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #11 had diagnoses of Pain in left shoulder,and Other chronic pain, Hypertensive heart disease with heart failure (high blood pressure), Paroxysmal atrial fibrillation (a type of irregular heartbeat, or arrhythmia, that occurs in brief episodes that last less than seven days), and Heart failure (a serious condition that occurs when the heart is unable to pump enough blood to meet the body's needs), Record review of Resident #11's Medication Administration Record (MAR) read in part . The resident had a scheduled medication of Hydrocodone-acetaminophen- Schedule II tablet; 10-325 mg; 1 tablet; oral. The MAR noted under Scheduled Start Date/Time, 12/04/2024 at 01:00, Not Administered: Drug/Item Unavailable Comment: MD ordered but med has not arrived from pharmacy- LVN B and on 12/04/2024 at 07:00, Not Administered: Other Comment: pending delivery. CN aware of unavailability- CMA A . Record review of Resident #11's MDS dated [DATE] noted the resident had a BIMS score of 12 indicating some cognitive impairment and had Other Chronic Pain. Resident #11 received scheduled pain medication regimen. The MDS did not indicate a frequency of the pain. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #11's Care Plan, undated read in part . Problem: Resident has Dx /Hx of chronic pain with potential for breakthrough issues. Goal: Resident will verbalize reduction of pain. Approach: Administer medications as ordered. Monitor and record effectiveness. Report adverse side effects. Resident is at risk for deterioration in ADLs RT Chronic pain . Record review of Physician Order Report dated 11/05/2024 - 12/05/2024 read in part . Prescription 12/19/2023 - Open Ended. hydrocodone-acetaminophen - Schedule II tablet; 10-325 mg; amt: 1 tablet; oral Special Instructions: FOR PAIN. [DX: Sciatica (A severe pain that radiates from the back into the hip and outer side of the leg caused by compression of the sciatic nerve), unspecified side]. Every 6 Hours; 01:00, 07:00, 13:00, 19:00 . Ordered by MD B. Record review of secure text dated 11/30/2024 at 2:30 PM sent by CMA A to NP noted that Resident #11 needed a refill on their Hydrocodone-acetaminophen. The NP acknowledged the text with a thumbs up emoji at 2:55 PM. Record review of secure text dated 12/01/2024 at 7:47 AM sent by CMA A to NP. The NP replied at 3:25 PM that she had sent the prescription refill to MD A yesterday. Interview on 12/05/2024 at 12:53 PM with Charge Nurse/LVN A. She said Medication Aides ordered medications for the medication cart. The medications have a reorder sticker and a date to reorder them by. She said the nurses also reorder medications. She said for controlled substances, the facility used a system called Signal to text the doctor or Nurse Practitioner. She said when reordering medications, you put the patient's name, dose and frequency and let the NP/doctor know the resident needs more medications, and the doctor sent the order to the pharmacy. She said she reviewed the medications cart weekly and looked at the dates on all medications. She said on her days off, on 12/02, staff messaged the doctor that the facility needed more of the resident's medication. She said the CMA A did not order the medication within seven days of the medication running out. She said the morning of 12/04/2024 when she came into work, CMA A notified her that Resident #11 was out of their Hydrocodone-acetaminophen. Charge Nurse/LVN A called MD A and notified her of needing more Hydrocodone-acetaminophen. She said the Hydrocodone-acetaminophen arrived at 1 PM on 12/04/2024. She said the resident received their Hydrocodone-acetaminophen on their next dose at 1 PM on 12/04/2024. She said the resident never stated she was in pain. She said she ordered medications and restocked her medication cart weekly. She said it was a few months ago since she was trained on ordering medications and following physician's orders. She said the DON, ADON, Administrator, and her as a charge nurse were responsible for oversight to ensure staff followed physician's orders. She said she oversaw the Medication Aides. She said the risk to residents when protocol or policy regarding following physician's orders were not followed could be physical harm, and or mental harm. (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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 12/05/2024 at 1:25 PM with CMA- A. She said on the blister pack there was a sticker that had an order after date. If a medication needed to be refilled, then she placed that reorder sticker on a medication refill sheet and sent the order to the pharmacy. Then if she worked the next day, she followed up with the night nurse to determine if the medication arrived because deliveries were at night. She said she ordered the Hydrocodone-acetaminophen for Resident #11. She said she followed up on the medication ordered with the NP. She said last week she worked the weekend 11/30- 12/01/2024 and she told the NP after 6pm on 12/01/2024 that the resident needed a refill on Resident #11's Hydrocodone-acetaminophen. She said if a resident needed a narcotic refilled, she had to ask NP for a refill. She said the NP told her ok on 11/30/2024 then she waited for the medication to arrive to the facility. She said she followed up with the NP on 12/01/2024. She said she was off on 12/02/2024 and 12/03/2024. She said she also notified the charge nurse on 12/03/2024. She said she administered medications to Resident #11. She did not recall when she last had training on orderings meds and following physician's orders. She said the DON was responsible for ensuring policy was followed for ordering meds and following physician's orders. She said if she saw medications were getting short then she would report to the charge nurse and if the charge nurse did not want to listen then she went to the DON. She said the risk to residents if staff did not follow physician's orders was the residents did not get their medications and then the residents could get sick, or the residents could be in pain. Interview on 12/05/2024 at 1:37 PM with DON. When reordering medications, she said if a resident's medication was a controlled substance, then the Medication Aide informed the nurse, and the nurse informed the doctor. The doctor then sent a written prescription into the pharmacy, then the facility waited for the medication to come in. She said the facility had e-kits, but Hydrocodone-acetaminophen not included. She said the resident's Hydrocodone-acetaminophen ran out on 12/03/202 and the Medication Aide should have contacted ADON B, then notified the NP on 12/02/2024 to reorder the Hydrocodone-acetaminophen. The medication had not arrived at the facility by 12/03/2024. Charge Nurse/LVN A and the NP sent the script to the pharmacy on 12/03/2024. She said she thought the failure occurred because NP did not send the script to the pharmacy in time to get the medication for Resident #11. She said she was responsible for oversight to ensure staff followed all clinical protocol and policy. She said the risk to residents of not following physician's orders depended on the situation. She said with medications, the resident could be in pain and the worst thing that could happen to the resident was pain for the resident. Interview on 12/05/2024 at 1:45 with CMA A, Charge Nurse/LVN A, and the DON. CMA A said she text the NP on 11/30 about reordering medications and followed up on 12/01/2024. The DON said ADON B followed up with the NP on 12/02/2024. Interview on 12/05/2024 at 2:16 PM ADON B. She said the Medication Aides and nurses reordered medications. She said for controlled substance there were no refills, the Medication Aides notified the nurse, to then notify the doctor to renew the prescription. She said she notified MD A who worked with MD B. Interview on 12/05/2024 at 2:41 PM with CMA A. She said Resident #11 had 4 or 5 tablets of Hydrocodone-acetaminophen left when she notified MD A on 11/30/2024. She said her procedure was to notify NP and at that time MD A had an emergency. She said normally she notified MD A when a controlled medication needed to be refilled. She said she did not have the number for MD B and NP. She said the nurse had MD B's number. She said there was no restriction from her getting MD B's number. She said she would not normally contact MD B and it was easier to get a hold of MD A. (continued on next page)

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F 0755

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

Record review of Resident #11's Physician Orders, dated 10/06/23 with an open-end date; Metoprolol Tartrate tablet; 25 mg; amount: 0.5 tab; oral. Special Instructions: give 25mg 1/2 tab to equal 12.5 mg total dose. Hold for SBP <110 OR HR <60. Give at noon.

Record review of Resident #11's Physician Orders, dated 03/14/2024 with an open-end date, reflected losartan tablet; 50 mg; amount: 1 tablet; oral. Special Instructions: Hold for SBP <110; Once A Day at 18:00.

Record review of Resident #11's Medication Administration Record (MAR) dated 11/5/2024 - 12/5/2024 reflected, the resident was administered Metoprolol and Losartan by MA C with the same blood pressure and pulse reading for both medication administration times on the following days:

November 8th: 12:00 PM & 6:00 PM B/P -148/63 and Pulse-66

November 10th: 12:00 PM & 6:00 PM B/P - 132/64 and Pulse-67

November 23rd: 12:00 PM & 6:00 PM B/P- 137/62 and Pulse- 78

November 27th: 12:00 PM & 6:00 PM B/P-133/88 and Pulse-63

November 28th: 12:00 PM & 6:00 PM B/P-146/63 and Pulse-67

December 2nd: 12:00 PM & 6:00 PM B/P-147/60 and Pulsie-67

December 3rd: 12:00 PM & 6:00 PM B/P-136/64 and Pulse-69

Record review of Resident #45's face sheet, dated 12/05/24, reflected a [AGE] year-old female who was admitted to the facility on [DATE]. Her diagnoses included Alzheimer's disease (a brain disorder that gradually destroys memory and thinking skills, and eventually the ability to carry out daily tasks:), Hypothyroidism (when the thyroid gland doesn't make enough thyroid hormones to meet your body's needs.) Generalized anxiety disorder, and major depressive disorder.

Record review of Resident #45's quarterly MDS assessment, dated 11/14/24, reflected a BIMS score of 10 out of 15, which indicated moderate cognitive impairment. The resident was independent and required set-up assistance from staff with ADL care.

Record review of Resident #45's care plan with a revision date of 09/19/2024 reflected a potential for complications, signs and symptoms related to diagnosis of hypertension. Resident receives anti-hypertensive and is at risk for side effects. Approach: Administer medications as ordered and monitor; Monitor and report BP as ordered. Notify MD of significant abnormalities.

Record review of Resident #45's Physician Orders, dated 11/14/2024, revealed, Diltiazem HCl tablet; 60 mg; amount: 1 Tab; oral; three times a day with Special Instructions: Hold for systolic Blood Pressure <100 and apical pulse is <60

Record review of Resident #45's Physician Orders, dated 11/14/2024, Amiodarone tablet; 200 mg; 1 TABLET; oral; twice a day; Special Instructions: HOLD for PULSE < 60.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #45's Medication Administration Record (MAR) dated 11/5/2024 - 12/5/2024 reflected, the resident was administered Diltiazem and Amiodarone by MA C with the same blood pressure (B/P) and pulse reading for 2 of 3 medication administration times on the following days: November 8th: 7:00AM & 3:00 PM B/P -164/98 and Pulse-93 November 10th: 7:00AM & 3:00 PM B/P - 136/77 and Pulse-74 November 18th: 7:00AM & 3:00 PM B/P -148/76 and Pulse-82 & (3:00 PM) Pulse-66 November 23rd: 7:00AM & 3:00 PM B/P- 133/61 and Pulse- 86 November 27th: 7:00AM & 3:00 PM B/P-133/88 and Pulse-77 November 28th: 7:00AM & 3:00 PM B/P-140/77 and Pulse-82 December 2nd: 7:00AM & 3:00 PM B/P-137/68 and Pulsie-63 December 3rd: 7:00AM & 3:00 PM B/P-114/67 and Pulse-70 Attempted telephone interview on 12/05/24 at 1:16 PM MA C regarding vital signs prior to administration of anti-hypertensive and cardiac medication administration. No response. left Voice mail message. Interview 12/05/24 at 1:57 PM with LVN A. She said the expectation was for the MA's to take vital signs (Blood pressure (B/P's) and pulse) prior to medication administration as ordered by the physician. She said if they do not check a resident B/P and pulse and a parameter was required for medication administration, it can drop the resident's B/P too low due to the initial dose given. The risk of them administering the med could include weakness, dizziness, or passing out. The worst thing that could happen is the blood pressure dropping too low and the resident could die. Interview 12/05/24 at 2:00 PM with ADON B, who has been at the facility for 1 week. She said the staff should perform vital signs (v/s) prior to admin of B/P meds due to parameters. She said you should not use the same v/s from the initial dose. She said not doing v/s prior could cause the resident to be overmedicated. She said the worst thing that could happen would be the B/P was so low that a resident could code. Interview on 12/05/24 at 2:09 PM with DON regarding B/P prior to Hypertension medication. She said that the B/P should be done prior to administration if there are parameters. She said the risk of not doing vital signs would be bottoming out which means the resident can become hypotensive. Interview on 12/05/24 at 2:16 PM with Regional Nurse, who said the staff should follow orders as written by the physician. She said the staff would not know the parameters if B/P was not taken. She said the risk was a lower B/P and the resident may become lethargic or have a lower B/P than desired and the resident could lead the resident to be transferred out of the facility to the hospital. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 12/05/24 at 2:21 PM with Interim Administrator, who said her expectation was for the nursing staff to check V/S as indicated on the orders. She said possible contraindications would be the resident could become lethargic and their v/s could be lower than normal levels. She said she was unsure as the worse that could happen. Record review of the facility's Administering Medications policy, revised dated December 2012, read in part . Policy Interpretation and Implementation. 8, The following information must be checked/verified for each resident prior to administering medications: a. Allergies to medications; and b. Vital signs, if necessary .

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F 0759

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Ensure medication error rates are not 5 percent or greater.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 48863

Based on observation, interview and record review the facility failed to ensure that the medication error rate was not five percent (%) or greater. The facility had a medication error rate of 7% based on 2 errors out of 28 opportunities, which involved 1 of 4 residents (Residents #45) reviewed for medication errors.

1. The facility failed to ensure MA A administered the correct dose of Clonazepam to Resident #45.

2. The MA failed to administer Methimazole to Resident #45 according to physician orders and administered the medication after meal instead of before meal.

These failures could place residents at risk of not receiving the intended therapeutic benefits of prescribed medications.

Findings include:

Record review of Resident #45's face sheet, dated 12/05/24, reflected a [AGE] year-old female who was admitted to the facility on [DATE]. Her diagnoses included Alzheimer's disease (a brain disorder that gradually destroys memory and thinking skills, and eventually the ability to carry out daily tasks:), Hypothyroidism (when the thyroid gland doesn't make enough thyroid hormones to meet your body's needs.) Generalized anxiety disorder, and major depressive disorder.

Record review of Resident #45's quarterly MDS assessment, dated 11/14/24, reflected a BIMS score of 10 out of 15, which indicated moderate cognitive impairment. The resident was independent and required set-up assistance from staff with ADL care.

Record review of Resident #45's, care plan dated 06/12/24, indicated she had a history of anxiety and on antianxiety medication. Her interventions were to Monitor for drug use effectiveness and adverse consequences, and monitor resident's mood and response to medication.

Record review of Resident #45's Physician Orders starting 11/15/24 reflected an active order for clonazepam tablet; 0.5 mg; amount: 1/2 TABLET; oral [DX: Generalized anxiety disorder] Twice A Day.

There was also an active order with a start date of 12/03/24 for Methimazole tablet; 5 mg; amount: 1 Tablet; oral with special instructions to administer 1 hour before meals.

Record review of Resident #45's MAR starting 11/15/24 reflected the Clonazepam 0.5 mg; amount: 1/2 TABLET; oral administered twice a day.

Record review of Resident #45's MAR starting 12/03/24 reflected methimazole tablet; 5 mg; 1 Tablet; oral; administered twice a day 1 hour before meals.

During medication pass observation on 12/05/24 at 8:39 AM, MA A administered Clonazepam 0.5 mg tablet and Methimazole 5mg tablet. Resident was observed with breakfast tray on bedside table with 75% of her breakfast eaten. MA proceeded to administer her medication to include the Clonazepam 0.5 tab.

(continued on next page)

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

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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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 12/05/24 at 9:31 AM, MA A said she had been working at the facility since 2021. She said she did on-boarding training and medication competences during that time but had not had any recent training on medication administration. She said Clonazepam was administered to Resident #45 for anxiety. She said she was unaware she was supposed to administer Clonazepam .25 mg instead of the Clonazepam 0.5 mg tablet because the tablet was already scored. She said she should have clarified the order with the nurses before administration. She said the risk of too much Clonazepam could cause side effects, including lethargy and dizziness. MA A said she should have administered the Methimazole as ordered. She said all medications should be administered as ordered by the physician. She said the purpose of this medication was to maintain appropriate thyroid levels and said the risk of not administering the medication before meals could lead to the medication not working properly. Interview on 12/05/24 at 9:49 AM with LVN A, who said MA A informed her today that she was administering the incorrect dosage for the Clonazepam. She said she would contact the attending physician to clarify the orders and make the corrections on the MAR and with the Pharmacy. She also said that she was informed that Methimazole was not being administered before meals as ordered. She said thyroid medications should be administered as ordered due to metabolism of the medication. She said it can interfere with absorption and not work properly, which could ultimately lead to a thyroid storm and/or hospitalization . Telephone Interview with the NP on 12/05/24 at 10:23 AM regarding the administration of Methimazole after meals. She said it does not really matter if the medication was administered before meals, like levothyroxine. However, the order said to take 60 mins before meals, and it should be administered as directed. Regarding the Clonazepam 0.5mg PO give 1/2 tab, it also should be administered as ordered. Interview on 12/05/24 at 12:37 PM with ADON A, who said her expectation of the staff was reading the MAR and clarifying orders with the ADON or DON before administering medication. She said the Methimazole should be administered as ordered to achieve the greatness effectiveness of the medication. She said she was unaware of the MA's quarterly or annual re-education. She said administering medications not as ordered can cause the resident not to receive a therapeutic dose, but it can also cause a resident to overdose and increase side effects such as drowsiness, confusion, dizziness and possible falls. Interview on 12/05/24 at 12:41 PM with the DON, who has been at the facility for 3 months. She said her expectation was to administer medications as ordered. She said the staff should check the MARs against the order and clarify the order. She said Clonazepam can cause increase drowsiness, and increase dizziness, and hallucinations, which can cause falls. Record review of the facility's Administering Medications policy, revised dated December 2012, read in part . Policy Interpretation and Implementation 20. As required or indicated for a medication, the individual administering the medication will record in the resident's medical record: a. The date and time the medication was administered; b. The dosage; c. The route of administration; d. The injection site (if applicable); e. Any complaints or symptoms for which the drug was administered, f. Any results achieved and when those results were observed, g. The signature and title of the person administering the drug .

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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 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. 45581 Based on observation, interview, and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety for the kitchen. The facility failed to ensure on 12/03/2024 at 8:15 AM that a container of bacon grease, chicken noodle soup and French toast were labeled and dated with the preparation date and expiration date. The facility failed to ensure a bag of open tortillas was sealed. The facility failed to ensure the label on the ground beef in the freezer was legible. These failures had the potential to place residents at risk of serious complications from foodborne illness because of their compromised health status. Record review of Food Receiving and Storage policy dated November 2022 read in part . Foods shall be received and stored in a manner that complies with safe food handling practices. 1. All foods stored in the refrigerator or freezer are covered, labeled, and dated (use by date). 7. Refrigerated foods are labeled, dated, and monitored so they are used by their use-by date, frozen, or discarded . Findings include: Interviews and observations on 12/03/2024 beginning at 8:15 AM with the Dietary Manager. The refrigerator had a container of what the Dietary Manager identified as bacon grease, chicken noodle soup and French toast did not reflect the preparation and expiration dates During the walkthrough of the freezer, a bag of tortillas was observed unsealed. The Dietary Manager identified ground beef that had a label but was illegible. Interview on 12/04/2024 at 2:48 PM with the Dietary Manager. She said the policy or procedure for prepared food was it needed to be labeled and dated with the preparation date and expiration date, and ensure the foods were sealed with a lid. She said what happened this survey was an employee forgot or was distracted. She said she in-serviced the kitchen staff on labeling and storing foods. She said she was last in-serviced on food storage and labeling 30 days ago. She said kitchen staff were in-serviced monthly. She said she was responsible for oversight to ensure staff followed protocol. She said the risk to the residents if policy or protocol was not followed was a possibility of contamination. She said the worst thing that could happen to residents when proper protocols are not practiced was diarrhea or stomach issues. U.S. Food and Drug Administration Food Code dated 2022 read in part . 3-305.11 (A) Except as specified in (B) and (C) of this section, FOOD shall be protected from contamination by storing the FOOD: (1) In a clean, dry location; (2) Where it is not exposed to splash, dust, or other contamination . (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	TAC Ch. 228 Subchapter A read in part . (a) The purpose of this chapter is to implement Texas Health and Safety Code, Chapter 437, Regulation of Food Service Establishments, Retail Food Stores, Mobile Food Units, and Roadside Food Vendors. (b) The department adopts by reference the U.S. Food and Drug Administration (FDA) Food Code 2017 (Food Code) and the Supplement to the 2017 Food Code. (c) The department does not adopt by reference the following sections, paragraphs, and subparagraph of the FDA Food Code, 3-202.13, 3-202.14(C), 3-202.18(A), 5-102.11, 5-102.13, 5-102.14, 5-104.11(B)(1), 6-101.11(B), 6-202.18, 8-201.11, 8-202.10, 8-203.10, 8-302.11-14, 8-303.10-30, 8-304.10, 8-304.20, 8-401.10, 8-401.20, 8-402.10, 8-402.20-40, 8-403.40, and 8-501.10-40, and the definitions for accredited program, drinking water, food establishment, game animal, general use pesticide, public water system, regulatory authority, safe material, service animal, and vending machine location. (d) In the event of a conflict, Texas law and rules in this chapter prevail over the adopted Food Code .

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48605 Based on observation, interview, and record review, the facility failed to maintain an infection control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of disease and infection for 1 (Resident #69) of 5 resident reviewed for infection control. The facility failed to ensure that CNA A, used appropriate PPE during urinary catheter care to Resident #69. These failures could place residents at-risk for infection due to improper care practices. Findings Included: Record review of Resident #36's face sheet dated 12/03/2024 revealed resident was admitted to the facility on [DATE], age [AGE] years old. Resident #69 had a diagnosis of Malignant neoplasm of liver (a cancerous tumor that can start in the liver or spread to the liver from another part of the body). Record review of Resident #69 doctor's order dated 11/19/2024 revealed that Resident was ordered Enhanced Barrier Precautions for Foley Catheter. Enhanced Barrier Precautions for a Foley urinary catheter means that healthcare workers should wear a gown and gloves when performing any high-contact care activities related to the catheter, such as changing the drainage bag or manipulating the catheter itself, as the presence of an indwelling catheter puts a patient at higher risk of acquiring or transmitting multidrug-resistant organisms (MDROs) and requires extra precaution to prevent infection. Observation on 12/05/2024 at 12:00pm, of urinary catheter care provided to Resident #69 by CNA A who did not implement Enhanced Barrier Precautions for urinary catheter care of Resident #69 while providing urinary catheter care the resident. After entering Resident #69's room, CNA A donned gloves but failed to donn (put on) a gown prior to providing urinary catheter care. CNA A provided urinary catheter care, by cleaning the urinary catheter, handling the bag, and emptying urine from the drainage bag without implementing the recommended Enhanced Barrier Precautions of wearing a gown. Interview on 12/05/2024 at 12:20pm, CNA A confirmed that Enhanced Barrier Precautions should be maintained for Resident #69. CNA A stated Resident #69 was on Enhanced Barrier Precautions for urinary catheter. CNA A stated that she was knowledgeable and had been trained on the facility's infection control policy. CNA A was able to articulate knowledge related to what PPE (gown and gloves) should be used when providing care for residents who are on Enhanced Barrier Precaution. CNA A stated that when the donning of PPE is not implemented infection could spread to other residents and staff. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the DON on 12/05/2024 at 1:10pm, who stated that she did not know why CNA A did not implement Enhanced Barrier Precautions and donn proper PPE when providing care to Resident #69. The DON stated that Resident #69 was on Enhanced Barrier Precautions for urinary catheter. The DON stated that CNA A should have donned PPE (gown and gloves) prior to entering the resident's room and when she provided urinary catheter care. The DON stated that staff had been trained on infection control and transmission-based precautions. The DON stated that when the donning of PPE is not implemented infection could spread to other residents and staff. The DON stated that all staff are responsible for ensuring that transmission-based precautions are implemented. Interview on 12/05/2024 at 1:45pm, with the Infection Preventionist, who stated that staff had been trained on infection control and transmission-based precautions. The Infection Preventionist stated that Resident #69 was on Enhanced Barrier Precautions for urinary catheter. The Infection Preventionist, stated that CNA should have donned PPE (gown and gloves) prior to entering the resident's room and when she provided care. The Infection Preventionist stated that when the donning of PPE is not implemented infection could spread to other residents. The surveyor requested the facility policy related to Infection Control and Transmission Based Precautions. The Infection Preventionist stated all staff are responsible for ensuring that transmission-based precautions are implemented. The Infection Preventionist stated additional training would be provided. The Infection Preventionist stated that all staff are offered refresher training courses and in services to ensure that staff are continually reminded of policies and procedures. Record review of staff trainings revealed that staff was on Infection Prevention and Enhanced Barrier Precautions on 10/15/2024 and 11/20/2024. Record review of the facility's provided policy, titled Enhanced Barrier Precautions, dated 03/2024, indicated . Enhanced barrier precautions (EBPs) are utilized to reduce the transmission of multi-drug resistant organisms (MDROs) to residents .Enhanced barrier precautions (EBPs) are used as an infection prevention and control intervention to reduce the transmission of multi-drug resistant organisms (MDROs) to residents . EBPs employ targeted gown and glove use in addition to standard precautions during high contact resident care activities when contact precautions do not otherwise apply .Gloves and gown are applied prior to performing the high contact resident care activity (as opposed to before entering the room) .Examples of high-contact resident care activities requiring the use of gown and gloves for EBPs include device care or use (central line, urinary catheter, feeding tube, tracheostomy/ventilator, etc.).