

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  455715	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  07/31/2024
NAME OF PROVIDER OR SUPPLIER  Monument Rehabilitation and Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE  120 State Loop 92 LA Grange, TX 78945	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48917</b></p> <p>Based on observation, interview, and record review, the facility failed to ensure residents had the right to be treated with respect and dignity for one (Resident # 11) of eight residents reviewed for dignity.</p> <p>Resident # 11 waited 14 minutes staring at her meal tray before a staff member set down to assist with feeding Resident # 11.</p> <p>This failure placed residents at risk of not being treated with dignity.</p> <p>Findings included:</p> <p>A record review of Residents # 11's face sheet dated 7/31/24 reflected a [AGE] year-old female admitted on [DATE] with diagnoses of dementia (A group of symptoms that affects memory, thinking and interferes with daily life.), traumatic subarachnoid hemorrhage (bleeding on the brain), wedge compression fracture of the T5-T6 vertebra (spinal fracture), major depressive disorder ( A mental condition characterized by a persistently depressed mood and long-term loss of pleasure or interest in life.), cervicgia (Neck pain),and anxiety disorder (A mental health disorder characterized by feelings of worry, anxiety, or fear that are strong enough to interfere with one's daily activities.)</p> <p>A record review of Resident # 11's care plan last revised on 5/09/2024 reflected she had ADL self-care performance deficit related to dementia, limited mobility, and terminal illness. Resident # 11's interventions reflected she needed total assistance by 1 staff to eat.</p> <p>An observation of meal service on 7/29/2024 at 1:00 pm revealed Resident # 11 lunch meal tray was sat in front of her. The Activity director came over and set up Resident # 11 meal tray without performing hand hygiene prior to touching meal tray and food items. After meal tray was set up the Activity Director walked away. Resident # 11 sat staring at her meal tray for 14 minutes before a staff member came over and sat down to assist with feeding Resident # 11 her meal tray.</p> <p>Interview with the Dietary Director on 7/29/2024 at 2:00 pm reflected the dining room trays are served after the hall trays go out. The Dietary Director said the meal tickets are in the order they are printed but they try to serve all residents at one table at a time. The Dietary Director said as for the trays of residents who need assistance those are not separated, they just come out in the normal order as they are printed.</p> <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of Meal Service policy dated 10/1/2018 reflected under heading policy: The facility believes that all residents should be always treated with dignity and respect. A respectful, positive dining experience is essential to the residents' quality of life and helps to identify residents' needs and improve their overall nutritional status. 7.Residents who require dining assistance will not have their trays delivered until a staff member is available to assist with dining.</p>		

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<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Reasonably accommodate the needs and preferences of each resident.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40884</b></p> <p>Based on observations, interviews, and record review the facility failed to ensure the residents received services in the facility with reasonable accommodation of each resident's needs for 2 (Resident # 9 and Resident #47) out of 8 residents reviewed for call lights.</p> <p>The facility failed to ensure Resident #9 and Resident #47's call light was within reach.</p> <p>This failure could affect all residents who needed assistance with activities of daily living and could result in needs not being met.</p> <p>Findings included:</p> <p>Record review of Resident #9's Face Sheet, dated 07/31/2024, reflected a [AGE] year-old female admitted to the facility on [DATE] with a diagnoses of history of falling (balance issues or other health conditions that increase the risk of falling), unspecified lack of coordination (uncoordinated movement due to a muscle control problem that causes inability to coordinate movements), and abnormal posture ( rigid body movements and chronic abnormal positions of the body.).</p> <p>Record review of Resident #9's Annual MDS Assessment, dated 06/04/2024, reflected the Resident had a BIMS score of a 6 indicating her cognition was severely impaired. Resident #9 was assessed to require assistance with the following ADLs: eating, oral hygiene, toileting hygiene, showers, upper and lower dressing, putting on /taking off footwear, and personal hygiene. She also required assistance with transfers.</p> <p>Record review of Resident #9's Comprehensive Care Plan, dated 06/17/2024 reflected Resident #9 had an ADL self-care deficit related to cognitive loss and limited mobility. Intervention: Resident #9 required assistance with transfers, bed mobility, dressing, eating, toileting, dressing, and grooming. Resident #9 had actual falls with no injury related to poor balance and unsteady gait. Intervention: keep in highly visible areas.</p> <p>(continued on next page)</p>		

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<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of Resident # 47's face sheet dated 7/31/24 reflected a [AGE] year-old male admitted on [DATE] with diagnoses of respiratory failure ( a condition that occurs when the lungs can't get enough oxygen into the blood or remove enough carbon dioxide from the body), traumatic brain injury ( brain dysfunction caused by an outside force, usually a violent blow to the head), dysphagia (difficulty swallowing foods or liquids, arising from the throat or esophagus), quadriplegia (a type of paralysis that causes severe or complete loss of motor function in all four limbs and the body from the neck down), altered mental status (a general term for a change in mental function that can range from slight confusion to coma), chronic pain syndrome (persistent pain that lasts weeks to years), need for assistance with personal care, hypertension (high blood pressure), contracture to both left and right hands ( a permanent tightening of the muscles, tendons, skin, and surrounding tissue that causes the joints to shorten and stiffen and a decrease in ROM in both hands), muscle wasting and atrophy (the loss of muscle mass and strength), neuromuscular dysfunction of bladder (a urinary tract condition that occurs when the nerves and muscles of the urinary system don't work together properly due to damage to the nervous system), cognitive communication deficit (a communication problem that's caused by a cognitive deficit rather than a language or speech deficit), aphasia ( a comprehension and communication (reading, speaking, writing) disorder resulting from damage or injury to a specific area in the brain), complete amputation at right hip joint, and gastronomy status (the presence of a gastrostomy, which is a surgical opening into the stomach for nutritional support or gastric decompression)</p> <p>Record review of Resident # 47's care plan revised on 1/4/24 reflected the resident was a high risk for falls related to spasticity and traumatic brain injury interventions reflect to be sure resident's call light was within reach and encourage resident to use it for assistance as needed. The resident needed prompt response to all requests for assistance. The care plan also reflected the resident had a communication problem related to head injury. Resident was nonverbal most of the time but will occasionally speak to staff and family. Will blink eyes yes and no and nod head no in response to questions. Interventions included anticipate and meet needs revised 5/6/24. Care plan reflected the resident has oxygen therapy PRN related to respiratory distress, decreased oxygen level revised 4/1/24 with interventions to include provide reassurance and allay anxiety. Have an agreed upon method for the resident to call for assistance (e.g. call light, bell). Stay with resident during episode of respiratory distress. Care plan reflected the resident had an ADL self-care performance deficit related to TBI interventions include resident to be totally dependent on staff for all aspects of ADL's revision on 2/16/24.</p> <p>Observation on 07/29/2024 at 9:41 AM to 9:47 AM Resident #9 was in her room sitting in her wheelchair. She had both feet propped up on her recliner. She had an overhead rolling table approximately 3 feet from where she was sitting. On the rolling table her call light was hanging over the table and the call button was not near her. The call button was hanging from the rolling table on the right side of the table and Resident #9 was sitting on the left side of the rolling table. Resident #9 attempted to reach for the call light. She was not able to reach the call light from where she was sitting in her wheelchair.</p> <p>Observation on 07/29/2024 at 9:45 AM Resident #9 attempted to reach for the call light and she was not able to reach it from where she was sitting in her wheelchair.</p> <p>(continued on next page)</p>		

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<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Observation on 7/30/24 at 4:02 pm of Resident # 47's room revealed Resident # 47 to be in bed resting looking out the window. Further observation revealed Resident # 47's call light and soft pad call device both to be hung on the opposite wall not within reach of Resident # 47. Resident # 47 asked if he needed any assistance. Resident # 47 shook his head no. Resident # 47 asked if he was ok currently and Resident # 47 shook head yes as Resident # 47 is primarily nonverbal and this is his primary way to communicate.</p> <p>Interview on 07/29/2024 at 9:43 to 9:47 AM Resident #9 stated no when she was asked if she knew where her call light was located. She began to look for the call light in her wheelchair and she looked around the room and saw it on the overhead rolling table. She stated she could not reach it but she saw it on the table ( she pointed to the overhead rolling table and to the call light). Resident #9 stated she did use her light when she needed help.</p> <p>In an interview on 07/29/2024 at 9:50 AM CNA Q entered Resident #9's room and stated the call light was not within reach of Resident #9. She stated the resident would not be able to use the call light if she had an emergency or needed anything from the staff. CNA Q stated Resident #9 had fallen in the past attempting to get out of her chair. She stated there was a possibility Resident #9 could fall or have an emergency and would not be able to call out for help. She stated she had been in-serviced on call lights and to place the call light near the resident when in their room. She stated she did not recall when she received the in-service.</p> <p>Interview on 7/30/24 at 1:00 pm with CNA A revealed that residents should have their call lights within reach so they could have their needs met. CNA A said most residents have a regular call light except Resident # 47 who has a soft pad call device that he used be he has contractures of both arms. CNA A said Resident # 47 was mainly nonverbal so he needed frequent checks to make sure his needs were met.</p> <p>In an interview on 07/31/2024 at 9:08 AM the Administrator stated all call lights were expected to be within reach of the resident when the resident was in their room. He stated there was a possibility if the call light were not in reach the resident may need nursing assistance and would not be able to call out for help.</p> <p>In an interview on 07/31/2024 at 10:06 AM LVN P stated if a resident's call light was not within reach of the resident there was a possibility a resident may fall and break a hip or hit their head on the floor attempting to reach the call light. He stated if the resident had an emergency, the resident may be able to yell for help but there were some residents that would not be able to yell very loud. It would be difficult to hear those residents. LVN P stated Resident #9 would be difficult to hear if staff were not near their rooms. He stated it was the responsibility of all staff in the facility to check call lights when they entered a resident room to ensure the call light was attached where the residents had easy access to use the call light. He stated he had been in-serviced on call lights and placing the call light within reach of the resident when they were in their room. LVN P did not recall the last time he received the in-service.</p> <p>(continued on next page)</p>		

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<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 07/31/2024 at 11:09 AM the DON stated it was all the staff's responsibility when they entered a resident room to ensure the call light was within reach of the resident. She stated if the call light were not within reach, it would be difficult for a resident to obtain the help they may need in a timely manner. She stated some residents were able to yell for help and some residents would not be able to yell loud enough. She stated a resident had a potential to fall if the resident attempted to reach for their call light. She stated a resident may fracture their hip, break their leg, or arm. The DON stated it was safe practice for all staff to ensure call lights were within reach of all residents. She stated an in-service had been given to all staff on call light placement. She stated she did not recall the date when the in-service was given to the staff.</p> <p>In an interview on 07/31/2024 at 11:40 AM CNA B stated all staff were responsible to check call lights when they entered a resident's room. She stated if the call light was not in reach the resident may fall attempting to reach the call light or try to find the call light. CNA B stated a resident may break a bone or gain a laceration on their head if they fell . She stated all call lights were expected to be within reach of all residents when they were in their room. CNA B stated it would be difficult to hear Resident #9 if she attempted to yell for help and the staff were not standing near her room. She stated she had been in-serviced on call lights and attach call lights where residents can reach it when in their room. CNA B did not recall the date of the last in-service she had on call lights.</p> <p>Record review of the Facilities Policy on Call Lights: Accessibility and Timely Response, dated 10/13/2022 reflected the following:</p> <p>The purpose of this policy is to assure the facility is adequately equipped with a call light at each residents' bedside, toilet, and bathing facility to allow residents to call for assistance. Call lights will directly relay to a staff member or centralized location to ensure appropriate response.</p> <p>Policy Explanation and Compliance Guidelines:</p> <ol style="list-style-type: none"> <li>1. All staff will be educated on the proper use of the resident call system, including how the system works and ensuring resident access to the call light.</li> <li>2. Staff will ensure the call light is within reach of resident and secured, as needed.</li> <li>3. The call system will be accessible to residents while in their bed or other sleeping accommodations within the resident's room.</li> <li>4. The call system must be accessible to the resident at each toilet and bath or shower facility. The call system should be accessible to a resident lying on the floor.</li> <li>5. Ensure the call system alerts staff members directly or goes to a centralized staff work area.</li> <li>6. All staff members who see or hear an activated call light are responsible for responding. If the staff member cannot provide what the resident desires, the appropriate personnel should be notified.</li> </ol>		

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<p>F 0577</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>Allow residents to easily view the nursing home's survey results and communicate with advocate agencies.</p> <p>40884</p> <p>Based on observations, interviews, and record review the facility failed to place the most recent survey readily accessible to residents in a place most frequented by residents for 9 of 9 residents reviewed for resident group meeting.</p> <p>The facility failed to have the survey manual readily accessible for residents to view the surveys.</p> <p>This failure could place residents at risk of not being able to fully exercise their rights to be informed of the facility's survey citation history.</p> <p>Findings included:</p> <p>Observation on 07/29/2024 at 3:00 PM revealed that the facility did not locate the survey book in common areas of the facility. There was no sign seen that reflected where the survey book was located.</p> <p>Observation on 07/30/2024 at 9:30 AM revealed that the state surveyor was unable to locate the survey book in common areas of the facility. There was no sign seen that reflected where the survey book was located.</p> <p>Record review of the Resident Council Minutes on 07/30/2024 from 8:30 AM to 8:50 AM revealed that during the Resident Council Meetings from 04/2024 to 07/2024 the residents were not explained that the resident had a right to view any surveys or investigations from the state. The Resident Council was not informed where the survey book was located.</p> <p>In a confidential group interview on 07/30/2024 from 10:00 AM to 10:35 AM, seven residents stated they did not know where or how to access the survey results in the facility. They did not understand or have the knowledge this manual existed in the facility. The residents in the group stated they would like to have access to this information, because the staff did not tell them anything about visits from the state. The residents in the group did not know the state sent a report to the facility of any type of visits. The residents in the group did not know where a sign was located informing the residents about the survey book. The five residents in the group stated if they reviewed the reports in a manual, they would prefer to be able to reach it themselves, and not have to ask for it. The five residents stated they would prefer the staff did not know they were wanting to review the reports from the state.</p> <p>In an interview on 07/30/2024 at 10:25 AM the Administrator stated the facility did have a survey binder and it was behind the nurse desk. He stated there was a sign that stated that the Annual State Inspection could be located at the Nursing Station.</p> <p>(continued on next page)</p>

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<p>F 0577</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>Observation on 07/30/2024 at 10:28 AM the Administrator had to reveal where the sign was located in the facility. The sign was not facing the area where people walk. It was not noticeable, and it was located in a cubby area on the side of the small wall located in the cubby area near the nurse's desk. The Administrator was observed removing the State survey binder from behind the nurse's desk. The binder was mixed with approximately eight other binders on the middle shelf behind nurse's station.</p> <p>In an interview on 07/31/2024 at 9:08 AM the Administrator stated the residents had a right to know they had access to the state survey binder. He stated one of the resident rights were to view the survey book. The Administrator stated the survey book was not readily accessible to the residents. He stated the residents had the right to view the survey binder without having to ask someone to get it for them. He stated the residents were not allowed behind the nurse's station. He stated the Activity Director reviewed resident rights during Resident Council. He stated the Activity Director was responsible for reviewing the resident rights.</p> <p>In an interview on 07/30/2024 at 11:49 AM the Activity Director V stated the survey binder was not discussed in Resident Council of where it was located or the availability of the binder. She stated she did not know at this time where the survey binder was located. She also stated she would need to check the resident rights about the state survey binder and verify if it was one of the resident rights. She stated she did review one resident right in the Resident Council meetings. The Activity Director V also stated she did not specify on the Resident Council Minutes what she reviewed. She stated she was not aware the residents did not understand what she was saying during the meetings ( Resident Council Meetings). She stated she only reviewed resident rights with the residents in Resident Council and she did not review resident rights with other residents . She stated all residents needed to know their resident rights in the facility. She stated if a resident did not know their resident rights it was a possibility it could affect their quality of life at the facility.</p> <p>Record review of Facility Policy on Resident Rights , dated November 2021, reflected informed of state survey reports and the nursing facility's plan of correction.</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 30633</p> <p>Based on observations and interviews the facility failed to provide a safe, clean, comfortable, and homelike environment; including housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior for one (Resident #1) of 8 residents reviewed for homelike environment.</p> <p>The facility failed to ensure two bedside tables were cleaned daily for three days observed during annual survey.</p> <p>This failure placed residents at risk for infections, injuries, and demoralization.</p> <p>The findings included:</p> <p>Review of the Face Sheet for Resident #1 reflected she was admitted on [DATE] with diagnosis of: hemiplegia to left side ( paralysis of limbs on the left side of body), metabolic encephalopathy (problem of the brain, history of traumatic brain injury (disruption in the normal function of the brain, muscle wasting and atrophy (decrease in size and wasting of muscle tissue), epilepsy, unspecified convulsions ( a group of disorders marked by problems in the normal functioning of the brain), and need for personal care.</p> <p>Review of the Quarterly MDS assessment for Resident #1 dated 6/11/24 reflected a BIMS score of 15 indicating normal cognitive function. Her physical assessment reflected she required substantial assistance for eating, hygiene, and dressing. She could accomplish some ADLs with one person assistance. She was assessed as always incontinent of bowel and bladder.</p> <p>Review of the Care Plan for Resident #1 reflected interventions were in place for: full code status, ADL performance deficit, history of falls/hemiplegia, antidepressant medication, anticoagulant medication, chronic pain r/t pelvic fracture, and vertebrae fractures.</p> <p>Review of the Face Sheet for Resident #21 reflected she was admitted on [DATE] with diagnoses of: myopathy (disorder of the skeletal muscles), morbid obesity, hypothyroidism ( when the thyroid gland does not make enough thyroid hormones to meet your body's needs), congestive heart failure ( weakened heart condition that causes fluid buildup in the feet, arms, lungs and other organs), muscle wasting and atrophy ( decrease in size of muscles) and peripheral vascular disease (slow and progressive circulation disorder caused by narrowing, blockage or spasms in a blood vessel.</p> <p>Review of the MDS assessment for Resident #21 dated 6/13/24 reflected a BIMS score of 15 indicating normal cognitive function. Her physical assessment reflected she had impairment to both arms and legs, she required one person assist for eating and grooming, and extensive assistance in all other ADLs. She was assessed as always incontinent of bowel and bladder.</p> <p>Review of the Care Plan for Resident #21 reflected interventions were in place for: her DNR status, ADL self-performance deficit, a history of falls, a urinary tract infection( infection in any part of the urinary system), Chronic back pain, and psych history related to sexual assault.</p> <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 7/30/24 at 8:20 am Resident #21 stated no one had ever cleaned the surface of her bedside table as far back as she could remember. She stated no one cleaned the table in between meals and incontinence care. She stated no one cleaned the table before setting her meal tray on it and no one helped to wash her hands.</p> <p>Observation of lunch service on 7/30/24, starting at 12:10 pm.</p> <p>At 12:15 pm Resident #21 stated her tray table or bedside table had not been cleaned. She also stated she had not been assisted to wash her hands.</p> <p>At 12:20 pm trays for 500 Hall exited the dining room and were checked by a nurse.</p> <p>At 12:22 pm trays were served to the first two rooms, Resident #10 and Resident #50 by Aides CNA M and CNA N. Neither resident was observed to be assisted with handwashing or cleaning their table.</p> <p>At 12:30 pm Resident #21 was not assisted to wash her hands and her tray table was not cleaned prior to being served her lunch tray.</p> <p>At 12:35 Resident #44 was served his lunch tray with a urinal containing approximately 300 mls of clear yellow urine sitting on the bedside table and left behind alongside his food.</p> <p>In an interview on 7/30/24 at 3:25 pm Housekeeper P stated each room in the facility was to be cleaned daily. He stated all touch surfaces were to be cleaned daily. He stated staff should be sure to follow policy during the current increase in Covid-19 infections in the facility . He stated there was a possibility if residents' rooms were not sanitized a resident may become ill with some type of virus.</p> <p>In an interview on 7/30/24 at 4:00 pm LVN L stated Residents should be assisted to wash their hands multiple times a day by aides and nurses. She stated caregivers should be wearing PPE when in Covid-19 rooms. She stated housekeeping was responsible for wiping down high touch surfaces once a day . She stated if not sanitized a resident may become ill.</p> <p>In an interview on 7/31/24 at 8:12 am Resident #21 stated no one cleaned her bedside table or helped her wash her hands before breakfast today.</p> <p>In an interview on 7/31/24 at 8:50am Resident #1 stated the staff did not help her wash her hands before breakfast today and did not help her wash her hands after getting up to the bathroom at 8:30 am.</p> <p>In an interview on 7/31/24 at 12:20 pm CNA A stated she assisted all the residents on 500 Hall to wash their hands this morning. She stated she can't speak for other aides, but she made sure everyone got help when they needed it. She stated tabletops and bedside tables were to be cleaned by housekeeping each day . She stated if a room was not sanitized a resident may become ill with breathing problems.</p>		

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NAME OF PROVIDER OR SUPPLIER  Monument Rehabilitation and Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE  120 State Loop 92 LA Grange, TX 78945	
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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 40884</p> <p>Based on observations, interviews, and record review the facility failed to ensure residents unable to conduct activities of daily living (ADLs) received the necessary services to maintain good grooming and personal hygiene for four of eight residents (Resident # 8, Resident #18, Resident #34, and Resident #50).</p> <ol style="list-style-type: none"> <li>The facility failed to ensure Resident #18 and Resident #50's facial hair was removed.</li> <li>The facility failed to ensure Resident # 8, and Resident # 34's nails were cleaned and did not have any rough edges.</li> </ol> <p>These failures could place residents at risk for poor hygiene, dignity issues, and decreased quality of life.</p> <p>Findings included:</p> <ol style="list-style-type: none"> <li>Record review of Resident # 18's Face Sheet dated, 07/31/2024, reflected a [AGE] year-old female admitted on [DATE] with diagnoses of muscle wasting and atrophy, not elsewhere classified, multiple sites ( thinning or loss of muscle tissue), lack of coordination (uncoordinated movement due to a muscle control problem that causes inability to coordinate movements), age-related physical debility (frail patients often present with symptoms including weakness and fatigue, medical complexity, and reduced tolerance to medical and surgical interventions), and type 2 diabetes mellitus without complications (a disorder in which the body does not produce enough or respond normally to insulin, causing blood sugar levels to be abnormally high).</li> </ol> <p>Record review of Resident #18's Quarterly MDS Assessment, dated 06/21/2024, reflected the resident had a BIMS score of 1 indicating her cognition was severely impaired. Resident #18 did not reject care. She did require assistance with the following ADLs: eating, oral hygiene, toileting hygiene, showers, upper and lower dressing, and required maximum assistance with personal hygiene.</p> <p>Record review of Resident #18's Comprehensive Care Plan , dated 06/25/2024, reflected Resident #18 had ADL self -care performance deficit related to dementia (impairment of memory and abstract thinking, and often with personality change). Intervention: Resident #1 required limited assistance by one staff with personal hygiene and oral care.</p> <p>Observation on 07/29/2024 at 11:01 AM Resident #18 was sitting in her room. She had facial hair above her upper lip and had hair on the right side of her chin. The hair was approximately 1-2 inches long.</p> <p>Interview on 07/29/2024 at 11:03 AM Resident #18 was not interview able.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Record review of Resident #50's Face Sheet dated, 07/31/2024, reflected a [AGE] year-old female admitted on [DATE] with diagnoses of depression ( a mood disorder that causes a persistent feeling of sadness and loss of interest), muscle wasting and atrophy, not elsewhere classified, multiple sites ( thinning or loss of muscle tissue), unspecified dementia, mild , with anxiety (impairment of memory and abstract thinking, and often with personality change and anxiety is often related to worries about coping with the condition and what the future holds).</p> <p>Record review of Resident #50's Quarterly MDS Assessment, dated 05/21/2024, reflected Resident #50 had a BIMS score of 7 indicating her cognition was severely impaired. Resident #50 required ADL assistance with eating, oral hygiene, toileting, upper and lower body dressing, putting on/ taking off footwear, and personal hygiene.</p> <p>Record review of Resident #50's Comprehensive Care Plan, dated 06/07/2024, reflected Resident #50 had an ADL self-care performance deficit related to dementia. Intervention: Resident #50 required assistance with personal hygiene.</p> <p>Observation on 07/29/2024 at 11:13 AM Resident #50 entered her room and was standing at the side of her bed. She had facial hair on the right and left side of her chin. The hair was approximately 1-2 inches long.</p> <p>Interview on 07/29/2024 at 11:14 AM Resident # 50 stated she was so embarrassed when asked if anyone had offered to remove hair on her chin. She stated she did not realize she had hair on her chin and if she did, she would have asked someone to remove it for her. She stated she was not able to remove hair from her chin anymore and needed help. She stated she had been visiting people and did not realize she had hair on her chin. She stated she never let anyone see her with hair on her chin. She stated it worried her. She stated she always wanted to look nice. Resident #50 stated she was worried other people would believe she did not take care of herself and it was embarrassing.</p> <p>2. Record review of Resident #8's Face Sheet , dated 07/31/2024, reflected a [AGE] year-old female admitted on [DATE] with diagnoses of other lack of coordination (uncoordinated movement due to a muscle control problem that causes inability to coordinate movements), age-related physical debility ( frail patients often present with symptoms including weakness and fatigue, medical complexity, and reduced tolerance to medical and surgical interventions), unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety (impairment of memory).</p> <p>Record review of Resident #8's Quarterly MDS Assessment, dated 05/22/2024, reflected the resident was not capable of completing BIMS assessment. The staff completed the Assessment for Mental Status. Resident #8 had poor short- and long-term memory recall, she did not know the current season, location of own room, staff names and faces, or that she was residing in a nursing facility. Her decision-making ability was severely impaired. She was also assessed to require assistance with the following ADLs: eating, oral hygiene, toileting hygiene, showers, upper and lower body dressing, and personal hygiene.</p> <p>Record review of Resident #8's Comprehensive Care Plan, dated 06/21/2024, reflected Resident #8 had an ADL self- care performance deficit related to dementia. Intervention: Resident required assistance with personal hygiene. She was at risk for signs/symptoms of depression related to dementia.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Observation on 07/29/2024 at 8:59 AM Resident #8 was in her room sitting in her wheelchair. Her middle finger and ring fingernails were rough around the edges on her right hand. Resident #8 also had blackish/ brownish hard substance underneath the forefinger, ring finger and middle fingernails on her right hand.</p> <p>Interview on 07/29/2024 at 9:02 AM Resident #8 was not interview able.</p> <p>Record review of Resident # 34's Face Sheet dated, 07/31/2024, reflected a [AGE] year-old male admitted on [DATE] and readmitted on [DATE] with diagnoses of lack of coordination (uncoordinated movement due to a muscle control problem that causes inability to coordinate movements), type 2 diabetes mellitus with diabetic neuropathy, unspecified (nerve damage caused by high blood sugar levels over time, leading to various complications in different parts of the body), unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance and anxiety (impairment of memory), and chronic angle -closure glaucoma, unspecified eye, stage unspecified ( occurs when a portion of the angle is intermittently obstructed, resulting in scarring).</p> <p>Record review of Resident #34's Quarterly MDS Assessment, dated 04/30/2024, reflected the resident had a BIMS score of 11 indicating his cognition was moderately impaired. Resident #34 required assistance with personal hygiene, showers, and putting on and taking off footwear.</p> <p>Record review of Resident #34's Comprehensive Care Plan dated, 06/21/2024, reflected Resident #34 had an ADL self-care performance deficit. Intervention: Bathing/Showering: check nail length and clean on bath day and as needed. Report any changes to the nurse. Resident required assistance with bathing/showering. Resident was assessed to refuse showers and to be shaved.</p> <p>Record review of Resident #34's Shower record dated 07/02/2024 - 07/31/2024 reflected Resident #34 did not refuse shower from 07/12/2024 thru -7/31/2024.</p> <p>Observation on 07/29/2024 at 9:39 AM Resident #34 was sitting in his wheelchair in his room watching television. Resident #34 had blackish hard substance underneath the forefinger and middle fingernails on his right hand. His middle and right fingernails were rough around the edges. There was an odor of bowel movement on his right hand.</p> <p>Interview on 07/29/2024 at 9:42 AM Resident # 34 stated he asked someone to clean and trim his nails two or three days ago. The person stated she would report it to a nurse to clean and trim his nails because he was a diabetic. He stated a nurse never came to his room. Resident #34 stated he would try to clean and trim his nails, but with his vision issues he was reluctant due to being a diabetic and did not want to cut his finger and get it infected. He stated he did this one time, his finger became infected, and he quit doing his own nail care. Resident #34 stated he thought he had bowel movement in his fingernails and did not know how it got into his nails.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>In an interview on 06/27/2024 at 11:20 AM LVN P stated the nurses and the CNAs were responsible for nail care. He stated the nurses were responsible to trim and clean all resident's nails with a diagnosis of diabetes. LVN P stated it was the CNAs responsibility to clean and trim all other residents' nails. He stated if anyone refused nail care it would be documented on their shower record. He stated if there was a blackish substance underneath the residents' nails, there was a possibility the substance had bacteria underneath the residents' nails. He also stated if a resident swallowed the bacteria there was a possibility a resident may become extremely ill with stomach issues such as diarrhea. He stated if a resident scratched themselves with rough nails there was a potential a resident may develop a skin tear. LVN P stated he was not aware of anyone refusing nail care. He stated he would need to refer to the shower record to know for certain if Resident # 8 or Resident #34 refused nail care. He stated if a female resident had facial hair on their chin there was a possibility the resident may become embarrassed with their appearance and may isolate themselves in their room.</p> <p>In an interview on 06/27/2024 at 11:09 AM the DON stated it was a joint effort between the CNAs and the nurses to complete nail care on the residents. She stated the nurses was responsible for residents with diagnosis of diabetes ( a disease in which the body's ability to produce or respond to the hormone insulin was impaired). The DON stated nail care was given during showers and as needed. She stated if a resident had blackish substance underneath their nails there was a possibility the substance may be some type of bacteria. The DON stated if the scent of feces was noticed underneath the residents' fingernails there was a potential this may be bacteria. She stated it was a possibility a resident may become physically ill such as vomiting or diarrhea if they ingested bacteria. She stated if a resident had rough fingernails there was a possibility the resident may scratch themselves and develop a skin tear. The DON stated if the female residents had facial hair on their chin or around the top lip of their mouth, it was a dignity issue. She stated the resident may become embarrassed and there was a possibility the resident may not want to interact with other residents.</p> <p>In an interview on 06/27/2024 at 11:30 AM CNA B stated the nurses completed all diabetic fingernails and the CNAs were responsible for all other residents' nails. She stated the CNAs were responsible to complete nail care such as trimming, filing, and cleaning the nails. CNA B stated if a resident's nails needed to be cleaned, trimmed, or filed and it was not their shower day the staff were expected to do any type of nail care as needed. She stated if a resident had blackish substance underneath their nails, it was probably some type of bacteria such as bowel movements. She stated if a resident swallowed bacteria it was a potential the resident may become ill with E. coli (a bacteria that is commonly found in the lower intestine of warm-blooded organisms) and may develop major stomach problems such as diarrhea. She stated she worked with Resident #8 and Resident #34, and she was not aware of them refusing nail care. CNA B stated sometimes Resident #34 would refuse to shave but she was not aware of him refusing nail care. She stated if a resident's nails were rough there was a possibility the resident may scratch themselves and develop a skin tear, or possibly scratch their eye and cause a tear on their eyeball. CNA B stated if a female resident had facial hair on their chin, a resident may become embarrassed over their appearance. She stated it would be a dignity issue and it was a possibility a resident may isolate themselves if they did not want anyone to see them with facial hair. CNA B stated it was the CNAs or nurses' responsibility to remove facial hair from the female's chin in the resident's room or during showers. She stated she was not aware of any female resident refusing to allow staff to remove unwanted facial hair from their face.</p> <p>Record review of the Facilities Policy on ADLs dated 05/26/2023 reflected A resident who was unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming, and personal, and oral hygiene.</p>		

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<p>F 0801</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician.</p> <p>48917</p> <p>Based on observation, interview, and record review, the facility failed to have sufficient staff with the appropriate competencies, and skills set to carry out the functions of the food and nutrition service for one cook (Cook G) of three dietary cooks reviewed for qualified dietary staff in that:</p> <p>Cook G had not received onboarding training with the appropriate competencies and skills to carry out the functions of the food and nutrition services department.</p> <p>This failure could place residents at risk of not having their nutritional needs met and place them at risk of food borne illness.</p> <p>Findings included:</p> <p>During an interview on 7/29/24 at 9:00 am the DD said all her staff including herself had the Texas Food Handlers License except for [NAME] G who was new and just started in the early part of July 2024. The DD said [NAME] G will be coming in to take her Texas Food Handlers course this week and get their food handlers license . The DD said [NAME] G had recently transitioned from the housekeeping department to dietary department. The DD said [NAME] G has worked several shifts since starting and was being trained by the DD, [NAME] E, and [NAME] F. The DD said [NAME] G has never prepared a meal by themselves and they have never been left in the kitchen without a team member present who has their Texas Food Handlers certification.</p> <p>During an observation and interview on 7/31/24 at 12:30 pm revealed [NAME] G to be in the DD office taking the Texas Food Handler online course. [NAME] G said they started in the dietary department on 7/11/24. [NAME] G said their normal shift was 12:00 pm-8:00 pm. [NAME] G said they have been receiving training from the DD, [NAME] E, and [NAME] F. [NAME] G said they have never worked in food service prior to this position. [NAME] G said they do not have a Texas Food Handlers certification, and which was why the DD requested they come in early today to be able to take the course today. [NAME] G said they have received Hands on training from the DD and the other cooks. [NAME] G said they have been allowed to assist in preparing the resident meals, wash dishes independently, serve tray line independently. [NAME] G said they have been trained on the different types of diets offered, menus and alternate meal options available. [NAME] G said they have not received or were unsure if they had received training on cross contamination, infection control, time temperature control, HACCP , recipes, and production records. [NAME] G said they had never received a job description to sign or nay other paperwork documents for this current position.</p> <p>Record review of dietary schedule for 7/15/24 - 8/12/24, revealed [NAME] G had worked 11 shifts in the dietary department as a cook.</p> <p>Record review of [NAME] G personnel file revealed a hire date of 3/1/24 with a job title of housekeeper signed by [NAME] G on 3/4/24. Job description of housekeeper in employee file dated 3/4/24.</p> <p>Interview on 7/29/24 at 9:00 am, DD was asked for the training documentation for [NAME] G. No training documents for [NAME] G provided prior to exit.</p> <p>(continued on next page)</p>		

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<p>F 0801</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of the cook job description undated revealed under Licensing requirements: Texas Food Handler Certificate</p> <p>And under Experience requirements: Knowledge of food preparation, sanitation, and hygienic methods. Knowledge of Universal Precautions and rules that govern hazardous waste. Previous experience in skilled nursing facility is preferred. Ability to follow oral and written directions.</p>		

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<p>F 0808</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure therapeutic diets are prescribed by the attending physician and may be delegated to a registered or licensed dietitian, to the extent allowed by State law.</p> <p>48917</p> <p>Based on observations, interviews, and record review, the facility failed to provide the physician prescribed therapeutic diet to 11 of 13 residents (Resident # 3, Resident # 9, Resident # 10, Resident # 12, Resident # 13, Resident # 22, Resident # 23, Resident # 25, Resident # 36, Resident # 156, and Resident # 207) reviewed for therapeutic diets, in that:</p> <p>Resident # 3, Resident # 9, Resident # 10, Resident # 12, Resident # 13, Resident # 22, Resident # 23, Resident # 25, Resident # 36, Resident # 156, and Resident # 207 did not receive a mechanical soft diet as ordered.</p> <p>This failure could place residents at risk for choking and causing further health issues.</p> <p>Findings included:</p> <p>A record review of Resident # 3's diet order dated 8/29/22 reflected an order for Regular diet mechanical soft texture, regular liquids consistency.</p> <p>A record review of Resident # 9's diet order dated 8/29/22 reflected an order for Regular diet mechanical soft texture, regular liquids consistency.</p> <p>A record review of Resident # 10's diet order dated 7/10/24 reflected an order for Regular diet mechanical soft texture, regular liquids consistency.</p> <p>A record review of Resident # 12's diet order dated 8/29/22 reflected an order for Regular diet mechanical soft texture, regular liquids consistency.</p> <p>A record review of Resident # 13's diet order dated 12/14/23 reflected an order for Regular diet mechanical soft texture, regular liquids consistency.</p> <p>A record review of Resident # 22's diet order dated 3/29/22 reflected an order for Regular diet mechanical soft texture, regular liquids consistency.</p> <p>A record review of Resident # 23's diet order dated 4/22/24 reflected an order for Regular diet mechanical soft texture, regular liquids consistency.</p> <p>A record review of Resident # 25's diet order dated 9/25/23 reflected an order for Reduced Concentrated Sweets mechanical soft texture, regular liquids consistency.</p> <p>A record review of Resident # 36's diet order dated 8/10/23 reflected an order for Regular diet mechanical soft texture, regular liquids consistency.</p> <p>A record review of Resident # 156's diet order dated 7/16/24 reflected an order for Regular diet mechanical soft texture, regular liquids consistency.</p> <p>(continued on next page)</p>		

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<p>F 0808</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A record review of Resident # 207's diet order dated 7/16/24 reflected and order for Renal-Liberalized diet mechanical soft texture, regular liquids consistency.</p> <p>Observation of kitchen lunch preparation on 7/29/24 at 11:00 am revealed tray line to be set up with chopped lettuce for beef soft tacos.</p> <p>Observation of lunch tray line service on 7/29/24 at 12:00 pm revealed mechanical soft diets receiving chopped lettuce on meal trays.</p> <p>Observation of lunch meal tray on 7/29/24 at 12:45 pm of Resident # 13's meal tray and meal ticket with order of Regular diet mechanical soft texture. Resident # 13's meal tray consisted of ground beef and tortilla mixture with shredded cheese as garnish on top of beef mixture with a side of chopped lettuce. Observation of Resident # 13 to be eating some of the lettuce.</p> <p>Record review of week 2-day 8 recipe for soft beef taco reflected under notes: 3. For ground and puree texture modifications, omit lettuce and tomatoes.</p> <p>Record review of week 2-day 8 production records signed by Dietary Director and RD reflected mechanical soft texture to receive 1/2 cup of shredded lettuce.</p> <p>Interview on 7/29/24 at 12:33 pm the Dietary Director said the cooks follow the production records when preparing the meals and the production records stated mechanical soft diets can have chopped lettuce. The Dietary Director was asked about the recipe for soft beef tacos indicating to omit the lettuce and tomato and modify with substitution, the Dietary Director reiterated the staff follow the production records for meal preparation. The Dietary Director was unsure about the policy concerning diet texture modifications and stated they would ask the RD and Administrator about the policy.</p> <p>Interview on 7/30/24 at 9:22 am reflected the Registered Dietician (RD) said the company and the facility followed the National Dysphasia Diet Level 3: Advanced protocol for their mechanical soft diets. The RD said this protocol allowed for residents to receive shredded lettuce. The RD said this protocol was the policy the facility follows. The RD said the recipes come from their grocery supplier and the facility follows the facility procedure/protocol if the recipe has a discrepancy and states differently than the facility policy/protocol.</p> <p>Interview with Dietary Director on 7/31/24 at 9:15 am reflected Dietary Director said the facility received whole heads of lettuce and they chop it themselves as receiving pre-shredded lettuce in was more expensive and usually does not have a long shelf life.</p> <p>Record review of mechanical soft diet textures in-service dated 6/3/24 presented by Dietary Director reflected 5 staff members signatures of attendance. In-service training documentation reflected</p> <p>Under heading What is a Mechanical Soft diet texture? An altered diet texture for residents who cannot safely chew or swallow regular/hard food textures but may still chew softer foods. Foods should be soft, moist. Meats are ground or minced, moist, and no larger than 1/4 inch pieces.</p> <p>Under heading Not approved foods: raw vegetables</p> <p>(continued on next page)</p>		

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F 0808  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Some	Record review of National Dysphagia Diet Level 3: Advanced policy provided by facility RD undated reflected mech soft to be handwritten in parenthesis at the top of the document next to the word advanced. Under heading considerations for specific food items: Raw fruits and vegetables-shredded lettuce is underlined, sliced tomatoes, and finely chopped tomatoes/salads as tolerated.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  455715	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  07/31/2024
NAME OF PROVIDER OR SUPPLIER  Monument Rehabilitation and Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE  120 State Loop 92 LA Grange, TX 78945	
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<p>F 0810</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide special eating equipment and utensils for residents who need them and appropriate assistance.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 48917</p> <p>Based on observation, interview, and record review, the facility failed to provide special eating equipment and utensils for residents who need them and appropriate assistance to ensure that the resident can use the assistive device when consuming meals and snacks for 1 resident (Resident # 2) of 8 residents reviewed for assistive devices.</p> <p>The facility failed to provide Residents# 2's physician ordered handled cup with lid for lunch.</p> <p>This failure put resident at risk for decreased fluid intake, dehydration, and decreased quality of life.</p> <p>Findings included:</p> <p>A record review of Residents # 2's face sheet dated 7/31/24 reflected a [AGE] year-old female admitted on [DATE] with diagnoses of cerebral palsy (A congenital disorder of movement, muscle tone, or posture.), intellectual disabilities (A neurodevelopmental condition that affects a person's intellectual functioning and adaptive behavior.), muscle wasting and atrophy (The loss of muscle mass and strength), dysphagia (Difficulty swallowing foods or liquids, arising from the throat or esophagus.), ataxia (Impaired balance or coordination can be due to damage to the brain), need for assistance with personal care., cognitive communication deficit (A communication problem that's caused by a cognitive deficit rather than a language or speech deficit), and age related physical debility.</p> <p>A record review of Resident # 2's care plan last revised on 1/26/2024 reflected she has potential nutritional problems related to cerebral palsy. Diet order RCS diet, mech soft, regular liquids consistency, Handled cup. Interventions reflected Resident # 2 will get a no spill handled cup with her meals to help aid with her drinking abilities. Provide serve diet as ordered. Monitor intake and record meal.</p> <p>A record review of Resident # 2's diet order dated 1/25/2024 reflected Reduced Concentrated Sweets diet, Mechanical Soft texture, Regular liquid consistency, handled cup with lid, divided plate, built up utensils, can have salads per speech therapy.</p> <p>Observation on 7/29/24 at 12:40 pm the Activity Director in dining room assisting Resident # 2 with their drink. Resident # 2 had a diet coke being poured into handled cup with lid by the Activity Director. The drink foamed over cup lid was applied to cup and given to Resident # 2. Cup slipped from Resident # 2's hands onto floor and spilled contents on floor. The Activity Director put Resident # 2 handled cup in the dirty dish area of dining room. The Activity Director went to Resident # 2's room got Resident # 2 another diet coke opened it then went to get straw to put inside can for Resident # 2. The Activity Director gave Resident # 2 the can of Diet coke with straw. A new clean handled spill proof cup was never provided to Resident # 2 during lunch meal service.</p> <p>Interview and observation on 7/29/24 at 2:00 pm with the Dietary Director reflected Resident # 2 has an order for a handled spill proof cup with all meals. The Dietary Director showed the kitchen had a quantity of 2 handled cups in the clean dish storage area that Resident# 2 used.</p> <p>(continued on next page)</p>		

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<p>F 0810</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Record review of Meal Service policy dated 10/1/2018 reflected under heading policy: The facility believes that all residents should be always treated with dignity and respect. A respectful, positive dining experience is essential to the residents' quality of life and helps to identify residents' needs and improve their overall nutritional status. 8. Assistive devices will be provided as ordered and documented in residents' care plans.</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>48917</p> <p>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 one of one kitchen reviewed for sanitation.</p> <ol style="list-style-type: none"> <li>1. The facility failed to ensure all items were labeled and dated.</li> <li>2. The facility failed to ensure all items were covered and stored properly.</li> <li>3. The facility failed to ensure sanitation practices were occurring in kitchen.</li> <li>4. The facility failed to ensure temperature logs were being completed.</li> </ol> <p>These failures placed residents at risk of foodborne illness.</p> <p>Findings included:</p> <p>Observation of the kitchen's ice machine on 7/29/24 at 7:00 am revealed the inside of the machine to have black debris and growth growing on the upper inside of the machine near the door.</p> <p>Observation of ice scoop receptacle on wall next to ice machine on 7/29/24 at 7:05 am revealed inside of receptacle to have dried brown appearing substance at the bottom of the receptacle.</p> <p>Observation of kitchen prep area worktable on 7/29/24 at 7:08 am revealed a staff member had a Styrofoam cup of coffee uncovered in work prep area near toaster, robot coupe blender, and block of butter unwrapped with butcher knife on wrapper next to it.</p> <p>Observation on 7/29/24 at 7:10 am in the clean dish storage area, there were steam table lids with dried particles on them. The lids were stored in bin with other clean steam table lids.</p> <p>Observation of walk-in refrigerator on 7/29/24 at 7:13 am revealed the following:</p> <ul style="list-style-type: none"> <li>*A cut unwrapped undated cucumber sitting on a tray with health shakes and chocolate syrup bottles.</li> <li>*A thawing brisket on bottom shelf on sheet pan undated.</li> </ul> <p>Observation of walk-in freezer on 7/29/24 at 7:16 am revealed the following:</p> <ul style="list-style-type: none"> <li>*A bag of frozen chicken breast that had been torn open with 1 single chicken breast remaining undated and unsealed.</li> <li>*A steam table pan of mixed vegetable blend with red peppers, green beans, broccoli, and mushrooms uncovered and undated on shelf.</li> </ul> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>*A package with half of an angel food cake undated and unsealed.</p> <p>Observation of dry storage area on 7/229/24 at 7:20 am revealed the following:</p> <p>*A container of brown sugar with the lid sitting on top of container with a gap of approximately 2-centimeter opening.</p> <p>*A container of flour with lid sitting on top of container with a gap of approximately 1-centimeter.</p> <p>*A gallon Ziploc bag with penne pasta inside unlabeled and undated.</p> <p>*An open storage bin with individually wrapped saltine crackers unlabeled and undated on bin.</p> <p>*An open storage bin with individually packaged ketchup packets with a label stating contents were flour and date of 10/20/23.</p> <p>*An opened storage bin with individually packaged mustard packets undated and unlabeled.</p> <p>*An opened box of tea bags undated unlabeled and with box partially torn open with part of box missing.</p> <p>*An undated container of unopened oatmeal.</p> <p>*An undated container of parsley flakes.</p> <p>Observation of kitchen prep drink station on 7/29/24 at 7:30 am revealed the following:</p> <p>*An undated gallon container of orange juice without lid approximately 1/4 full.</p> <p>*6 juice glasses full of orange juice without lids on table. A stack of lids were present next to glasses that had been filled.</p> <p>Observation of temperature logs on 7/29/24 at 7:33 am revealed the following:</p> <p>*The daily dish machine temperature and sanitizer log had not been completed for lunch on 7/10/24, breakfast on 7/25/24, and breakfast and lunch on 7/26/24.</p> <p>*The walk-in freezer temperature log had not been completed for 4/30/24, 7/27/24, and 7/28/24.</p> <p>*The walk-in refrigerator temperature log had not been completed for 7/27/24 and 7/28/24.</p> <p>*The pot/sink sanitizer test strip log had not been completed for dinner 7/25/24, breakfast 7/26/24, and lunch 7/26/24.</p> <p>*The daily meal/ food temperature log had not been completed for dinner 7/21/24 and breakfast 6/10/24.</p> <p>(continued on next page)</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Observation of three-compartment sink on 7/29/24 at 7:38 am revealed dried particles, dirt, grime, and a single hair black in color on the dish drain side of the sink.</p> <p>Observation of dish machine rack storage dolly on 7/29/24 at 7:40 am revealed dirt, grime, dried particles, and paper scraps on storage dolly surface where dish machine racks are stored.</p> <p>Observation of lunch tray line on 7/29/24 at 12:15 pm revealed the 400 hall cart trays being loaded into meal cart with charro beans in bowls uncovered and bowls of soup uncovered.</p> <p>Observation of breakfast meal cart on 7/30/24 at 7:50 am revealed the 200 hall meal cart doors open in hallway with bowls of oatmeal on resident trays uncovered. Meal cart unattended at time of observation.</p> <p>Observation on 7/30/24 at 9:15 am Dietary Aide I was in kitchen with his beard guard down under chin not covering beard.</p> <p>Observation on 7/30/24 at 9:22 am of kitchen revealed large 55-gallon trash can in kitchen without lid.</p> <p>Observation on 7/30/24 at 12:05 pm Dietary Aide I was in kitchen working the lunch tray line with beard guard under chin not covering beard.</p> <p>Observation on 7/31/24 at 9:20 am of kitchen revealed large 55-gallon trash can in kitchen without lid.</p> <p>Observation on 7/31/24 at 9:21 am of kitchen revealed spatula hanging in clean utensil storage area with dried particles on surface.</p> <p>Observation on 7/31/24 at 9:24 am of kitchen revealed inside of juice dispenser nozzle to be caked with red and orange slimy buildup.</p> <p>Observation on 7/31/24 at 12:19 pm of Dietary Aide J in kitchen prepping mayonnaise cups for lunch meal service. Observation further revealed mayonnaise cups to be put on meal trays uncovered and loaded onto meal cart.</p> <p>Interview on 7/29/24 at 9:00 am the Dietary Director said the cleaning logs are posted on the cooler and each staff member has different parts of the kitchen they are responsible for cleaning. The Dietary Director said the cleaning schedule was posted on the cooler right next to the cleaning logs. The Dietary Director said all staff are trained in kitchen sanitation in part of their new hire onboarding training. The Dietary Director said everyone who comes into the kitchen was required to wear hair restraints and beard restraints for the males. The Dietary Director said when items are received, they are dated with the receipt date and stored using the First In First Out method. DD said once items are opened or prepared, they are dated with the open/preparation date and the discard date.</p> <p>Record review of dietary cleaning schedule posted for week of 6/24/24 revealed the following:</p> <p>*cleaning task of toaster completed 6/24/24,</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>*cleaning task of microwave completed 6/24/24 by Dietary Aide K,</p> <p>*cleaning task of can opener completed 6/24/24 by Dietary Director and 6/25/24 by Dietary Aide K,</p> <p>*cleaning task of cook shelves and steam table completed by [NAME] F undated,</p> <p>*cleaning task of storeroom completed by [NAME] F undated, and</p> <p>*cleaning task of dish machine completed by [NAME] F undated.</p> <p>Record review of weekly dietary cleaning schedule posted for week of 7/1/24-7/8/24 with cleaning task of:</p> <p>*dry storage completed 7/1/24 by Dietary Aide I,</p> <p>*cleaning task of walk-in freezer completed on 7/1/24 by [NAME] E,</p> <p>* cleaning task of walk-in cooler completed on 7/1/24 by Dietary Director,</p> <p>*cleaning task of reach-in cooler completed 7/10/24 by Dietary Director,</p> <p>*cleaning task of mop under/between ovens, fryer and steamer completed on 7/1/24 by Dietary Director, and on 7/2/24 by Dietary Aide I, and</p> <p>*cleaning task of dish room completed on 7/1/24 and 7/2/24 by [NAME] F.</p> <p>Record review of general kitchen sanitation policy dated 10/1/2018 reflected under heading policy: The facility recognizes that food-borne illness has the potential to harm elderly and frail residents. All nutrition and foodservice employees will maintain clean, sanitary kitchen facilities in accordance with the state and US food codes to minimize the risk of infection and food borne illness. Under heading procedure:</p> <ol style="list-style-type: none"> <li>1. Clean and sanitize all food preparation areas, food-contact surfaces, dining facilities and equipment. After each use, clean and sanitize all food-contact surfaces of equipment.</li> <li>4. Clean and sanitize all multi-use utensils and food-contact surfaces of equipment used in the preparation or storage of potentially hazardous food prior to each use. Clean and sanitize food-contact surfaces of equipment and multi-use utensils used for preparation of potentially hazardous foods on a continuous or production line basis at scheduled intervals throughout the preparation period based on food temperature, type of food and amount of food particle accumulation.</li> <li>5. After cleaning and until use, store and handle all food-contact surfaces of equipment and multi-use utensils in a manner that protects the surfaces from manual contact, splash, dust, dirt, insects, and other contaminants</li> <li>6. Clean non-food-contact surfaces of equipment at intervals as necessary to keep them free of dust, dirt, and food particles and otherwise in a clean and sanitary condition.</li> </ol> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Record review of the dietary food handling policy undated under heading purpose: The purpose of this procedure is to provide guidelines for the d=safe preparation, handling, and storage of perishable food and proper environmental cleaning. Under heading general guidelines 13. Clean uniforms, hairnets or caps should be worn daily. All facial hair should be covered.</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 40884</p> <p>Based on observations, interviews, and record review, the facility failed to maintain an infection control 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 4 of 8 (Resident #2, Resident #11, Resident #19 and Resident #44) residents reviewed for infection control practices.</p> <ol style="list-style-type: none"> <li>1. Business Office Manager failed to don PPE according to the facility protocol prior to entering COVID isolation.</li> <li>2. The CNAs serving food trays failed to ensure Resident #44 was served his meal under safe sanitary conditions.</li> <li>3. Activity Director observed assisting Resident # 11 in dining room with meal set up touching ready to eat food items with ungloved hands and without performing hand hygiene in between residents.</li> <li>4. CNA A observed passing hall tray for Resident # 2 and assisting Resident # 2 with meal tray set up with ungloved hands and without performing hand hygiene between residents.</li> </ol> <p>These failures could lead to the spread of infection to residents, residents' illness, and/ or distress.</p> <p>Findings included:</p> <ol style="list-style-type: none"> <li>1. Observation on 07/30/2024 at 12:40 PM the BOM was in the dining room and volunteered to take Resident # 19 meal tray to her room on 400 hall. Business Office Manager exited the dining room with the meal tray and carried it to COVID Resident # Business Office Manager donned N95 mask ( personal protective equipment that are used to protect the wearer from particles of liquid from contaminating the face) and did not sanitize her hands. She entered Resident #19's room with meal tray. She exited Resident #19's room approximately nine minutes after entering the room.</li> </ol> <p>Observation on 07/30/2024 at 12:46 PM revealed the protocol of donning and doffing PPE was on the door of Resident #19's room and had instructions of the proper PPE to wear prior to entering the room.</p> <p>Observation on 07/30/2024 at 12:46 PM revealed the following was the protocol of PPE by CDC guidelines prior to entering Resident #19's room:</p> <ol style="list-style-type: none"> <li>1. Use Personal Protective Equipment : PPE must be donned correctly before entering the patient area (e.g., isolation room, unit if cohorting).</li> <li>2. Preferred PPE use N95 or higher respirator , face shield or goggles, one pair of clean, non-sterile gloves, and isolation gown.</li> </ol> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>3. Acceptable Alternative PPE- use face mask, face shield or goggles, face mask N95 or higher respirators are preferred but facemasks are an acceptable alternative. One pair of clean , non-sterile gloves, and an isolation gown.</p> <p>Observation on 07/30/2024 at 12:46 PM revealed the following form on Resident #19's room, everyone must clean their hands, including before entering and leaving the room.</p> <p>In an interview on 07/30/2024 at 12:48 PM the BOM stated she did not sanitize her hands, place gloves on her hands, or wear a gown prior to entering Resident #19's room . She stated this was a COVID isolation room. She stated she thought she only needed to wear a mask and not anything else when entering an isolation room. She stated she did not sanitize or wash her hands prior to leaving the room. She was standing by Resident #19's room and stated she did not read the signs on the door and if she had read the signs she would have known the proper protocol she was to follow with wearing gloves, gowns, and sanitizing her hands. She stated she did bring cellophane and other container lids from the residents' meal tray out of the room. The BOM stated she was not to bring anything out of the room, and she did not discard these items prior to leaving the room. She stated she had been in-serviced on PPE, but she misunderstood the difference when it was COVID isolation and Non-COVID isolation. She stated she needed to read the signs or ask a nurse to ensure she was using the proper PPE. The BOM stated she did not follow facility protocol on wearing the proper PPE when she entered Resident #19's room . She stated both Residents in that room did have COVID.</p> <p>Observation on 07/30/2024 at 12:53 PM the BOM did not sanitize her hands when she exited Resident #19's room and during the interview. She walked down the end of the 400 hall to the front of the 400 hall and entered the therapy room, went into the restroom, washed her hands, and threw away the items she had in her hands when she exited Resident #19's room in the trash in the therapy bathroom.</p> <p>In an interview on 07/30/2024 at 1:15 PM the BOM stated she did enter the therapy room, wash her hands, and disposed of the lids and cellophane off of the meal tray she delivered to the COVID room Resident #19's room . She stated she was required to sanitize her hands prior to leaving the room and she should have sanitized her hands as soon as she exited the room. She stated there was a potential she could have contaminated her clothes and hands while around residents with COVID. The BOM apologized for touching the state surveyors' clothes and arm after she exited Resident #19's room . She stated, I was not to touch anyone or anything until I washed my hands. She stated there was a possibility she could contaminate other residents, staff, or visitors with COVID if she was not wearing the proper PPE when she entered a COVID isolation room. She stated there was protocol in place of the correct PPE to wear, to sanitize hands, and she did not follow the facility protocol. The BOM stated she had been in-service on the facility protocol of wearing the proper PPE. She stated it was recently but did not recall the date.</p> <p>In an interview on 07/31/2024 at 9:08 AM the Administrator stated the staff were expected to follow facility protocol for PPE when entering COVID isolation rooms. He stated the staff were expected to wear gown, face mask, face shield or goggles, and sanitize hands prior to donning gloves. He stated they had recent in-services for all staff on wearing PPE in COVID isolation rooms. The Administrator stated the forms on Resident #19 was the facilities protocol of what to wear prior to entering the room. He stated the BOM did not follow the facility protocol/policy on PPE when entering or exiting a COVID positive resident room. He did not reply when asked if there was a potential when a staff did not wear proper PPE in COVID room, that it could be spread to other staff or residents.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>In an interview on 07/31/2024 at 11:09 AM the DON stated the infection control forms on Resident #19's door was the facility protocol for the proper use of PPE and hand sanitation. She stated the facility was following CDC recommendations. The DON stated anyone including non- nursing staff were expected to sanitize their hands prior to donning gloves. The staff were required to Donn gown, N95 face mask, and face shield prior to entering any COVID isolation room. She stated all of the information of what to wear and how to Donn PPE was on the door of Resident #19's room . She stated if anyone did not follow the facility protocol of wearing PPE in a COVID isolation room there was a potential the person may contaminate other staff, residents, or visitors. She stated when someone exits a COVID isolation room the person was expected to wash their hands in the room prior to exiting. The DON also stated if the person did not wash their hands or sanitize their hands prior to exiting the COVID isolation room they were to sanitize their hands immediately after exiting the room. The DON stated both residents in Resident #19's room did have COVID.</p> <p>2. Review of the Face Sheet for Resident #44 reflected he was admitted on [DATE] with diagnoses of: malignant neoplasm of renal pelvis ( the area at the center of the kidney), dementia with psychotic disturbance and anxiety, UTI ( infection in any part of the urinary system, pain to right arm/wrist, history of falling, high blood pressure, anemia, malignant skin cancer, and atrial fibrillation (irregular heart beat).</p> <p>Review of the quarterly MDS assessment dated [DATE] reflected: a BIMS score of 7 indicated severe cognitive impairment. His physical assessment reflected he was independent in eating and some oral hygiene, but needed at least one to two person assist for dressing, bathing, and other ADLs. He was assessed as occasionally incontinent of bladder and always continent of bowels.</p> <p>Review of the Care Plan for Resident #44 reflected interventions were in place for: DNR status, high risk of fractures or injuries r/t renal cancer untreated, ADL performance deficit r/t cancer and weakness, impulsive behavior problem, impaired cognitive function, lower extremity weakness, terminal prognosis r/t renal cancer, and the resident elected to be on palliative care.</p> <p>Review of the Face Sheet for Resident #1 reflected she was admitted on [DATE] with diagnoses of: hemiplegia to left side ( paralysis of limbs) , metabolic encephalopathy ( a problem of the brain) , history of traumatic brain injury ( happens when a sudden , external, physical assault damages the brain, muscle wasting and atrophy, epilepsy, unspecified convulsions, and need for personal care.</p> <p>Review of the quarterly MDS assessment for Resident #1 dated 6/11/24 reflected a BIMS score of 15 indicating normal cognitive function. Her physical assessment reflected she required substantial assistance for eating, hygiene, and dressing. She could accomplish some ADLs with one person assistance. She was assessed as always incontinent of bowel and bladder.</p> <p>Review of the Care Plan for Resident #1 reflected interventions were in place for: full code status, ADL performance deficit, history of falls/hemiplegia, antidepressant medication, anticoagulant (inhibiting the coagulation of the blood) medication, chronic pain r/t pelvic fracture, and vertebrae fractures.</p> <p>Review of the Face Sheet for Resident #21 reflected she was admitted on [DATE] with diagnoses of: myopathy , morbid obesity, hypothyroidism, congestive heart failure , muscle wasting and atrophy, and peripheral vascular disease .</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  455715	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  07/31/2024
NAME OF PROVIDER OR SUPPLIER  Monument Rehabilitation and Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE  120 State Loop 92 LA Grange, TX 78945	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the MDS assessment for Resident #21 dated 6/13/24 reflected a BIMS score of 15 indicating normal cognitive function. Her physical assessment reflected she had impairment to both arms and legs, she required one person assist for eating and grooming, and extensive assistance in all other ADLs. She was assessed as always incontinent of bowel and bladder.</p> <p>Review of the Care Plan for Resident #21 reflected interventions were in place for: her DNR status, ADL self-performance deficit, a history of falls, a UTI, chronic back pain, psych history related to sexual assault.</p> <p>In an interview on 7/30/24 at 8:20 am Resident #21 stated no one had ever cleaned the surface of her bedside table as far back as she could remember. She stated no one cleaned the table in between meals and incontinence care. She stated no one cleaned the table before setting her meal tray on it and no one helped to wash her hands.</p> <p>3. A record review of Residents # 11's face sheet dated 7/31/24 reflected a [AGE] year-old female admitted on [DATE] with diagnoses of dementia (a group of symptoms that affects memory, thinking, and interferes with daily life.), traumatic subarachnoid hemorrhage (bleeding on the brain), wedge compression fracture of the T5-T6 vertebra (spinal fracture), hypertension (high blood pressure), hyperlipidemia (a condition in which there are high levels of fat particles (lipids) in the blood), major depressive disorder ( a mental condition characterized by a persistently depressed mood and long-term loss of pleasure or interest in life.), hypothyroidism (a condition in which the thyroid gland doesn't produce enough thyroid hormone.), cervicalgia (neck pain), bullous pemphigoid (a rare skin condition causing large, fluid-filled blisters.), and anxiety disorder (a mental health disorder characterized by feelings of worry, anxiety, or fear that are strong enough to interfere with one's daily activities.)</p> <p>A record review of Resident # 11's care plan last revised on 5/09/2024 reflected she had an ADL self-care performance deficit related to dementia, limited mobility, and terminal illness. Resident # 11's interventions reflected she needed total assistance by 1 staff to eat.</p> <p>4. A record review of Residents # 2's face sheet dated 7/31/24 reflected a [AGE] year-old female admitted on [DATE] with diagnoses of cerebral palsy (a congenital disorder of movement, muscle tone, or posture.), intellectual disabilities (a neurodevelopmental condition that affects a person's intellectual functioning and adaptive behavior.), pain in left leg, muscle wasting and atrophy (the loss of muscle mass and strength), dysphagia (difficulty swallowing foods or liquids, arising from the throat or esophagus.), ataxia (impaired balance or coordination can be due to damage to the brain), hyperlipidemia (a condition in which there are high levels of fat particles (lipids) in the blood.), major depressive disorder ( a mental health disorder characterized by persistently depressed mood or loss of interest in activities also called major depression or clinical depression), hypertension ( high blood pressure), need for assistance with personal care, type 2 diabetes ( adult onset diabetes a group of diseases that result in too much sugar in the blood), cognitive communication deficit (a communication problem that's caused by a cognitive deficit rather than a language or speech deficit), age related physical debility, and bilateral feet deformity.</p> <p>A record review of Resident # 2's care plan last revised on 5/10/2023 reflected she had an ADL self-care performance deficit related to impaired balance, cerebral palsy, ataxia, pain in left leg, age related physical debility, and bilateral feet deformity. Resident # 2's interventions reflected she needed supervision with setup assist of 1 staff to eat.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER  Monument Rehabilitation and Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE  120 State Loop 92 LA Grange, TX 78945	
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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Observation on 7/29/24 at 12:30 pm of the Activity Director in the dining room assisting Resident # 11 in setting up meal trays including touching ready to eat food of soft tacos without gloved hands and without performing hand hygiene in between residents. Observation of Activity Director providing clothing protectors to residents and touching residents' clothes without performing hand hygiene in between each resident. Observation of Activity Director getting residents in dining room, getting residents drinks, and straws without performing hand hygiene between residents.</p> <p>Observation on 7/29/2024 at 7:48 am of CNA A passing breakfast hall trays for 200 hall. CNA A went to pass tray to Resident # 2, assisting with meal tray set up with ungloved hands, and without performing hand hygiene between residents.</p> <p>The facility protocol/policy for following infection control prevention of wearing PPE was the CDC guidelines (not dated) listed during observations of the signs on the door of .</p> <p>Review of the facility policy Promoting Resident Dignity dated 1/13/23 reflected the employees were to protect and promote Resident rights and treat each resident with respect and dignity. Resident requests will be responded to in a timely manner. Residents personal space is to be respected and maintained in a clean sanitary manner.</p> <p>Record review of dietary hand washing policy dated 10/1/2018 reflected under heading policy: The facility recognizes that food-borne illness has the potential to harm elderly and frail residents. All nutrition and food service employees will practice good hand washing practices to minimize the risk of infection and food borne illness. Under heading procedure: 2. Hands should be washed after the following occurrences: I. Assisting residents.</p> <p>Record review of hand hygiene policy dated 10/24/2022 reflected under heading policy: All staff will perform hand hygiene procedures to prevent the spread of infection to other personnel, residents, and visitors. This applies to all staff working in all locations within the facility. Under heading definitions: Hand Hygiene is a general term for cleaning your hands by handwashing with soap and water or the use of an antiseptic hand rub also known as alcohol-based hand rub.</p> <p>Review of the facility policy Infection Prevention and Control Program dated 5/13/24 reflected the facility has established and maintained a safe, sanitary, and comfortable environment to help prevent the spread and development of communicable diseases and infection per accepted national standards and guidelines. All staff are responsible for following policy and guidelines. Hand Hygiene shall be performed in accordance with established hand hygiene procedures. Environmental cleaning and disinfection shall be performed according to facility policy.</p> <p>48917</p>		