| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 455906 | A. Building<br>B. Wing | 08/29/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Stephenville Rehabilitation and Wellness Center | 2601 Northwest Loop<br>Stephenville, TX 76401 |

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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0759<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure medication error rates are not 5 percent or greater.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48883<br><br>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 5.88% based on 2 errors out of 34 opportunities, which involved 2 of 7 residents (Resident #24 & Resident #39) reviewed for medication errors.<br><br>1. The facility failed to ensure LVN B administered potassium chloride liquid diluted with 4-6 oz (ounces) of water prior to administration given for hypokalemia (low potassium) to Resident #24 according to physician orders.<br><br>2. The facility failed to ensure MA A administered the correct dose of Ferrous gluconate (iron) given for anemia (a problem of not having enough healthy red blood cells or hemoglobin to carry oxygen to the body's tissues) to Resident #39 according to physician orders.<br><br>These failures could place residents at risk of inadequate therapeutic outcomes and GI distress.<br><br>Findings included:<br><br>Resident #24<br><br>Review of Resident #24's electronic face sheet dated 08/29/2024 revealed he was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses to include: aphasia (difficulty swallowing), and gastrostomy status (tube that allows fluid, medication, and formula to be administered into stomach without having to swallow). No evidence that hypokalemia (low potassium) was a diagnosis.<br><br>Review of Resident #24's annual MDS assessment dated [DATE] revealed Resident #24 was rarely or never understood. Further investigation revealed Resident #24 had a feeding tube while a resident.<br><br>Review of Resident #24's comprehensive care plan last reviewed on 06/21/2024 revealed Resident had ADL self-care performance deficit related to impaired mobility. Goal: ADL needs will be anticipated and met by staff through next review. Interventions: Eating: The resident is NPO (nothing by mouth) and is totally dependent on licensed nurse for G-tube (gastric tube) feeding. Further review of care plan revealed Resident #24 had diagnosis of hypokalemia. Goal: The resident will be free from s/sx of complications of cardiac problems through the review date. Interventions: Give meds as ordered by the physician. Monitor and document side effects. Report adverse reactions to MD PRN.<br><br>(continued on next page) |

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

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455906 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 08/29/2024 |
|---|---|---|---|
| NAME OF PROVIDER OR SUPPLIER: Stephenville Rehabilitation and Wellness Center | | STREET ADDRESS, CITY, STATE, ZIP CODE: 2601 Northwest Loop Stephenville, TX 76401 | |

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|---|---|
| F 0759<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of Resident #24's electronic Physician Orders revealed the following order dated 09/22/2021: Potassium Chloride Solution 20 mEq/15ml (10%) Give 15ml via G-tube three times a day for hypokalemia. Dilute with 4-6 oz of water prior to administration.<br><br>Review of Resident #24's electronic August 2024 MAR revealed Potassium Chloride Solution 20 MEQ/15ML (10%) Give 15ml via G-tube three times a day for Hypokalemia Dilute with 4-6 oz of water prior to administration. Start Date- 09/22/2021<br><br>During an observation on 08/28/2024 at 8:55 a.m., LVN B administered Potassium Chloride Solution 15ml through G-tube after flushing tube with 30cc water before and after administration. LVN B did not dilute Potassium Chloride in 4-6 oz of water prior to administration.<br><br>During an interview on 08/29/2024 at 9:24 a.m., LVN B stated she did not dilute Potassium with 4-6 oz of water prior to administering through G-tube. She stated she did not read the physician's order fully which led to the failure. She stated she did not know what negative effect not diluting medication could have on the resident without looking it up.<br><br>Resident #39<br><br>Record review of Resident #39's electronic face sheet dated 08/29/2024 revealed she was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses to include: anemia (a problem of not having enough healthy red blood cells or hemoglobin to carry oxygen to the body's tissues).<br><br>Record review of Resident #39's quarterly MDS assessment dated [DATE] revealed: BIMS score of 15 which indication cognition was intact.<br><br>Record review of Resident #39's comprehensive care plan last reviewed on 07/22/2024 revealed Resident had anemia. Goal: Will remain free of s/sx or complications related to anemia through review date. Interventions: Give medications as ordered.<br><br>Record review of Resident #39's Physician Orders revealed the following order dated 06/11/2024: Ferrous Gluconate Tablet 324 (38Fe) mg Give 1 tablet by mouth two times a day for anemia.<br><br>Review of Resident #39's electronic August 2024 MAR revealed Ferrous Gluconate Tablet 324 (38Fe) MG Give 1 tablet by mouth two times a day for anemia. Start Date- 04/11/2024<br><br>During an observation on 08/28/2024 at 7:50 a.m., MA A put Ferrous Gluconate 240 (27Fe) mg 1 tablet into medication cup. Resident #39 swallowed Ferrous Gluconate 240 (27Fe) mg tablet.<br><br>During an interview on 08/28/2024 at 7:55 a.m., MA A stated she had given 240mg Ferrous Gluconate to Resident #39. She did not state that medication was the wrong dosage.<br><br>(continued on next page) |

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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Stephenville Rehabilitation and Wellness Center | 2601 Northwest Loop Stephenville, TX 76401 |

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| F 0759<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on 08/29/2024 at 8:18 a.m., the DON stated she expected facility staff to follow physician's orders. She stated if OTC (over the counter) medication was not available with correct mg she expected for facility staff to notify herself or ADON so that physician could be notified, and order clarified. She stated that she had been told by MA A wrong dosage of Ferrous Gluconate had been administered to Resident #39 and she notified ordering physician. She stated Resident #39's order has since been updated with correct dosage of 240 mg. She stated the pharmacy monitors that orders are followed by nurses and MAs by performing medication passes with facility staff. She stated the pharmacy monitors that orders are correct in the medical record. She denied any negative effect occurred to Resident #39 from MA administering wrong dosage of medication.<br><br>During a follow up interview on 08/29/2024 at 1:06 p.m., the DON stated she was informed by LVN B of not diluting Potassium Chloride Solution was not diluted during medication pass to Resident #24 on 08/28/2024. She stated MD had been present at facility during lunch time on 08/29/2024 and he did not know why his order stated Potassium Chloride Solution should be diluted. She stated she had reached out the pharmacy and due to Potassium Chloride being administered via G-tube, was not told it had to be diluted. She stated no negative effect occurred to Resident #24 for medication not being diluted but stated that the physician's order should have been followed. She stated that staff should reach out to her or the ADON who would communicate with MD to get order clarified if there was a question on MD's orders.<br><br>Record review of the facility's policy titled Administering Medication revised in December 2012 revealed: Medication shall be administered in a safe and timely manner, and as prescribed .The Director of Nursing Services will supervise and direct all nursing personnel who administer medications and/or have related function .Medication must be administered in accordance with the orders, including and required time frame . If a dosage is believed to be inappropriate or excessive for a resident, or a medication has been identified as having potential adverse consequences for the resident or is suspected of being associated with adverse consequence, the person preparing or administering the medication call contact the resident's Attending Physician or the facility's Medical Director to discuss the concerns .The individual administering the medication must check the label to verify the right resident, right medication, right dosage, right time and right method (route) of administration before giving the medication.<br><br>Review of drugs.com accessed on 08/30/2024 at https://www.drugs.com/cdi/potassium-chloride-liquid-and-powder.html revealed: Use potassium chloride liquid and powder as ordered by your doctor. Read all information given to you. Follow all instructions Closely. Take with or right after a meal. Mix with water as you have been told before drinking.<br><br>Review of drugs.com accessed on 08/30/2024 at https://www.drugs.com/mtm/ferrous-gluconate.html revealed: Use this medication exactly as directed on the label, or as prescribed by your doctor. Do not use it in larger amounts or for longer than recommended. |

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| Stephenville Rehabilitation and Wellness Center | 2601 Northwest Loop<br>Stephenville, TX 76401 |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48883<br><br>Based on observation, interview, and record review, the facility failed to store all drugs and biologicals in locked compartments and permit only authorized personnel to have access to the keys for 1 (cart #1) of 8 medication carts reviewed for medication storage in that:<br><br>The facility failed to ensure medication cart #1 was locked and secured while unattended.<br><br>This failure could result in a drug diversion.<br><br>Findings included:<br><br>During an observation on 08/27/2024 at 12:36 PM, revealed the 200-hall medication cart on 200 hall was unlocked with no staff present or within eyesight. There was also a visitor walking down the hall with unlocked medication cart. Nurse observed toward the end of the hall near the nurses' station checking meal tickets and assisting with passing out lunch trays. The medication cart had medications that included albuterol inhaler, Miralax (laxative), artificial tears, nitroglycerin (vessel dilation), lancets (needles to prick skin during glucometer checks), insulin pens and insulin pen needles, nasal sprays, docusate sodium (for constipation), Bisacodyl (laxative), acetaminophen (pain medication), lactulose (laxative), amiodarone (heart antiarrhythmic medication), Eliquis (anticoagulant), metoprolol (heart antiarrhythmic medication), potassium, Singulair (used to treat asthma), Depakote (anticonvulsant), melatonin, multivitamin, acidophilus (probiotic), Aspirin, cholestyramine (binds to bile to prevent reabsorption in the intestinal tract), and duloxetine (antidepressant).<br><br>During an interview on 08/27/2024 at 12:41 PM, RN C stated she was responsible for unlocked medication cart. She stated the cart should be locked when she was not present. She stated she should have locked the cart. RN C stated she had just given medication to room [ROOM NUMBER] then had to start passing hall lunch trays. She stated that leaving medication cart unlocked could allow resident to have access to medication inside of cart.<br><br>During an observation on 08/28/2024 at 07:11 AM revealed the 200-hall medication cart on 200 hall was unlocked with no staff present or within eyesight. LVN D was in resident's room with door closed. LVN D left out of the room with an insulin pen in her hand. The medication cart had medications that included albuterol inhaler, Miralax (laxative), artificial tears, nitroglycerin (vessel dilation), lancets (needles to prick skin during glucometer checks), insulin pens and insulin pen needles, nasal sprays, docusate sodium (for constipation), Bisacodyl (laxative), acetaminophen (pain medication), lactulose (laxative), amiodarone (heart antiarrhythmic medication), Eliquis (anticoagulant), metoprolol (heart antiarrhythmic medication), potassium, Singulair (used to treat asthma), Depakote (anticonvulsant), melatonin, multivitamin, acidophilus (probiotic), Aspirin, cholestyramine (binds to bile to prevent reabsorption in the intestinal tract), and duloxetine (antidepressant).<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455906 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 08/29/2024 |
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| NAME OF PROVIDER OR SUPPLIER: Stephenville Rehabilitation and Wellness Center | | STREET ADDRESS, CITY, STATE, ZIP CODE: 2601 Northwest Loop, Stephenville, TX 76401 | |

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|---|---|
| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on 08/28/2024 at 07:13 AM, LVN D stated the medication cart should have been locked. She stated she was responsible for the medication cart and felt the failure occurred due to button on the medication cart needed to be pushed hard. She thought that she had locked the cart when she walked away.<br><br>During an interview on 08/29/2024 at 08:18 AM, the DON stated she expected for medication carts to be locked when not in use by nurse and nurse not within eyeshot of the cart. She stated nurses had been trained on locking medication carts and she did not know why medication cart had been unlocked. She stated nurse managers and pharmacist were responsible for monitoring that medication carts were stored locked. She stated not locking medication cart could lead to medication diversion.<br><br>Review of facility policy titled Storage of Medications dated April 2007 revealed: The facility shall store all drugs and biologicals in a safe, secure, and orderly manner .The nursing staff shall be responsible for maintaining medication storage and preparation areas in a clean, safe, and sanitary manner .Compartments (including, but not limited to, drawers, cabinets, rooms, refrigerators, carts, and boxes.) containing drugs and biologicals shall be locked when not in use, and trays or carts used to transport such items shall not be left unattended if open or otherwise potentially available to others. |

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| Stephenville Rehabilitation and Wellness Center | 2601 Northwest Loop Stephenville, TX 76401 |

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F 0803

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident.

**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44558

Based on observation, interview, and record review the facility failed to follow menus for 1 of 1 lunch meal reviewed.

This facility failed to follow the menu when preparing lunch meal on 08/27/2024.

This failure could place residents at risk for a decline in health status due to inadequate or inappropriate nutritional intake.

The findings included:

Review of Resident #50's face sheet reflected a [AGE] year-old female who was admitted on [DATE] with diagnoses included Alzheimer's Disease, Hyperlipidemia (an excess of lipids or fats in your blood), Type II Diabetes Meletus.

During an observation on 08/27/2024 at 12:22 PM revealed Resident #50's pureed diet at the lunch mealtime did not have a dessert or mixed vegetables on her tray.

During an interview on 08/27/2024 at 4:36 PM, the Dietician stated she expected the facility to follow the recipes. The Dietician stated if an item was on the meal ticket, then it should be provided unless there was a substitution. The Dietician stated the substitution should have been documented before the meal. The Dietician stated if a resident was on a pureed diet, the resident should receive a desert. The dietician stated she and the Dietary Manager would monitor to ensure the menus were followed. The dietician stated since she was not in the building, she did not know why the menu was not followed. The dietician stated the facility had menus that the facility followed due to nutrition and resident's rights. The dietician stated not following the menu could cause residents to be missing proper nutrition if all items were not served. The dietician stated she believed the dietary manager and dietary staff in the kitchen would monitor that the kitchen was serving out meals in a timely manner. The dietician stated cold foods should be served cold, hot foods should be served hot and that French fries should not be served cold and hard. The dietician stated she did not know what effect it could have on residents as she was not in the building at the time.

During an interview on 08/27/2024 at 2:24 PM, the Dietary manager stated the marinated vegetables did not get made and that was why the resident did not receive them. The dietary manager stated she saw that the desert did not get pureed, and she tried to start making it, but could not get enough made because she kept getting called to other things in the kitchen. The dietary manager stated her expectations were that all the residents receive the food on the menu. The dietary manager stated she personally does the prep work and due to her boss being in the kitchen checking everything, it affected the dietary manager of not seeing that the marinated vegetables had not been prepared. The dietary manager stated the failure could affect the resident's and could cause weight loss.

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| Stephenville Rehabilitation and Wellness Center | 2601 Northwest Loop<br>Stephenville, TX 76401 |

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| F 0803<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During an interview on 08/29/2024 at 8:51 AM, the ADMN stated her expectations were that the menus be followed for all diet types. The ADMN stated mechanical soft diets and puree diets should have gotten a vegetable and a desert. The ADMN stated the failure occurred because the dietary aide missed it. The ADMN stated if the resident were not getting the full meal, it would cause a decreased intake, decreased nutritive value and a decreased calorie intake. The ADMN stated she and the nurses were responsible for ensuring the meal trays have the appropriated diet, and diet consistency. The ADMN stated the menus should be followed. The ADMN stated all but one resident ate meals from the kitchen.<br><br>Review of Week at a Glance menus reflected for lunch on 08/27/2024 was BBQ Cheeseburger on a bun, lettuce and tomato, pickle spear, Confetti Coleslaw, French Fries, Chocolate Chip Cookie. The alternate menu was Tuna Salad Sandwich, lettuce and tomato, broccoli salad, Garden Pasta salad.<br><br>During a review of facility's policy titled Meal Distribution (dated 0/2017) reflected:<br><br>Procedures:<br><br>All meals will be assembled in accordance with the individualized diet order, plan of care and preferences.<br><br>All food items will be transported promptly for appropriated temperature maintenance.<br><br>The nursing staff will be responsible for verifying meal accuracy and the timely delivery.<br><br>During a review of facility's titled Menus (dated revised 9/2017) reflected:<br><br>Menus will be served as written, unless a substitution is provided in response to preference, unavailability of an item, or a special meal. |

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| NAME OF PROVIDER OR SUPPLIER Stephenville Rehabilitation and Wellness Center | | STREET ADDRESS, CITY, STATE, ZIP CODE 2601 Northwest Loop Stephenville, TX 76401 | |

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| F 0804<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44558<br><br>Based on observation, interview and record review, the facility failed to ensure that each resident received food that was palatable, attractive and at a safe and appetizing temperature of 1 of 1 lunch meal in 1 of 1 kitchen tested for nutritive value, flavor, and appearance.<br><br>The facility failed to provide palatable food served at an appetizing temperature to residents, during lunch on 08/27/2024.<br><br>This failure could affect the residents who ate food from the facility kitchen by placing them at risk of poor food intake and/or dissatisfaction of meals served.<br><br>The findings included:<br><br>During an observation on 08/27/2024 at 2:24 PM, the DM obtained temperatures of test tray. The results were: [NAME] slaw vinegary to taste, flavor of burger good but cold; French Fries cold. The temperature of BBQ burger patty was 100.5 degrees Fahrenheit; temperature of [NAME] slaw 54.6 degrees; temperature of French Fries 94.1; and temperature of salad lettuce/tomato/onion 70.1 degrees.<br><br>During an interview on 08/27/2024 at 2:24 PM the DM stated the temperature of the BBQ burger patty should have been at least 165 degrees. The temperature of the [NAME] slaw should have been 41 degrees or lower. The temperature of the French Fries should have been 135 degrees or higher. The temperature of the salad: lettuce/tomato/onion should have been 41 degrees or lower.<br><br>During an interview on 08/27/2024 at 2:32 PM, the DM stated that everything was not reaching correct temperature due to having to use Styrofoam containers. The DM also stated having to wait for trays to be hand washed and waiting for trays to dry before sending out rest of meal prevented the meals to remain at palatable temperature. The DM stated the effect on residents was that they could have weight loss.<br><br>The temperature of the BBQ burger patty should have been at least 165 degrees. The temperature of the [NAME] slaw should have been 41 degrees or lower. The temperature of the French Fries should have been 135 degrees or higher. The temperature of the salad: lettuce/tomato/onion should have been 41 degrees or lower.<br><br>During an interview on 08/27/2024 at 4:36 PM, The dietician stated cold foods should be served cold and hot foods served hot. She stated the French Fires should not be served cold and hard. The dietician did not have an answer to why coleslaw taste like vinegar.<br><br>During an interview on 08/29/2024 at 2:26 PM, ADMN stated all but one resident eats meals from the kitchen. The ADMN stated his expectations were that all food be served to the residents at palatable temperature.<br><br>During a review of facility's policy titled Meal Distribution (dated 0/2017) reflected:<br><br>Procedures:<br><br>(continued on next page) |

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| NAME OF PROVIDER OR SUPPLIER: Stephenville Rehabilitation and Wellness Center | | STREET ADDRESS, CITY, STATE, ZIP CODE: 2601 Northwest Loop Stephenville, TX 76401 | |

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| F 0804<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | All food items will be transported promptly for appropriated temperature maintenance.<br><br>44728 |

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F 0849

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services.

**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44728

45732

Based on interview and record review, the facility failed to collaborate with hospice representatives and coordinate the hospice care planning process for each resident receiving hospice services, to ensure quality of care for the resident, ensuring communication with the hospice medical director, the resident's attending physician and others participating in the provision of care for 3 (Resident #80, Resident #63, and Resident #46) of 12 residents reviewed for hospice services.

The facility failed to maintain required hospice forms and documentation, that included the hospice plan of care and certificate of terminal illness to ensure Resident #80, Resident #63, and Resident #46 received adequate end-of-life care.

The facility failed to have physicians' orders for Hospice Care for Resident #80, Resident #63, and Resident #46.

This failure could place the residents who receive hospice services at-risk of receiving inadequate end-of-life care due to a lack of documentation, coordination of care, and communication of resident needs.

The findings included:

Resident #80

Review of Resident #80's electronic face sheet revealed a [AGE] year-old male admitted to the facility on [DATE] with diagnoses to include: anxiety, depression, and dementia. Further review of electronic face sheet revealed resident was on hospice services.

Review of Resident #80's Quarterly MDS assessment dated [DATE] revealed: BIMS score of 08 which indicated mild cognitive impairment. Further review of the MDS Section O Special Treatments, Procedures, and Programs revealed Hospice Care.

Review of Resident #80's Care plan last reviewed on 06/10/2024 revealed: Focus: The resident has a terminal prognosis. Admit to Hospice Services on 03/19/24. Goal: Dignity and autonomy will be maintained at highest level. Interventions: Observe resident closely for signs of pain, administer pain medication as ordered, and notify physicians immediately if there is breakthrough pain. Work with hospice team to ensure the resident's spiritual, emotional, intellectual, physical, and social need are met.

Review of Resident #80's electronic Physicians Orders revealed no evidence of an order for Hospice services.

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455906 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 08/29/2024 |
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| NAME OF PROVIDER OR SUPPLIER Stephenville Rehabilitation and Wellness Center | | STREET ADDRESS, CITY, STATE, ZIP CODE 2601 Northwest Loop Stephenville, TX 76401 | |

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 0849<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Review of Resident #80's electronic record revealed no evidence of the required hospice forms and documentation, that included the hospice plan of care and certificate of terminal illness for Resident #80.<br><br>During an interview on 08/28/24 at 10:13 AM, LVN B stated she did not know if Resident #80 was on hospice services or not. She stated the only way to know was to look at the orders. LVN B stated Resident #80 did not have an order for hospice which as to her understanding meant he was not on hospice services.<br><br>Resident #63<br><br>Review of Resident #63's electronic face sheet revealed an [AGE] year-old female admitted to the facility on [DATE] with diagnoses to include: depression, anxiety, and dementia, and kidney disease. Further review of electronic face sheet revealed resident was on hospice services.<br><br>Review of Resident #63's Quarterly MDS assessment dated [DATE] revealed: BIMS score of 14 which indicated no cognitive impairment. Further review of the MDS Section O Special Treatments, Procedures, and Programs revealed Hospice Care.<br><br>Review of Resident #63's Care plan last reviewed on 06/06/2024 revealed: Focus: The resident has a terminal prognosis. Receiving Hospice Services. Goal: Comfort will be maintained. Interventions: Work with hospice team to ensure the resident's spiritual, emotional, intellectual, physical, and social need are met.<br><br>Review of Resident #63's electronic Physicians Orders revealed no evidence of an order for Hospice services.<br><br>Review of Resident #63's electronic record revealed initial hospice care plan initiated 05/26/22 with no updates to date.<br><br>Resident #46<br><br>Review of Resident #46's electronic face sheet revealed a [AGE] year-old male admitted to the facility on [DATE] with diagnoses to include: depression, anxiety, and dementia. Further review of electronic face sheet revealed resident was on hospice services.<br><br>Review of Resident #46's Quarterly MDS assessment dated [DATE] revealed: BIMS score of 14 which indicated no cognitive impairment. Further review of the MDS Section O Special Treatments, Procedures, and Programs revealed Hospice Care.<br><br>Review of Resident #46's Care plan last reviewed on 08/19/2024 revealed: Focus: The resident has a terminal prognosis. Receiving Hospice Services. Goal: Comfort will be maintained. Interventions: Observe resident closely for signs of pain, administer pain medication as ordered, and notify physicians immediately if there is breakthrough pain. Work with hospice team to ensure the resident's spiritual, emotional, intellectual, physical, and social need are met.<br><br>Review of Resident #46's electronic Physicians Orders revealed no evidence of an order for Hospice services.<br><br>(continued on next page) |

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| F 0849<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Review of Resident #46's electronic record revealed no evidence of the required hospice forms and documentation, that included the hospice plan of care and certificate of terminal illness for Resident #46.<br><br>During an interview on 08/29/24 at 9:50 AM, RN E stated the only way she would know that a resident was on hospice services would be to look at the orders.<br><br>During an interview on 08/29/24 at 2:00 PM, the DON who stated all hospice residents should have an order in the computer and have a binder on cite. DON stated she was not sure what documents were required from hospice, but she could get them at any time. She stated residents did not have to have a binder and nothing in the binder affected the care of hospice residents. DON stated not having an order for hospice did not affect residents care because the nurse would still have contacted the primary doctor and treat the resident the same whether being on hospice services or not. The DON stated her staff needed more training on hospice services. She stated communication with hospice services was not needed because her staff would communicate with the physician if any extra care was needed.<br><br>During an interview on 08/29/2024 at 2:18 PM, the ADON who stated the Hospice records were in the Hospice notebook that was located at the nurse's station. ADON stated the required documents were not in the facility at this time after looking for the Hospice Notebook at the nurses' station without finding it, and that she called Hospice and was faxed the required documents. She stated the documents should have already been in the facility.<br><br>Record review of the facility's Hospice Services Nursing Home Hospice Agreement dated effective April 4, 2023, between the nursing facility and Hospice revealed: .Section III. Services Furnished by The Hospice. Subsection A. Hospice Plan, the hospice is responsible for the professional management of the hospice patient's hospice care. The hospice shall develop, at the time an eligible resident is admitted to the hospice program, a hospice plan for management and palliation of the resident's terminal illness. The hospice plan is in a written document which will be a detailed description of the scope and frequency of hospice services and supplies needed to meet the resident's needs. The hospice plan will specify services and supplies are related to the patient's terminal illness, and therefor, will be furnished by hospice. The hospice shall furnish a copy of the hospice plane to the home within 8 days of being accepted by the hospice into its hospice program. Such hospice plan will be furnished to the home in and will be updated every two weeks or more frequently as deemed necessary by the hospice, and a copy of the updated hospice plan will be furnished every two weeks to the home. |