STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455908	A. Building B. Wing	12/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Schulenburg Regency Nursing Center	111 College St Schulenburg, TX 78956

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42600 Based on interviews and record review, the facility failed to ensure the residents rights to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive for 1 of 5 residents (Resident #26) reviewed for advanced directives. The facility failed to ensure Resident #26's out of hospital do-not-resuscitate (OOH-DNR) order form was signed by a physician. These failures could place residents at-risk of having their wishes dishonored or delay necessary medical treatment or intervention due to confusion. Finding included: Review of Resident #26 face sheet revealed a [AGE] year-old female admitted on [DATE] with diagnoses of unspecified dementia, altered mental status, cognitive communication deficit, hypertensive heart disease with heart failure, and unspecified diastolic (congestive) heart failure. Review of Resident #26 physician orders dated [DATE] reflected an order for do not resuscitate. Review of Resident #26 care plan dated [DATE] revealed resident or family requested to be DNR. Interventions included chart to have proper documentation of DNR status and goals included resident decision to be honored through review date. Review of Resident#26's out-of-hospital do-not-resuscitate (ooh-dnr) order form revealed no physician signature in the physician statement section. Further review revealed there was no physician signature in the section all persons who have signed above must sign below, acknowledging that this document has been properly completed. (continued on next page)

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

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

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on [DATE] at 3:17 PM, LVN C stated that she knew what a resident's code status was by a list provided by the ADON/DON. She stated that the list is updated often and that it was also in their chart. She stated that she verified an OOH-DNR was complete and valid because it was in the resident's chart and uploaded into the document section. LVN C stated that you had to make sure there were signatures on the OOH-DNR. LVN C stated an OOH-DNR is not considered valid if it did not have physician signature. LVN C reviewed Resident #26's OOH-DNR and stated that it did not have any physician signature. LVN C stated that because the OOH-DNR did not have a physician signature the resident would have to be a full code and it was not valid. She stated that unfortunately the resident's wishes may not be met if they had an OOH-DNR and are put as a full code. During an interview on [DATE] at 3:22 PM, LVN D stated that she knew a resident's code status because it was in their chart on their face sheet and as an order. She stated she verified that an OOH-DNR is complete and valid by the physician signature. LVN D stated that if an OOH-DNR did not have a physician signature it was not considered valid. LVN D viewed Resident #26's DNR and stated that it did not have physician signatures and it should have them. During an interview on [DATE] at 3:56 PM, SW stated that she knew a resident's code status was because she participated in getting signatures for OOH-DNRs. SW stated their code status is also in the system on their face sheet and there were copies of the OOH-DNRs. She stated that she verified that an OOH-DNR is valid by when she witnessed the resident or representative sign it and then it was sent to the doctor. SW stated it was incomplete until doctor signed it. SW stated she is unsure if there was an audit to see if OOH-DNRs were completed. She stated nurse handles scanning the OOH-DNR into the resident's chart. SW viewed Resident #26's OOH-DNR and stated it was not valid because it did not have physician signature. She stated that if a resident did not have a valid OOH-DNR a medical professional may assume it was valid and the resident may pass and later realize the resident was a full code. She stated that it was not valid, and staff performed CPR it would have also been a major concern. During an interview on [DATE] at 2:54 PM, DON stated that staff knew a resident's code status because it was in PCC and binders were also available with the document. She stated that code status was also posted at the nurses stations. She stated that the SW was supposed to verify if an OOH-DNR was complete or valid. She stated that the SW should audit the document when they initially get the OOH-DNR. DON stated she expected that OOH-DNRs are audited quarterly. DON stated an OOH-DNR was not valid without a physician signature. She stated that the potential harm of an incomplete OOH-DNR was not following the wishes of the family or resident. DON stated that if an OOH-DNR was not valid the facility could potentially perform CPR, and if a resident did not want CPR it may lead to trauma. During an interview on [DATE] at 3:04 PM, ADM stated that audits are completed monthly for advanced directives. She stated during the audit it was reviewed the accuracy of the OOH-DNR and match it to the order in the resident's chart. She stated the SW was responsible for completing OOH-DNR audits, but it has been a collaboration with nursing recently. She stated that an OOH-DNR should include physician signatures. ADM stated that the potential harm was that they may not resuscitate someone if an OOH-DNR was not valid. Review of facility policy Advanced Directives dated [DATE] revealed the resident has the right to formulate an advance directive, including the right to accept or refuse medical or surgical treatment. Advance directives are honored in accordance with state law and facility policy. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of health and safety code 166.083(b)(4)(6) revealed an OOH-DNR order at minimum must contain statement that the physician signing the document is the attending physician of the person and that the physician is directing health care professionals acting in out-of-hospital settings, including a hospital emergency department, not to initiate or continue certain life-sustaining treatment on behalf of the person and places for the printed names and signatures of the witnesses or the notary public's acknowledgment and for the printed name and signature of the attending physician of the person and the medical license number of the attending physician Further review of health and safety code 166.089(3) revealed an OOH-DNR order form appears valid when it includes the signature or digital or electronic signature of the declarant or persons executing or issuing the order and the attending physician in the appropriate places designated on the form for indicating that the order form has been properly completed.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42600 Based on interviews and record review, the facility failed to develop and implement a comprehensive person-centered care plan with resident rights, which included measurable objectives and time frames to meet the resident's mental and psychosocial needs for 3 of 10 residents (Residents #17, #41 and #98) reviewed for care plans. 1. The facility failed to update Resident #17's care plan to reflect current needs for suprapubic catheter care. 2. The facility failed to update Resident #17's care plan to reflect current needs with transfers. 3. The facility failed to update Resident #41's care plan to reflect current diet consistency orders. 4. The facility failed to update Resident #98's care plan to reflect current needs with transfers. This failure placed residents at risk of not receiving the appropriate care and services to maintain the highest practical well-being. Findings included: Record Review of Resident #17's admission record dated 12/11/24 revealed an [AGE] year-old male admitted on [DATE]. Resident #17's diagnoses include benign neoplasm of prostate (an abnormal growth near the prostate), hematuria (blood in the urine), obstructive and reflux uropathy (urine cannot flow in through the urinary system due to an obstruction), need for assistance with personal care, and ankylosing spondylitis (an inflammatory disease that can cause back pain, stiffness, and hunched posture). Record Review of Resident #17's quarterly MDS dated [DATE] revealed resident was unable to complete a BIMS assessment that indicated severe cognitive impairment. The MDS revealed Resident #17 required substantial/maximal assistance to complete dependence on staff for all the assessment under functional abilities. The quarterly MDS revealed an Indwelling catheter under the section labeled Bladder and Bowel. Record review of Resident #17's physician order summary dated 12/11/2024 revealed Resident #17 had orders as follows: 1. Catheter: Catheter care with Incontinent Wipes Every Shift with a start date of 7/11/2024 2. Catheter: Change Foley Catheter or Supra-pubic Catheter [a tube inserted directly into the bladder through the abdominal wall to drain urine] as indicated for infection, obstruction, or when closed system is compromised as needed with a start date of 12/4/2024. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. Catheter: Change Foley Catheter or Supra-pubic Catheter as indicated for infection, obstruction or when closed system is compromised everyday shift on the 4th for 1 day with a start date of 12/4/2024 4. Catheter: Change leg strap or stat lock with each foley change and prn as needed 5. Catheter: Ensure Catheter is draining properly to bedside privacy bag and leg strap is in place every shift. 6. Catheter: Monitor for signs/symptoms of infection with a start date of 7/11/2024 7. Catheter: Monitor Output Every Shift 8. Irrigate Foley with 500 ml's distilled water-push 100 ml's in and pull out and repeat until clear as needed for hematuria with a start date of 10/29/2024. 9. May use [mechanical] lift and x 2 assist to transfer safely. Record review of Resident #17's Care Plan dated 9/5/2023 and revised on 3/25/24 revealed The resident has an ADL self-care performance deficit. Interventions included Transfer: The resident requires assist x one staff member to move between surfaces. Further review revealed no mention of Suprapubic Catheter throughout the plan. Review of Resident #41 face sheet revealed a [AGE] year-old female admitted on [DATE] with diagnoses of heart failure, disturbances of salivary secretion, and dysphagia. Review of Resident #41 care plan with revision date of 03/10/2022 revealed resident was at risk for weight loss and interventions included diet of mechanical soft texture with regular consistency liquids with date of 10/17/2022 with additional interventions listed on 04/20/2024 of mechanical soft texture and regular consistency liquids with date per resident request. Review of Resident #41 nursing progress note dated 11/07/2024 revealed hospice nurse gave new order per hospice physician to change diet consistency to regular texture. Review of physician's telephone orders for Resident #41 dated 11/07/2024, revealed change diet consistency to regular texture. Review of Resident #41 physician order dated 11/07/2024 revealed reduced concentrated sweets diet, regular texture, regular consistency. Record Review of Resident #98's admission record dated 12/10/24 revealed a [AGE] year-old female with an admitted [DATE]. Resident #98's diagnoses included Chronic pain, fatigue, repeated falls, lack of coordination, muscle weakness, reduced mobility, need for assistance with personal care, and unspecified dementia (a disease that affects the short- and long-term memory). Record Review of Resident #98's quarterly MDS dated [DATE] revealed a BIMS score could not be assessed due to severe cognitive impairment. The MDS revealed Resident #98 was substantial/maximal assistance to dependence on staff for all assessment under the self-care functional abilities section. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record Review of Resident #98's Care Plan dated 3/15/2024 and revised on 7/9/2024 revealed The resident has an ADL self-care performance deficit. Interventions included Transfers: The resident requires assistance x one with transfers, providing weight bearing assistance, guidance as needed. Record Review of Resident #98's Order Summary Report dated 10/10/24 revealed an order stated, May use [mechanical] lift and x 2 assist to transfer safely. During an interview on 12/12/24 at 9:28 AM, LVN E stated she had worked at the facility about a year. She stated Resident #17 and Resident #98 require a [mechanical] lift and assistance x 2 staff for a safe transfer. She stated the DON and management are responsible for updating care plans for residents during the resident's care plan meeting or as changes occur. LVN E stated that the CNAs look at ADL sheets, which are provided when they sign in for the day, to determine care for each resident. She stated she was not sure who used the care plan. During an interview on 12/12/24 at 9:53 AM, LVN F stated she had worked at the facility about 4 years. She stated MDSN, activities, therapy and ADM was responsible for updating all care plans. LVN F stated the care plans are updated every Wednesday during their meeting. She stated she was not sure who used the care plans for the residents. During an interview on 12/12/24 at 2:18 PM, MDSN stated she was responsible for completing and updating care plans. She stated that care plans should be updated for falls, skin issues, changes in medications and any significant event. MDSN stated that care plans should be updated for new catheters and for changes in requirement for transfers. She stated that nursing staff, activities staff and dietary staff all utilized the care plan when they provide care to the resident and not updating the care plans could affect how they provide the care. During an interview on 12/12/24 at 2:39 PM, the DON stated MDSN was responsible for updating the care plans and they should have been updated quarterly, with any significant change in care, and/or new preferences identified by staff. She stated that she expected care plans to be updated when a resident had a new order for a catheter or when the resident's need changes for how care is provided. She stated if diet orders were changed then the care plan should be updated too. The DON stated the care plans are reviewed by MDSN, DON and during the quarterly meetings. She stated that floor staff used the MAR and NMAR and ADL sheets for daily care instructions. During an interview on 12/12/24 at 3:04 PM, the ADM stated MDSN was responsible for updating the care plans quarterly, annually and with any significant change, incident/accident, or new preference. She stated that care plans should have been updated when a diet order changes, when a resident's requirements for transfers and when a resident had a new order for a catheter. The ADM stated the care plans are used by the interdisciplinary team and if they were not updated correctly then it could cause the team to provide care incorrectly. Review of policy titled Resident Assessments and dated 2001 and revised in 2022 revealed. Policy statement A comprehensive assessment of every resident's needs is made at intervals designated by OBRA and PPS requirements. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Policy Interpretation and Implementation 1) The resident assessment coordinator is responsible for ensuring that the interdisciplinary team conducts timely and appropriate resident assessment and reviews according to the following requirements: 4. Significant Change in status assessment 3) A comprehensive assessment includes: a. completion of the MDS. b. completion of the care is assessment process and c. development of the comprehensive care plan. 50872

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42600 Based on observation, interview, and record review, the facility failed to maintain an Infection 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 3 of 12 residents (Resident #9, Resident #25 , Resident #102,) observed for infection control. 1. The facility failed to ensure all staff donned PPE when entering rooms of residents' rooms who were on droplet precautions. 2. The facility failed to ensure PPE was adequately stocked for residents on droplet precautions. These failures could place residents at risk of cross-contamination and development of infection. Findings included: Review of Resident #9 face sheet revealed a [AGE] year-old female admitted on [DATE] with diagnoses of Dementia (a decline in mental ability that affects memory, thinking, and behavior), heart failure, and chronic fatigue (a long-term illness that causes severe fatigue and makes it difficult to perform daily activities). Review of Resident #9 care plan revealed Resident #9 had increased potential to contract COVID 19 in facility. Interventions included to follow CDC and health department guidelines regarding COVID recommendations and precautions. Further review revealed of care plan with revision date of 12/11/2024 that resident had recent diagnoses of COVID 19 with position test. Interventions included to enforce strict isolation with proper donning and doffing of isolation equipment. Observation on 12/12/24 at 10:03 AM revealed CNA Y walked into Resident #9's room without face shield or goggles on. Review of Resident #25 face sheet revealed an [AGE] year-old male admitted on [DATE] with diagnoses of COVID-19 (an infectious disease caused by the SARS-CoV-2 virus), metabolic encephalopathy (a brain disorder caused by a chemical imbalance in the blood that affects brain function) and anxiety (a feeling of fear, dread, and uneasiness that can be a normal reaction to stress). Review of Resident #25 care plan dated 04/09/2024 revealed resident with increased potential to contract COVID due to communal living, interventions included to follow CDC and health department guidelines regarding COVID recommendations and precautions. Further review revealed care plan dated 12/07/2024 Resident #25 had recent diagnoses of COVID 19 with interventions to enforce strict isolation with proper donning and doffing of isolation equipment. Observation on 12/10/2024 at 2:19 PM revealed PPE observed outside of Resident #25's room. Resident had droplet precaution sign posted on door to room. Observation on 12/11/24 at 11:47 AM revealed no face shields available for staff outside of Resident #25's room. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #102's face sheet revealed an [AGE] year-old female admitted on [DATE] with diagnoses of COVID-19 (respiratory virus), anxiety disorder (a mental health condition that causes excessive and uncontrollable feelings of fear or worry that can interfere with daily life), depression (a mental health condition that can affect how a person feels, thinks, and behaves), and essential hypertension (a condition where blood pressure is chronically elevated but there is no known cause). Review of nursing progress notes for Resident #102 dated 12/09/2024 revealed Resident to begin strict covid isolation - contact & droplet precautions. Review of Resident #102's care plan dated 12/09/2024 revealed resident with recent diagnoses of COVID 19 virus with interventions that included enforce strict isolation with proper donning and doffing of isolation equipment along with strict hand washing. Observation on 12/10/2024 at 12:00 PM revealed CNA O entered Resident #102's room with gown, gloves, N-95 mask and a surgical mask under the N-95 mask. CNA O was not wearing a face shield or goggles. Observation on 12/10/2024 at 2:13 PM revealed MA Q entered Resident #102's room with gown, gloves and surgical mask. MA Q was not wearing a face shield or goggles. Observation on 12/10/2024 at 2:14 PM revealed a plastic bin with PPE in front of Resident #102's room and it included gowns, gloves, N-95 masks and surgical masks. There were no goggles or face shields in the cart. Observation on 12/10/2024 at 2:19 PM revealed a sign on Resident #102's door that revealed droplet precautions were in place. Further observation revealed a sign titled sequence for putting on personal protective equipment (PPE) Instructions included to don gown, mask or respirator, goggles or face shield and gloves. Observation revealed an additional sign posted that everyone must make sure their eyes, nose and mouth are fully covered before room entry. During an interview on 12/10/2024 at 2:17 PM MA Q stated that Resident #102 had COVID. MA Q did state why she did not have a face shield or goggles on entering Resident #102's room. Observation on 12/11/2024 at 9:55 AM revealed a plastic bin with PPE in front of Resident #102's room and it included gowns, gloves, N-95 masks and surgical masks. There were no goggles or face shields in the cart. Observation on 12/11/24 at 11:47 AM revealed no face shields available for staff outside of Resident #25's room. Observation on 12/12/24 at 10:03 AM revealed CNA walked into Resident number #9's room without face shield or goggles on. Observation on 12/12/2024 at 10:35 am revealed a large box in the housekeeping manager's office with face shields in it. During an interview on 12/10/20245 at 2:17 PM MA Q stated that Resident #102 had COVID. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with LVN Z on 12/11/24 at 10:35 am, she stated that if a resident had droplet precaution it should have been posted on the door. They were supposed to follow the sign on the door for putting on and taking off the PPE. They were supposed to wear a face mask, dispose of all the gear inside, and wash their hands. If there was not PPE available, she would have requested it from housekeeping. Interview with CNA Y on 12/11/2024 at 10:03 am 12/11/2024, she stated that when she went into a room she put on gown, gloves and masks. When she exited a room, she took off gloves first, then gown, then mask, and then washed hands inside. She sanitized her hands outside the room. She stated that she did not like the face shield because it made her hot. She was not sure if she was supposed to wear the face shield. She stated if she did not have PPE, she would go to the nurse and ask her. She stated that housekeeping came to check and stock PPE. She thought she had an in-service from one of the nurses in November. She stated that if she does not have PPE, she could get other residents sick. Interview with LVN AA on 12/12/2024 at 10:13 am, she stated that housekeeping came to check and stock up on PPE. She thought they needed face shields, and she stated she had an in-service in November for infection control. If they did not have PPE housekeeping or nurses would get PPE it out of the linen closet. She stated that she could get other residents sick if they do not wear PPE properly. Interview with LA BB A on 12/12/2024 at 10:14 am she stated that another housekeeping staff was responsible for ensuring PPE was available. She stated that she did not check for PPE while she was cleaning the halls. She would occasionally check if the box were was obviously low from the outside. They had someone come this morning to fill up the PPE. If there was no PPE she would not go in the room. She thought her last in-service was 3 months ago. Interview with LA CC B on 1112/12/2024 at 10:35 am, she stated it was her responsibility to stock PPE. PPE included gowns, gloves, blue bags, face shields, and masks. She was responsible for placing signs on the doors and checking PPE every morning. If there was not enough PPE available when she was in the facility she expected a verbal request, a text or a phone call from any staff that needed more PPE. She stated there were plenty of face shields available for staff. She stated the residents could be in danger if she did not stock the PPE for the direct care staff. Attempted telephone interview with CNA O on 12/12/2024 at 12:19 PM. Attempted telephone interview with MA Q on 12/12/2024 at 12:20 PM. Interview with RN A, the infection preventionist, on 12/12/24 at 01:49 PM, she stated that employees were supposed to wear goggles or face shields when going in the rooms. Interview with the DON on 12/12/2024 at 1:45 PM she said the facility did yearly PPE in-services or anytime there was a new COVID case. She stated that staffed needed to wear face shields or goggles. There was no reason staff should not have face shields on. The housekeeping was responsible for stocking the PPE. They had designated one person to stock it each morning. She stated that it would spread disease to other residents if staff did not wear proper PPE. DON stated staff were supposed to wear N95 masks and staff should not just wear surgical masks. DON stated staff should not wear an N95 mask over a surgical mask. She stated staff knew the order of PPE because they should look at the signs on the door. DON stated staff should just throw the face shield away and get a new one after they exited a room. (continued on next page)

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of facility in-services revealed an in-service was completed on 09/10/2024 with the topic of COVID-19. Informed review included how COVID-19 spreads, sequence for putting on PPE, and that staff must ensure their eyes, nose and mouth were fully covered. Review of facility policy dated September 2022 titled Coronavirus Disease (COVID-19) - Using Personal Protective Equipment revealed Personnel who enter the room of a resident with suspected or confirmed SARS-CoV-2 infection adhere to standard precautions and use NIOSH-approved N95 or equivalent or higher-level respirator, gown, gloves and eye protection. Further review revealed an N95 respirator and eye protection (goggles or a face shield that covers the front and sides of the face) is applied upon entry to the resident room or care area.