STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455931	A. Building B. Wing	06/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Advanced Rehabilitation and Healthcare of Vernon	4401 College Dr Vernon, TX 76384

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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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41944 Based on interview and record review the facility failed to ensure assessments accurately reflected the resident's status for 1 of 7 residents (Resident #90) reviewed for accuracy of assessments. 1. The facility failed to ensure Resident# 90's MDS accurately reflected that he did not an enteral feeding tube. This failure could place residents at risk for not receiving care and services to meet their physical needs and promote feelings of well-being and quality of life. The findings included: Record review of Resident #90's admission profile, dated 6/6/24, reflected a [AGE] year-old male whose most recent admitted was 06/16/21. Resident #5 had diagnoses which included: cerebral infarct (a dead A condition caused by disrupted blood flow to the brain causing brain cells to die), hypertension (high bleed pressure) and atrial fibrillation (an irregular heart rhythm causing inadequate blood flow to the body). Record review of Resident #90s Admission MDS, dated [DATE], Section K0300 reflected Resident #90 did have a feeding tube while a resident of the facility. Section C revealed he had a BIMS score of 10 (moderate cognitive impairment). Record review of Resident # 90's physician active order summary report dated 6/6/24 reflected he was on a mechanical soft diet with concentrated carbohydrate snacks ordered 3 times a day. There was no order for a feeding tube or for tube feedings. In an interview and an observation on 06/04/24 at 11:01 AM, Resident #90 stated he had never had a feeding tube. No enteral feeding tube site was noted to Resident # 90's abdomen during the observation. (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455931	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/06/2024
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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an Interview on 6/06/24 at 10:03 AM, MDS Coordinator C stated Resident #90 did not have a G tube. She stated she completed MDS Section K and documented the resident had a feeding tube while a resident at the facility. She stated it was a documentation error which she made because she was not paying attention. She stated failure to document the MDS properly could result in the resident not receiving needed care She stated she was responsible for the accuracy of the MDS, and no one monitored her for accuracy since she was a Registered Nurse. She stated the facility followed the RAI Manual as their policy for completing Resident Assessments. In an interview on 6/06/24 at 12:00 PM, the DON said she expected the MDS to accurately reflect the resident's condition at the time of assessment. She stated the MDS RN Coordinator was responsible for monitoring the accuracy of the assessment. Review of CMS'S RAI Version 3.0 Manual version 1.17.1 dated October 2019 revealed: The RAI process has multiple regulatory requirements. Federal regulations at 42 CFR 483.20 (b)(1)(xviii), (g) and (h) require that. (1) the assessment accurately reflects the resident's status (2) a registered nurse conducts or coordinates each assessment with the appropriate participation of health professionals (3) the assessment process includes direct observation, as well as communication with the resident and direct care staff on all shifts. Nursing homes are left to determine. (1) who should participate in the assessment process (2) how the assessment process is completed (3) how the assessment information is documented while remaining in compliance with the requirements of the Federal regulations and the instructions contained within this manual.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 14408 Based on observation, interview, and record review, the facility failed to provide an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community, for 2 of 32 residents (Residents #19 and #105) reviewed for activity programming, as evidenced by: 1. Resident #19 did not have an in-room activity plan developed and implemented to meet her individual interests, abilities, and needs. 2. Resident #105 did not have an in-room activity plan developed and implemented to meet his individual interests, abilities, and needs. 3. There was not a system in place to identify the residents requiring one-to-one individual activity programming. This failure could place the residents at risk for isolation, decline in cognitive status, and decreased feelings of well-being within their environment. The findings included: 1. Resident #19 Review of Resident #19's Admission Record, dated 6/06/2024, revealed a [AGE] year-old female admitted to the facility on [DATE]. The resident's diagnoses included: chronic atrial fibrillation (irregular heartbeat); hypertension (high blood pressure); pulmonary hypertension (type of high blood pressure that affects the lungs and the right side of the heart); hyperlipidemia (high cholesterol); hypothyroidism (thyroid gland disorder); chronic kidney disease (loss of kidney function); and diabetes mellitus type 2 (insufficient production of insulin causing high blood sugar). Review of Resident #19's Annual MDS assessment, dated 9/27/23, revealed a BIMS was not conducted, and the resident had memory problems and modified independence in decision making skills. Section F Activity Preferences documented a response of not very important for the selection options: reading materials; listening to music; being around animals or pets; doing things with groups of people; doing favorite activities; going outside for fresh air; and participation in religious services or practices. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #19's comprehensive care plan, dated 5/21/2020, revealed it addressed the concern area of Activities and the resident's dependence on staff for cognitive stimulation, activity attendance, and social interaction related to cognitive impairment and risk for isolation. The documented goal was for Resident #19 to maintain involvement in cognitive stimulation and social activities as desired through the next review. The interventions included to provide a program of activities of interest that empower the resident by encouraging and allowing choice, self-expression, and responsibility; to provide activities which did not involve overly demanding cognitive tasks and to engage the resident in simple structured activities; and to respect the resident's right to refuse to attend activities. The most recent revisions to the interventions for this care plan were dated 3/22/2023 and documented to invite the resident to scheduled activities and to assist and escort the resident to activity functions. The care plan had not been revised to address the resident's lack of participation in group activities and did not include the option of one-to-one individual activity programming. Review of Resident #19's electronic health record progress notes revealed an Activity Progress Note dated 4/11/2023. The Activity Director documented Resident #19 was not one for attending too many of the activities provided here in our facility. She loves to stay in her room and watch television. She does tend to have her days and nights mixed up, so she comes out of her room at night and talks to the staff and drinks coffee. She is on a regular diet and takes all of her meals in the comfort of her own room. Will continue to monitor and encourage. There were no further or more recently documented Activity Progress Notes in Resident #19's electronic health record. Observation on 6/03/24 at 3:06 PM revealed Resident #19 was resting in bed. She was awake and had her eyes open. The television in her room was not turned on. Resident #19 picked up a fig bar snack from her overbed table, opened the package, and ate half of the fig bar. She stated it was good. Observation on 6/05/24 at 9:20 AM revealed Resident #19 was resting in bed with her eyes closed. In an interview on 6/05/24 at 9:20 AM, CNA E, who was in the hallway near Resident #19's room, stated Resident #19 was hard of hearing and did not usually attend activities. He stated he had not seen any visitors for Resident #19. 2. Resident #105 Review of Resident #105's Admission Record, dated 6/06/2024, revealed an [AGE] year-old male admitted to the facility on [DATE]. The resident's diagnoses included: ataxia (loss of muscle control that causes clumsy movements); gastro-esophageal reflux disease (back-flow of stomach acid into the throat); dementia (memory problems and impaired thought processes); hypertension (high blood pressure); neuropathy (nerve damage that causes weakness, numbness, and pain in hands and feet); and Parkinsonism (neurological condition characterized by movement problems such as tremors, slowness of movement, and rigidity). Review of Resident #105's Admission MDS Assessment, dated 5/17/2024, revealed a BIMS score of 6 out of 15, indicating cognitive impairment. Section F Activity Preferences documented a response of very important for the selection options: being around animals or pets; doing favorite activities; going outside for fresh air; and participation in religious services or practices; and somewhat important for the selection options: listening to music; keeping up with current news; and doing things with groups of people. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #105's comprehensive care plan, dated 5/24/24, revealed it addressed cognitive impairment. There was not a care plan to address activity programming and activity participation. Review of Resident #105's Admission Activity Evaluation, dated 5/30/2024, revealed a standardized form for selecting and documenting activity preferences, activity pursuits, personal demographic information, physical status, and the name and date of the person completing the evaluation. The form had not been completed and was blank with no questions answered except for the type of evaluation and the date. Observation on 6/03/24 at 4:23 PM revealed Resident #105 was in bed with his eyes closed. He was using oxygen at 3 lpm via nasal cannula. The room lights were turned off and the room was dark. Observation on 6/04/24 at 10:14 AM revealed Resident #105 was seated in a wheelchair and was using portable oxygen at 2 lpm via nasal cannula. His wheelchair was positioned at a table in the living room area at end of his hallway. Resident #105 was holding a padded cloth cube with buttons sewn to the fabric. Review of the May 2024 activity calendar schedule and the June 2024 activity calendar revealed room visits were scheduled at 1:00 PM on Monday, Tuesday, Wednesday, and Friday. During an interview and record review on 6/06/24 at 5:47 PM, the Activity Director stated he did an activity evaluation in the residents' electronic health records when he was prompted to by the computer. He stated it was usually for new admissions or for re-admissions, when someone had gone to the hospital and was readmitted . The Activity Director stated he did not have a list of residents that he did in-room visits with and did not document when he did do one-to-one activities with the residents. He stated he did not document individual resident activity programming. The Activity Director stated he did in-room activities mostly with the residents who did not like group activities and came to him and asked him to come to their rooms and polish their fingernails. He stated he did write progress notes. He reviewed Resident #19's electronic health record and stated the last note he documented was on 4/11/2023 and it was a late entry for 4/05/2023 when it was due. He stated he had not documented any further notes for Resident #19. The Activity Director stated Resident #19 would occasionally get in her wheelchair and go to the dining room during bingo. He stated she did not play but she did watch. The Activity Director stated he did not do in-room activities with Resident #19. He stated the resident did her own thing. He stated he had not seen any family members or anyone else visit Resident #19. The Activity Director stated he was also a CNA and worked the night shift. He stated Resident #19 had her days and nights mixed up and she was more active at night. He stated she would sleep during the day and get up in her wheelchair at night and would talk with the staff. He stated that was when he had the most interaction with her. The Activity Director stated Resident #19 loved coffee and ate cereal with milk around 2:00 AM for a snack. He stated the staff made instant coffee if there was not any brewed coffee available for her to drink. The Activity Director stated there was a monthly activity calendar in the resident's room. He stated the staff, usually the CNAs, reminded and invited Resident #19 to attend group activities. The Activity Director stated he would look for a policy and procedure for activity programming. In an interview on 6/06/24 at 6:03 PM, the Activity Director discussed activity programming for Resident #105. The Activity Director stated, He has dementia and there's nothing I can do with him. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility's Recreation Services Policies and Procedures Manual, dated 1/2015, revealed [in part]: Resident Needs Recreation becomes extremely significant in meeting each resident's needs for quality of life. Well planned programs must be designed to enhance residents' abilities to function at their highest practicable level as well as to allow them to realize their own abilities to function at their own potential for fulfillment. The process must include assessing the residents' functional abilities, interests and needs, developing mutually agreed upon goals and the use of specialized recreation services as approaches to meet the individualized goals. Recreation services include recreation treatment services and opportunities for recreation participation .

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F 0761 Level of Harm - Minimal harm or potential for actual harm 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. 41944 Based on observation, interview and the facility failed to ensure that drugs and biologicals were secured and stored in locked compartments, and permit only authorized personnel to have access to the keys for 1 of 3 medication carts (Hall 4 medication cart) observed for medication storage, in that:. The Hall 4 Medication cart was left unlocked. This failure placed the residents at risk for medications being misappropriated or for potential harm and adverse reactions from access to medications not prescribed for them. The findings included: In an observation and interview on 6/15/2024 that lasted from 09:03 AM to:9:25 AM the Hall 4 nurses' medication cart was left unlocked by RN F in the open hallway at 9:03 AM as she entered a resident's room to administer medications. There was no other nurse to attend the cart in the hallway of Hall 4. There was 1 housekeeping staff in the area of the cart. RN F returned to the cart and stated she should not have left theHall 4 medication cart unlocked and unattended in the hallway. She stated she left it unlocked because she was busy and nervous with the surveyor watching her pass meds, she just did not think to lock it. She stated failure to lock the cart could result in drug diversion or a resident getting a medication that was not intended for them . In an interview on 6/5/24 at 10:00 AM the DON stated she expected the nurses to keep the medication room door locked and the medication cart locked at all times when not in use and unattended. She stated failure to do so could result in a resident coming along and getting a medication that was not intended for them or result in a drug diversion. Record review of the facility policy Medication Storage, dated 1/20/21, revealed the following [in part]: General Guidelines: a. All drugs and biologicals will be stored in locked compartments (i.e., medication carts, cabinets, drawers, refrigerators, medication rooms) under proper temperature controls. b. Only authorized personnel will have access to the keys to locked compartments. c. During a medication pass, medications must be under the direct observation of the person administering medications or locked in the medication storage area/cart. 2. Narcotics and Controlled Substances: a. Schedule II drugs and back-up stock of Schedule III, IV and V medications are stored under double-lock and key.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 14408 Based on interview and record review, the facility failed to maintain medical records that were complete and accurately documented in accordance with accepted professional standards and practices for 8 of 32 residents (Residents #57, #8, #43, #68, #82, #100, #105, and #261) whose records were reviewed for accurate and complete documentation. 1. The facility failed to ensure physician orders were written for Resident #57 for dialysis. 2. The facility failed to ensure Resident #8's Out of Hospital - Do Not Resuscitate Order form included a date for the physician's signature and included the physician's license number. 3. The facility failed to ensure Resident #43's Out of Hospital - Do Not Resuscitate Order form included the physician's printed name. 4. The facility failed to ensure Resident #68's Out of Hospital - Do Not Resuscitate Order form included the physician's license number and was signed in the correct section for Physician Statement. 5. The facility failed to ensure Resident #82's Out of Hospital - Do Not Resuscitate Order form included a date for the physician's signature, the physician's printed name, and the physician's license number. 6. The facility failed to ensure Resident #100's Out of Hospital - Do Not Resuscitate Order form included a date for the physician's signature, the physician's printed name, and the physician's license number. 7. The facility failed to ensure Resident #105's Out of Hospital - Do Not Resuscitate Order form included a date for the physician's signature, the physician's printed name, and the physician's license number. 8. The facility failed to ensure Resident #261's Out of Hospital - Do Not Resuscitate Order form included a date for the physician's signature and the physician's license number. This failure could place residents at risk for discrepancies in the provision of necessary medical care and services and desired end-of-life decisions not being honored. The findings included: 1. Resident #57 Review of Resident #57's Admission Record, dated 6/06/2024, revealed a [AGE] year-old female admitted [DATE]. The resident's diagnoses included: diabetes mellitus type 2 (insufficient production of insulin causing high blood sugar); paroxysmal atrial fibrillation (irregular heartbeat); major depressive disorder (a mood disorder that causes persistent feelings of sadness and a loss of interest in activities once enjoyed); and end stage kidney disease (kidney failure). (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #57's Quarterly MDS, dated [DATE], documented she had a BIMS score of 12 out of 15 which indicated she was cognitively intact, a diagnosis of end stage kidney disease, and received dialysis treatments. Record review of Resident 57's physician orders dated 06/06/24 revealed she did not have a completed order for hemodialysis treatments (a procedure where a dialysis machine and a special filter called an artificial kidney, or a dialyzer are used to clean an individual's blood. During an observation and interview on 6/03/24 at 9:03 AM, Resident #57 was in her wheelchair propelling herself down the hall. She stated she was on her way to dialysis and received dialysis 3 times a week. In an interview on 6/06/24 at 4:44 PM, the DON stated Resident #57 should have an order for her dialysis that was complete and personalized naming the specific care the resident was ordered to receive. She stated the order was written by ADON B. She stated she felt the failure occurred due to the fact that the electronic health record generated a template for the order and the nurse did not go back and complete the order to the personal needs of the resident. She stated It should have been caught during the morning meetings when the nurses go over new physician orders to ensure they are complete. In an interview on 6/06/24 at 4:50 PM, ADON B stated she had written the dialysis order for Resident #57 and the order was not complete. She stated she should have gone back when she received the specific dialysis orders from the dialysis center and completed the order. She stated she was responsible for ensuring the order was complete and accurate. Review of the facility policy titled Transcribing or Noting and discontinuing Orders, dated reviewed 02/10/21, revealed [in part]: Physician orders are written and transcribed, noted, and discontinued by the Charge Nurse onto the MAR, TAR or other center designated area. - The ADON or designee validates the order and transcription then enters the physician order into the Electronic Physician Order system MEDICATION/TREATMENT ORDER TRANSCRIPTION - Document the times of the administration ordered for prescribed medication or treatment according to center specified practice e.g., medication pass schedule - If general administration times are ordered for treatment administration the treatment may be assigned a shift for administration based upon work-load distribution or center practices e.g., dressing change can be transcribed onto the TAR for 2-10p shift. 2. Resident #8 (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #8's Admission Record, dated 6/04/2024, revealed a [AGE] year-old female admitted to the facility on [DATE]. The resident's diagnoses included: diabetes mellitus type 2 (insufficient production of insulin causing high blood sugar); hypertension (high blood pressure); anxiety; major depressive disorder (a mood disorder that causes persistent feelings of sadness and a loss of interest in activities once enjoyed); schizoaffective disorder (a mental health condition that is marked by a mix of schizophrenia symptoms, such as hallucinations and delusions, and mood disorder symptoms, such as depression, mania and a milder form of mania called hypomania); convulsions (seizures); hypothyroidism (thyroid gland disorder); and malignant neoplasm of the right kidney (cancer of the kidney). The form documented the resident had an Advance Directive of an OOH-DNR. Review of Resident #8's OOH-DNR Order form revealed it was signed by the resident and two witnesses on 4/06/22. The Physician's Statement section had an illegible signature and the physician's printed name. The signature was not dated and the physician's license number was not documented on the form. 3. Resident #43 Review of Resident #43's Admission Record, dated 6/06/2024, revealed a [AGE] year-old male admitted to the facility on [DATE]. The resident's diagnoses included: diabetes mellitus type 2 (insufficient production of insulin causing high blood sugar); hypertension (high blood pressure); psychosis with delusions (a loss of contact with reality - generally considered a common symptom of severe mental illness with beliefs that have no basis in reality); post-traumatic stress disorder (a mental health condition that develops following a traumatic event characterized by intrusive thoughts about the incident, recurrent distress/anxiety, flashback and avoidance of similar situations); anxiety; gastro-esophageal reflux disease (back-flow of stomach acid into the throat); chronic kidney disease (loss of kidney function); and a left leg above the knee amputation. The form documented the resident had an Advance Directive of an OOH-DNR. Review of Resident #43's OOH-DNR Order form revealed it was signed by his responsible family member and two witnesses on 12/13/2021. The Physician's Statement section had an illegible signature that was dated 12/15/2021 and documented the physician's license number. The physician's printed name was not documented on the form. 4. Resident #68 Review of Resident #68's Admission Record, dated 6/06/2024, revealed a [AGE] year-old female admitted to the facility on [DATE]. The resident's diagnoses included: diabetes mellitus type 2 (insufficient production of insulin causing high blood sugar); hypertension (high blood pressure); depression (sad mood state); bipolar disorder (serious mental illness characterized by extreme mood swings, ranging from extreme excitement episodes to extreme depressive feelings); schizophrenia (a mental disorder characterized by delusions, hallucinations, disorganized thoughts, speech and behavior); anxiety; dysphonia (hoarse voice); and dysphagia (swallowing problem). The form documented the resident had an Advance Directive of an OOH-DNR. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #68's OOH-DNR Order form revealed it was signed by her responsible family member and two witnesses on 3/20/24. The Directive by Two Physicians section had an illegible signature dated 3/20/24 and the resident's attending physician's printed name. The form did not document the physician's license number. The Physician's Statement section, which should have been completed and signed by the attending physician, was blank. 5. Resident #82 Review of Resident #82's Admission Record, dated 6/06/2024, revealed a [AGE] year-old male admitted to the facility on [DATE]. The resident's diagnoses included: diabetes mellitus type 2 (insufficient production of insulin causing high blood sugar); hypertension (high blood pressure); major depressive disorder (a mood disorder that causes persistent feelings of sadness and a loss of interest in activities once enjoyed); bipolar disorder (serious mental illness characterized by extreme mood swings, ranging from extreme excitement episodes to extreme depressive feelings); schizophrenia (a mental disorder characterized by delusions, hallucinations, disorganized thoughts, speech and behavior); post-traumatic stress disorder (a mental health condition that develops following a traumatic event characterized by intrusive thoughts about the incident, recurrent distress/anxiety, flashback and avoidance of similar situations); anxiety; and cerebral infarction (stroke). The form documented the resident had an Advance Directive of an OOH-DNR. Review of Resident #82's OOH-DNR Order form revealed it was signed by the resident and two witnesses on 6/12/24. The Physician's Statement section had an illegible signature that was not dated, and the physician's license number and printed name were not documented on the form. 6. Resident #100 Review of Resident #100's Admission Record, dated 6/04/2024, revealed an [AGE] year-old female admitted to the facility on [DATE]. The resident's diagnoses included: end stage heart failure; hypertension (high blood pressure); hypothyroidism (thyroid gland disorder); anxiety; gastro-esophageal reflux disease (backflow of stomach acid into the throat); dementia (memory problem and cognitive impairment); and chronic kidney disease, stage 3 (progressive kidney failure). The form documented the resident had an Advance Directive of an OOH-DNR. Review of Resident #100's OOH-DNR Order form revealed it was signed by her responsible family member and two witnesses on 1/24/2024. The Physician's Statement section had an illegible signature that was not dated, and the physician's printed name and license number were not documented on the form. The physician did not sign in the final section for signatures of all persons who had signed the form and acknowledged the form was properly completed. 7. Resident #105 Review of Resident #105's Admission Record, dated 6/06/2024, revealed an [AGE] year-old male admitted to the facility on [DATE]. The resident's diagnoses included: ataxia (loss of muscle control that causes clumsy movements); gastro-esophageal reflux disease (back-flow of stomach acid into the throat); dementia (memory problems and impaired thought processes); hypertension (high blood pressure); neuropathy (nerve damage that causes weakness, numbness, and pain in hands and feet); and Parkinsonism (neurological condition characterized by movement problems such as tremors, slowness of movement, and rigidity). The form documented the resident had an Advance Directive of an OOH-DNR. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Advanced Rehabilitation and Healthcare of Vernon		STREET ADDRESS, CITY, STATE, ZIP CODE 4401 College Dr Vernon, TX 76384	

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #105's OOH-DNR Order form revealed it was signed by his responsible family member and two witnesses on 5/29/24. The Physician's Statement section had an illegible signature that was not dated, and the physician's license number and printed name were not documented on the form. In an interview on 6/06/24 at 12:15 PM, the DON stated Resident #105 was diagnosed with lung cancer. She stated the resident's family did not want to send him to an oncologist or receive aggressive cancer treatments. The DON stated the family had chosen to have Resident #105 receive hospice services. 8. Resident #261 Review of Resident #261's Admission Record, dated 6/06/2024, revealed a [AGE] year-old male admitted to the facility on [DATE]. The resident's diagnoses included: diabetes mellitus type 2 (insufficient production of insulin causing high blood sugar); osteoarthritis (arthritis in the bones); peripheral vascular disease (narrowed arteries reduce blood flow to the arms or legs); atherosclerotic heart disease (occurs when the blood vessels that carry oxygen and nutrients from the heart to the rest of the body (arteries) become thick and stiff - sometimes restricting blood flow to the organs and tissues); and left leg below the knee amputation. Review of Resident #261's OOH-DNR Order form revealed it was signed by his responsible family member and two witnesses on 2/27/2024. The Physician's Statement section had an illegible signature that was not dated, and the physician's license number was not documented on the form. The physician did not sign in the final section for signatures of all persons who had signed the form and acknowledged the form was properly completed. In an interview on 6/05/24 at 4:09 PM, the Administrator stated the prior Social Service Director, who was not a social worker, had been responsible for explaining the advanced directives and OOH-DNR Order forms to the new admission residents and/or their responsible parties. The Administrator stated the Social Service Director used the instructions on the back side of the OOH-DNR Order form to complete the form. She stated she did not think there was a facility policy and procedure for completing advanced directives and OOH-DNR Order forms and she would need to look for a policy and procedure. In an interview on 6/06/24 at 6:53 PM, the Business Office Manager stated the previous Social Service Director had been employed in the facility for approximately one year and had left employment in the facility on 3/13/2024. She stated now the AIT was responsible for the Social Services Department duties. The Business Office Manager stated she did the Admission Packet business paperwork for the new admission residents and the Social Services Director reviewed the Advanced Directives information with the new admission resident and/or their responsible party. The Business Office Manager stated a signed copy of the OOH-DNR Order form was sent to the physician's office to be signed. She stated when it was returned to the facility, a copy was put in the code folder in the rotunda (binder notebook located at the nurses station) and the original would be in a file in the Social Services Director's office. The Business Office Manager stated one of the ADONs was responsible for entering the OOH-DNR order in the physician orders in the resident's electronic health record. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview and record review on 6/06/24 at 6:45 PM, the AIT stated she brought up the topic of Advanced Directives during the care plan meetings with the residents and their representatives and explained the Advanced Directive options. She stated that was done about day 13 after admission. The AIT stated she had worked in the facility in the Social Worker position from 2015 to 2020. She stated she returned one year ago as the Business Administration Coordinator and Marketing Director and now was an AIT. She said she was well versed in Advanced Directives due to her background in Social Service Work. She provided an OOH-DNR Order form she had recently completed that had been signed by the physician. The form did not include the physician's license number. The AIT believed the document to be a binding valid legal document even with the missing information. In an interview on 6/06/24 at 7:03 PM, the two RN ADONs both said a resident was not DNR status until the DNR was in hand. They said for a DNR to be valid it must have 2 witness signatures, the physician's signature, and the resident's or Power of Attorney's signature. The ADONs completed the last step for a resident to be DNR status. The DON was present during the interview and said during the morning staff meeting, the Social Worker told them when an OOH-DNR Order was back from the physician's office and the nursing staff needed to put a DNR order in the resident's electronic health record. The DON said the nurses put the order in the resident's electronic health record. Both ADONs said they did not always look at a resident's OOH-DNR Order form to make sure that it was filled in completely. They said sometimes they did not look at them at all, and the Social Worker was the first set of eyes to check for accuracy. The ADONs said they just took the OOH-DNR Order form from the Social Worker without checking the form for accuracy and completion before writing the order and entering it in the resident's electronic health record. The DON said that was one of their failures. Review of the Instructions for Issuing an OOH-DNR Order, dated as revised July 1, 2009, revealed the following [in part]: PURPOSE: The Out-of-Hospital Do-Not-Resuscitate (OOH-DNR) Order on reverse side complies with Health and Safety Code (HHSC), Chapter 166 for use by qualified persons or their authorized representatives to direct health care professionals to forgo resuscitation attempts and to permit the person to have a natural death with peace and dignity. This Order does NOT affect the provision of other emergency care, including comfort care. Applicability: This OOH-DNR Order applies to health care professionals in out-of-hospital settings, including physicians' offices, hospital clinics and emergency departments. Implementation: A competent adult person, as least [AGE] years of age, or the person's authorized representative or qualified relative may execute or issue an OOH-DNR Order. The person's attending physician will document the existence of the Order in the person's permanent medical record . In addition .the attending physician must sign .in the physician's statement section .The original or a copy of a fully and properly completed OOH-DNR Order shall be honored by responding health care professionals . Definitions: (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Attending Physician: A physician, selected by or assigned to a person, with primary responsibility for the person's treatment and care and is licensed by the Texas Medical Board, or is properly credentialed and holds a commission in the uniformed services of the United States and is serving on active duty in this state .

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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 41495

Based on observations, interview and record review, the facility failed to establish and 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 1 of 3 residents (Resident #71) when reviewed for infection control.

1.The facility failed to ensure CNA D washed or sanitized her hands between glove changes as appropriate while providing incontinence care for Resident # 71.

This failure could place residents at risk for cross contamination and the spread of infection.

The findings included:

Record review of Resident #71's face sheet, dated 06/6/24, reflected a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #71 had diagnoses of: muscle weakness, and hemiplegia (paralysis of the right side of the body). and diabetes with hyperglycemia (a condition that results from too much sugar in the blood which can result in the symptom of increased urination).

Record review of Resident #71's MDS Admission Assessment, dated 12/11/23 reflected Resident #71 required partial to moderate assistance with most ADLs and was always incontinent of bladder and frequently incontinent of bowels . Resident #71 had a BIMS score of 12 (moderate cognitive impairment).

Observation and interview on 6/6/24 at 10:42 a.m. of incontinence care for Resident #71 revealed CNA D, before the start of care, washed her hands, gathered supplies, and explained the procedure to Resident #71. She then donned gloves and removed Resident #71's urine soiled brief. She then performed incontinent care and removed the soiled brief and her gloves and her gloves and did not sanitize her hands between glove changes. She applied new gloves and fastened the resident's brief. She gathered the soiled supplies in a bag and washed her hands before leaving the room. She stated she knew she should have changed gloves and sanitized her hands before touching the resident and the clean brief. She stated this could lead to cross contamination and infection.

In an interview on 6/6/24 at 10:50 AM, CNA D stated cross contamination was mixing clean with dirty and that she should have washed her hands before she retrieved Resident #71's clean brief and fastened it. She stated Resident #71 could get an infection for not following good infection control practice. She stated she had yearly competency check and had been in-service on infection control and hand hygiene in the last 3 months.

In an interview on 6/6/24 at 1:00 PM the DON stated she was responsible as the Infection Preventionist for infection control in the facility. The DON stated all staff were expected to follow standard precautions which included washing hands or using hand sanitizer after changing gloves while providing care. She stated CNA D knew she should change gloves and sanitize her hands when touching a clean area after removing a soiled brief. She stated failure to practice good hand hygiene could result in an adverse outcome for the resident due to infection. She stated staff were monitored for competency through annual and spot competency checks.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the facility's policy and procedure for Handwashing/Hand Hygiene, dated 11/12/27, reflected the following [in part]: Policy: Staff involved in direct resident contact will perform proper hand hygiene procedures to prevent the spread of infection to other personnel, residents, and visitors. Policy Explanation and Compliance Guidelines: 1. Hand hygiene is a general term that applies to either handwashing or the use of an antiseptic hand rub, also known as alcohol-based hand rub (ABHR). 2. Staff will perform hand hygiene when indicated, using proper technique consistent with accepted standards of practice. 3. Hand hygiene is indicated and will be performed under the conditions listed in, but not limited to, the attached hand hygiene table. Either antimicrobial Soap and Water or Alcohol Based hand Rub: Before applying and after removing personal protective equipment., including gloves.