

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  455960	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  07/09/2024
NAME OF PROVIDER OR SUPPLIER  Hays Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE  1900 Medical Pkwy San Marcos, TX 78666	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 38073</p> <p>Based on observation, interview, and record review, the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at S483.10(c)(2) and S483.10(c)(3), that including measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment for 1 of 10 residents (Resident #1) reviewed for care plans.</p> <p>The facility failed to include in Resident #1's comprehensive care plan the behaviors of sleeping in other residents' beds.</p> <p>This failure placed residents at risk of not having their individual care needs met.</p> <p>Findings included:</p> <p>Review of the undated face sheet for Resident #1 reflected a [AGE] year-old female admitted to the facility on [DATE]. Her diagnoses included vascular, dementia, need assistance with personal care, generalized anxiety disorder, cognitive communication deficit, major depressive disorder, cortical age-related cataract, adjustment disorder with mixed anxiety and depressed mood, and insomnia.</p> <p>Review of the quarterly MDS for Resident #1 dated 04/12/24 reflected her cognition was severely impaired, and she rarely or never made decisions. It reflected she was always incontinent of bowel and bladder.</p> <p>Review of the care plan for Resident #1 dated 11/19/23 reflected the care plan did not address the residents behaviors.</p> <p>Review of the nursing progress notes from March through June 2024 for Resident #1 reflected the following:</p> <p>*03/17/24 documented by LVN B Note Text: Resident observed lying on another resident's bed, staff attempted to redirect resident, but she refused, putting herself on the floor and started crawling. Staff managed to assist resident to chair and placed resident in dining room.</p> <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:  455960	Facility ID:  455960  If continuation sheet Page 1 of 7

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>*06/11/24 documented by LVN C Note Text: Resident noted going into other resident's rooms and trying to get in their beds. Resident redirected and assisted back to her room and into bed several times throughout the evening.</p> <p>Observation on 07/09/24 at 09:23 AM revealed Resident #1 asleep in Resident #2's bed in the secure unit.</p> <p>Observation on 07/09/24 at 01:04 PM revealed Resident #1 lying on her side asleep in Resident #2's bed with her head on the pillow and her mouth over the exposed top of the fitted sheet.</p> <p>During an interview on 07/09/24 at 12:59 PM, the ABOM stated she thought the behavior of sleeping in other residents' beds was care planned for Resident #1. She stated the interventions staff should attempt when Resident #1 slept in another resident's bed were to redirect if the behavior affected the other resident.</p> <p>During an interview on 07/09/24 at 01:40 PM, the DON stated she had seen Resident #1 lie down in other residents' beds but did not know it was a frequent behavior. The DON stated Resident #1's behavior of sleeping in other residents' beds should have been care planned. She stated the MDS nurse did most of the care planning, but this issue was probably not the MDS nurse's responsibility, because it had not been discussed with her in morning meeting or shown up as a concern. The DON stated she did not know whose responsibility it was, yet, because she still had to investigate.</p> <p>Review of facility policy dated 12/23 and titled Comprehensive Resident Centered Care Plan reflected the following: It is the policy of this facility that the interdisciplinary team (IDT) shall develop a comprehensive person-centered care plan for each resident that includes measurable objectives and timeframes to meet a resident's medical, nursing, mental and psychosocial needs that are identified in the comprehensive assessment. 4. The facility IDT will develop and implement a comprehensive person-centered, culturally-competent, and trauma-informed care plan for each resident within seven (7) days of completion of the Resident Minimum Data Set (MDS) and will include resident's needs identified in the comprehensive assessment, any specialized services as a result of PASARR recommendation, and resident's goals and desired outcomes, preferences for future discharge and discharge plan.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38073</b></p> <p>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 4 of 10 residents (Resident #1, Resident #2, Resident #3, and Resident #4) reviewed for infection control.</p> <p>The facility failed to ensure that Resident #1 did not sleep in the bed of Resident #2 twice on 07/09/24.</p> <p>The facility failed to ensure that Resident #1 did not eat off Resident #3's meal tray and that Resident #3 did not eat after Resident #1.</p> <p>The facility failed to ensure a shared baby doll was sanitized after it had been in bed with Resident #5 and before Resident #4 came into close contact with it.</p> <p>These failures placed residents at risk of infectious disease.</p> <p>Findings included:</p> <p>Resident #1</p> <p>Review of the undated face sheet for Resident #1 reflected a [AGE] year-old female admitted to the facility on [DATE]. Her diagnoses included vascular, dementia, need assistance with personal care, generalized anxiety disorder, cognitive communication deficit, major depressive disorder, cortical age-related cataract, adjustment disorder with mixed anxiety and depressed mood, and insomnia.</p> <p>Review of the quarterly MDS for Resident #1 dated 04/12/24 reflected her cognition was severely impaired, and she rarely or never made decisions. It reflected she was always incontinent of bowel and bladder.</p> <p>Review of the care plan for Resident #1 dated 11/19/23 reflected the following: [Resident #1] has bowel/bladder incontinence r/t impaired cognition , unaware of need.</p> <ul style="list-style-type: none"> <li>o BRIEF USE: uses disposable briefs. Change prn.</li> <li>o INCONTINENT: Check as required for incontinence. Wash, rinse and dry perineum. Change clothing PRN after incontinence episodes.</li> </ul> <p>The care plan did not address the re goals or interventions related to her behaviors.</p> <p>Review of the nursing progress notes for Resident #1 reflected the following:</p> <p>*03/17/24 documented by LVN B Note Text: Resident observed lying on another resident's bed, staff attempted to redirect resident, but she refused, putting herself on the floor and started crawling. Staff managed to assist resident to chair and placed resident in dining room.</p> <p>(continued on next page)</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>o REGULAR diet, MECHANICAL SOFT texture, THIN LIQUIDS consistency No mixed consistencies, extra gravy, no breads/dry solids. Double protein portions TID with meals.</p> <p>Resident #4</p> <p>Review of the undated face sheet for Resident #4 reflected an [AGE] year-old female admitted to the facility on [DATE]. Her diagnoses included dementia, cognitive communication deficit, and need for assistance with personal care.</p> <p>Review of the quarterly MDS for Resident #4 dated 04/25/24 reflected her cognition was severely impaired, and she rarely or never made decisions.</p> <p>Review of the care plan for Resident #4 dated 05/05/24 reflected the following: [Resident #4] is at risk for severe acute respiratory infection r/t exposure of transmissible respiratory disease (e.g. COVID, Influenza, RSV, etc.). Will be free of s/sx of infection through the review date.</p> <p>Observation on 07/09/24 at 01:04 PM revealed Resident #1 lying on her side asleep in Resident #2's bed with her head on the pillow and her mouth over the exposed top of the fitted sheet. The bed was made neatly, but the blankets were only pulled 3/4 up the mattress, and the sheet and pillow were exposed to Resident #1's hands, face, and hair.</p> <p>During an interview on 07/09/24 at 09:23 AM, the ABOM stated the person lying in Resident #2's bed was Resident #1.</p> <p>During an interview on 07/09/24 at 12:59 PM, the ABOM stated she noticed earlier that morning that Resident #1 had been lying in another resident's bed. The ABOM stated she thought the behavior of sleeping in other residents' beds was care planned for Resident #1. She stated the interventions staff should attempt when Resident #1 slept in another resident's bed were to redirect if the behavior affected the other resident. The ABOM stated she thought the behavior was chronic and thus not affecting other residents, so the staff should have been keeping an eye on the situation (of Resident #1 being in other residents' beds) The ABOM stated if Resident #1 went into a room of a resident on isolation precautions, they would definitely redirect her. The ABOM stated they also made sure the beds were made and cleaned after she slept in them. She stated they did not change the bed linens every time, because they did not always see her in the beds, and if she was lying on top of the blankets, there would be no transmission of any bodily fluids. The ABOM stated if Resident #1's brief leaked, they would notice, and the bed linens would be changed. The ABOM stated she had not noticed when Resident #1 got out of Resident #2's bed and had not spoken to staff about it. She stated she was sure the staff in the unit had been keeping an eye out for any problems related to Resident #1 lying in other resident beds.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 07/09/24 at 01:09 PM, LVN A stated Resident #1 got into other residents' beds frequently, and if they got her up out of one bed, she would go to another bed. She stated Resident #1 was a heavy wetter and they had to check the beds after she got out of them to see if they needed to be changed. LVN A stated Resident #1 also got dirty when she ate and could have smeared some food on the other resident's pillows. LVN A stated it was also possible for Resident #1 to be exposed to Resident #2's bodily fluids or food particles when lying in her bed. She stated they should have cleaned up the linens after Resident #1 slept in them. She stated she did not know why that was not done. She stated it was probably not realistic for them to change the linens every time.</p> <p>Observation on 07/09/24 at 11:46 AM revealed Resident #1 seated in a chair at a dining table in the secure unit and eating lunch. After she finished eating her dessert (diced peaches), she got up from the table and walked to Resident #3's table, picked up a spoon from Resident #3's tray, and began eating Resident #3's peaches. She took several bites before CNA B stopped her, took the spoon, and redirected Resident #1 to her own plate. The peaches remained on Resident #3's plate and Resident #3 picked up her fork and began eating them. She ate the rest of the peaches.</p> <p>Observation on 07/09/24 at 11:56 AM revealed CNA B asked Resident #4, who was ambulating down the hall of the secure unit toward the rooms in her wheelchair, if she wanted to hold her baby. Resident #4 stopped going down the hall and came back to the common area of the secure unit. CNA B went into the room of Resident #5 who was sleeping under the covers with a baby doll in her arms and pressed up against her face. CNA B carefully removed the doll from Resident #5's arms without waking her up and brought it to Resident #4, who took it and immediately began kissing the doll and touching its face, head, and body. MA C assisted Resident #4 with a yogurt snack, and Resident #4 kissed the doll and got yogurt on the doll's face, which MA C helped clean up with a towel.</p> <p>During an interview on 07/09/24 at 12:05 PM, MA C stated they only had one big baby doll, so the residents shared it. MA C stated they had two small baby dolls, but the residents placed those in drawers sometimes, so they got lost. MA C stated the residents loved holding the doll, and she and CNA B had been discussing the need for more baby dolls but had not brought it to the attention of the activity director or ADM. MA C stated they were supposed to sanitize the doll when they gave it to a different resident. She stated they had purple-topped or bleach wipes they could have used and should have sanitized between uses.</p> <p>During an interview on 07/09/24 at 01:40 PM, the DON stated she had seen Resident #1 lie down in other residents' beds but did not know it was a frequent behavior. The DON stated it had been a long time since she had seen it. The DON stated the behavior could cause cross-contamination and infection. She stated the doll should have been disinfected before it was given to a different residents. She stated Resident #2 should not have been allowed to eat the contaminated peaches and should have been provided with a fresh dish of peaches. The DON stated it was hard to prevent contamination in the secure unit, because all the residents wandered, but they had to try. She stated she was the infection preventionist and was responsible for ensuring infection control was effective. She stated she monitored the system for compliance by in-servicing the staff daily during their 02:00 PM stand up meeting. She stated she was not sure why the staff in the secure unit had allowed so many instances of cross contamination. The DON stated she had not specifically in-serviced about the dolls, Resident #1 lying down in people's beds, or Resident #1 trying to take food off people's trays. She stated they did a lot of general infection control training.</p> <p>(continued on next page)</p>		

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