STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455963	A. Building B. Wing	08/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Carthage Healthcare Center	701 S Market St Carthage, TX 75633

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44933 Based on observation, interview, and record review, the facility failed to ensure residents had the right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences for 2 of 14 residents (Resident #8 and Resident #15) reviewed for reasonable accommodations. The facility failed to ensure Resident #8 and Resident #15's call light was placed within reach. This failure could place residents at risk for unmet needs. Findings included: 1. Record review of Resident #8's face sheet dated 08/18/24 indicated Resident #8 was a [AGE] year-old, female and admitted on [DATE] and readmitted on [DATE] with diagnoses including hemiplegia (paralysis of one side of the body) and hemiparesis (is one-sided muscle weakness) following cerebral infarction (stroke) affecting left non-dominant and flaccid hemiplegia affecting right dominant side. Record review of Resident #8's quarterly MDS assessment dated [DATE] indicated Resident #8 was usually understood and usually understood others. Resident #8 had minimal difficult hearing, clear speech, and moderately impaired vision. Resident #8 had a BIMS score of 10 which indicated moderately impaired cognition. Resident #8 was dependent for toileting hygiene and chair/bed-to-chair transfer. Resident #8 was always incontinent for urine and bowel. Resident #8 had functional limitation in range of motion impairment for one side of both her upper and lower extremities. Resident #8 used a wheelchair for mobility. Record review of Resident #8's care plan dated 12/15/20, edited 07/07/24, indicated Resident #8 was at risk for falls related to left side hemiparesis and personal preference to be in high position. Intervention included keep call light in reach of resident. 2. Record review of Resident #15's face sheet dated 08/18/24 indicated Resident #15 was a [AGE] year-old, female and admitted on [DATE] and readmitted on [DATE] with diagnoses including difficulty walking, muscle weakness, unsteadiness on feet, and history of falling. (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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455963	A. Building B. Wing	08/20/2024

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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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #15's quarterly MDS assessment dated [DATE] indicated Resident #15 was usually understood and usually understood others. Resident #15 had minimal difficulty hearing with hearing aids used, clear speech, and impaired vision with corrective lenses used. Resident #15 had a BIMS score of 10 which indicated moderately impaired cognition. Resident #15 required partial assistance for toileting hygiene and walk 10 feet and supervision for chair/bed-to-chair transfer, toilet transfer, and sit to stand. Resident #15 was frequently incontinent for urine but always continent for bowel. Resident #15 had functional limitation in range of motion impairment for both side of her lower extremities. Resident #15 used a wheelchair for mobility. Record review of Resident #15's care plan dated 01/23/20, edited 08/05/24, indicated Resident #15 had multiple problems that affected her ability to walk. Resident #15 had a history of falls, the potential to fall and at risk for injury related to falls. Intervention included make sure my call light is within reach and respond quickly. During an observation on 08/18/24 at 10:35 a.m., Resident #15 was sitting up in her bed. Resident #15's call light was on the floor. During an observation and interview on 08/18/24 at 4:35 p.m., Resident #8 was sitting in a wheelchair, in front of her refrigerator. Resident #8 said her call light did not work and she did not know where it was. Both of Resident#8's call lights were behind the foot of her bed, on the floor. She said staff told her they would come in at the right times to assist her, so she did not need her call light. During an observation and interview on 08/19/24 at 8:42 a.m., Resident #15 was sitting up in her bed. Resident #15's call light was on the floor. Resident #15 said she could get herself up if she needed help. Resident #15 said she did not know where her call light was. During an interview on 08/20/24 at 1:40 p.m., CNA B said he was assigned to Resident #15 on 08/19/24. He said he did not recall where Resident #15's call light was that day. He said Resident #15 kept a lot of stuff in her bed and the call light probably fell on the floor. He said it was the CNAs, or whomever entered resident's room to make sure call lights were in reach. He said it was important for call lights to be in reach so the resident could get help. He said when call lights were not in reach, residents could fall and hurt themselves. On 08/20/24 at 2:00 p.m., attempted to contact CNA P regarding Resident #8's call light placement on 08/18/24. CNA P did not answer the call and unable to leave voice message. CNA P did not return call before exit. During an interview on 08/20/24 at 2:36 p.m., RN M said it was everyone responsibility to ensure call light were in reach of residents. She said staff should do frequent rounding to ensure resident's call lights were in reach. She said residents could harm themselves if call light were not within reach. She said Resident #15 could transfer herself but needed supervision. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 08/20/24 at 3:56 p.m., the DON said when CNAs exited resident's room, they should ensure call light were within reach of the residents. She said before all staff exited resident's rooms, they should ensure call lights were within reach. She said charge nurses should ensure call lights were within reach by doing rounds. She said call lights needed to be within reach so residents could get assistance. She said call lights not being within reach of resident, placed them at risk for falls, not getting needed assistance and needs not being met. During an interview on 08/20/24 at 4:30 p.m., the ADM said she expected call lights to be within reach of the residents and answered timely. She said all staff should make sure call lights were in reach. She said the charge nurses should be ensuring call lights were within reach of residents. She said call lights needed to be within reach always to ensure resident could get the help they needed. She said residents were at risks for falls if their call lights were not within reach. Record review of a facility's Answering the Call light policy revised 03/2021, indicated .when the resident is in bed or confined to a chair be sure the call light is within easy reach of the resident .

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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 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Encode each resident's assessment data and transmit these data to the State within 7 days of assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44933 Based on interview and record review, the facility failed to ensure an encoded, accurate, and complete MDS discharge assessment was electronically completed and transmitted to the CMS System within 14 days after completion for 1 of 1 resident (Resident #44) reviewed for discharge MDS assessments. The facility did not ensure Resident #44's discharge MDS assessment was completed and transmitted within 14 days of completion. This failure could place residents at risk of not having records completed and submitted in a timely manner as required. Findings included: Record review of Resident #44's face sheet dated 08/19/24, indicated Resident #44 was an 85-years-old female, admitted on [DATE] with a diagnosis which included non-ST elevation myocardial infarction (is a type of involving partial blockage of one of the coronary arteries, causing reduced flow of oxygen-rich blood to the heart muscle). Resident #44 was discharged home with services on 04/19/24. Record review of Resident #44's discharge assessment-return not anticipated MDS assessment dated [DATE] indicated Resident #44 discharge date was 04/19/24. The MDS indicated Resident #44's observation end date was 04/19/24. The MDS did not indicate submission. During an interview on 08/20/24 at 2:38 p.m., the MDS Coordinator said she was responsible for completing and submitting MDS. She said Resident #44's discharge assessment should have been completed and submitted within 14 days of her discharge. She said the corporate MDS coordinator monitors the MDS assessments she completed. She said it was important to complete and submit discharge assessments because it ensured that proper documentation was collected prior to discharge. She said the facility ran reports on MDS assessments completion and submission. She said she did not know how Resident #44's discharge assessment got missed. During an interview on 08/20/24 at 4:30 p.m., the ADM said she expected the MDS coordinator to follow the MDS Completion and Submission policy. She said the MDS Coordinator was responsible for submitting discharge assessment timely. She said the corporate MDS Coordinator should be ensuring the facility's MDS Coordinator completed and submitted assessment timely. She said timely assessment submission was important ensure the facility was following CMS guidelines. Record review of a facility's MDS Completion and Submission Timeframes policy revised 07/2017 indicated . our facility will conduct and submit resident assessments in accordance with currency federal and state submission timeframes .the assessment coordinator or designee is responsible for ensuring that resident assessment are submitted to CMS QIES assessment submission and processing system in accordance with current federal and state guidelines .timeframes for completion and submission of assessments is based on the current requirements published in the Resident Assessment Instrument Manual . (continued on next page)

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	455963	A. Building B. Wing	08/20/2024

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record Review of the CMS RAI Version 3.0 Manual, dated October 2023, indicated, in Chapter 2, page 2-39 09. Discharge Assessment-Return Not Anticipated (A0310F), Must be completed (item Z0500B) within 14 days after the discharge date (A2000 + 14 calendar days). The RAI Manual further revealed the discharge assessment-return not anticipated must be submitted within 14 days after the MDS completion date (Z0500B +14 calendar days) .

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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 - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44933 Based on interview and record review, the facility failed to ensure assessments accurately reflected the resident's status for 2 of 14 resident reviewed for assessments. (Resident #8 and Resident #15) The facility failed to ensure Resident #8's falls on 05/29/24 and 07/07/24 were coded on her MDS. The facility failed to ensure Resident #15's falls on 05/09/24, 06/26/24, and 07/06/24 were coded on her MDS. The facility failed to ensure Resident #15's diagnosis of dementia (is a general term for loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life) was coded on her MDS. The facility failed to ensure Resident #15 was coded for receiving an anticoagulant (medicines that help prevent blood clots) not antiplatelet (medications that prevent platelets from sticking together and forming blood clots). These failures could place residents at risk of not having individual needs met. Findings included: 1. Record review of Resident #8's face sheet dated 08/18/24 indicated Resident #8 was a [AGE] year-old, female and admitted on [DATE] and readmitted on [DATE] with diagnoses including hemiplegia (paralysis of one side of the body) and hemiparesis (is one-sided muscle weakness) following cerebral infarction (stroke) affecting left non-dominant and flaccid hemiplegia affecting right dominant side. Record review of Resident #8's quarterly MDS assessment dated [DATE] indicated Resident #8 was usually understood and usually understood others. Resident #8 had minimal difficult hearing, clear speech, and moderately impaired vision. Resident #8 had a BIMS score of 10 which indicated moderately impaired cognition. Resident #8 was dependent for toileting hygiene and chair/bed-to-chair transfer. Resident #8 was always incontinent for urine and bowel. Resident #8 had functional limitation in range of motion impairment for one side of both her upper and lower extremities. Resident #8 used a wheelchair for mobility. The MDS did not reflect Resident #8 had falls during the assessment period. Record review of Resident #8's care plan dated 12/15/20, edited 07/07/24, indicated Resident #8 was at risk for falls related to left side hemiparesis and personal preference to be in high position. Intervention included keep call light in reach of resident. Record review of Resident #8's Safety Events- Fall dated 05/29/24 indicated .05/29/24 at 10:38 a.m. Unwitnessed fall-no visible injury . Record review of Resident #8's Safety Events-Fall dated 07/07/24 indicated .07/07/24 at 1:00 p.m.Fall . (continued on next page)

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	455963	A. Building B. Wing	08/20/2024

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Record review of Resident #15's face sheet dated 08/18/24 indicated Resident #15 was a [AGE] year-old, female and admitted on [DATE] and readmitted on [DATE] with diagnoses including dementia, history of falling and acute embolism (is an obstruction or blockage in a blood vessel) and thrombosis (occurs when blood clots block your blood vessels). Record review of Resident #15's current ICD-10 Diagnoses provided 08/20/24 indicated dementia in other disease classified elsewhere with behavioral disturbance. Date diagnosed [DATE]. Record review of Resident #15's quarterly MDS assessment dated [DATE] indicated Resident #15 was usually understood and usually understood others. Resident #15 had minimal difficulty hearing with hearing aids used, clear speech, and impaired vision with corrective lenses used. Resident #15 had a BIMS score of 10 which indicated moderately impaired cognition. Resident #15 required partial assistance for toileting hygiene and walk 10 feet and supervision for chair/bed-to-chair transfer, toilet transfer, and sit to stand. The MDS indicated Resident #15 received antiplatelet during last 7 days not anticoagulant. The MDS did not reflect Resident #15's diagnosis of dementia, and falls on 05/09/24, 06/26/24, and 07/06/24. Record review of Resident #15's care plan dated 01/23/20, edited 07/03/24, indicated Resident #15 had a communication deficit. Resident #15 was at risk for further decline as my disease progresses related to dementia. Intervention included encourage me to communicate. Record review of Resident #15's care plan dated 01/23/20, edited 08/05/24, indicated Resident #15 had multiple problems that affected her ability to walk. Resident #15 had a history of falls, the potential to fall and at risk for injury related to falls. Intervention included make sure my call light is within reach and respond quickly. Record review of Resident #15's care plan dated 03/04/24, edited 07/05/24, indicated Resident #15 was at risk for associated complications with use of anticoagulant Eliquis. Intervention included monitor for signs and symptoms of bruising and bleeding. Record review of Resident's 15's consolidated physician orders 07/01/24-08/20/24 indicated Eliquis (an anticoagulant; is used to treat or prevent deep venous thrombosis, a condition in which harmful blood clots form in the blood vessels of the legs) tablet 2.5 mg, 1 tablet oral, Diagnosis: acute embolism and thrombosis, twice a day. Start 03/04/24 and no end date. Record Review of Resident #15's MAR dated 07/01/24-07/31/24 indicated Eliquis tablet 2.5 mg, amount to administer: 1 tablet oral, Diagnosis: acute embolism and thrombosis, twice a day. Start 03/04/24. Resident #15 received 60 doses of Eliquis. Record review of Resident #15's progress noted dated 05/09/24 at 3:54 a.m., indicated post-fall follow up . initial progress note post fall .resident [Resident #15] placed call light on this SN [LVN T] answered and observed resident [Resident #15] on the floor by bed . Record review of Resident #15's Safe Events-Fall dated 07/06/24 indicated .07/06/24 at 11:17 a.m.fall . resident room .witnessed .LVN S . Record review of Resident #15's Safe Events-Fall dated 07/16/24 indicated .07/16/24 at 5:15 a.m. unwitnessed fall without injury .LVN O . (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 08/20/24 at 2:38 p.m., the MDS Coordinator said she was responsible for MDS assessments. She said Resident #15 was on an anticoagulant not antiplatelet. She said coding Resident #8 and Resident #15's falls depended on if it was claimed on the previous MDS assessment. She said if Resident #15's dementia diagnosis was listed on her diagnosis list, then it should be on the MDS. She said she reviewed a lot of different information such as physician notes, orders and progress note to complete the MDS assessment. She said she was human, so sometimes things were missed. She said an accurate MDS assessment was important because the information help make the resident's care plan. She said the corporate MDS coordinator oversaw the MDS assessment she completed. She said the corporate MDS reviewed resident's MDS assessments weekly. During an interview on 08/20/24 at 3:56 p.m., the DON said she was still learning about what was required on MDS assessments. She said the MDS Coordinator was responsible for completing most section on the MDS. She said she checked the MDS assessment, to the best of her ability, before she signed them for submission. She said an accurate MDS assessment was important because it affected the insurance and billing. She said the Regional MDS Coordinator was responsible for helping and reviewing MDS assessment completed by the facility's MDS Coordinator. During an interview on 08/20/24 at 4:30 p.m., the ADM said the MDS coordinator was responsible for MDS assessment accuracy. She said she expected resident's falls, diagnoses, and current medication type to be coded on the MDS assessment. She said the Regional MDS Coordinator should be monitoring the facility's MDS Coordinator. She said accurate MDS assessment were important for billing and insurance. She said the information coded on the MDS assessment helped form the resident's plan of care. Record review of a facility Certifying Accuracy of the Resident Assessment policy dated 11/2019 revealed . the information captured on the assessment reflects the status of the resident during the observation period for that assessment .the Resident Assessment Coordinator is responsible for ensuring that an MDS assessment has been completed for each resident

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	455963	A. Building B. Wing	08/20/2024

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Carthage Healthcare Center	701 S Market St Carthage, TX 75633

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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 0642 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a qualified health professional conducts resident assessments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44933 Based on interviews and record review, the facility failed to ensure a registered nurse signed and certified that the MDS assessment was completed for 1 of 1 resident (Resident # 44) reviewed for MDS completion. The facility failed to ensure the RN signed Resident #44's discharge MDS assessment as completed. This failure could place residents at risk for incomplete or inaccurate documentation that does not completely reflect the resident's status. Findings included: Record review of Resident #44's face sheet dated 08/19/24, indicated Resident #44 was an [AGE] year-old female, admitted on [DATE] with a diagnosis which included non-ST elevation myocardial infarction (is a type of involving partial blockage of one of the coronary arteries, causing reduced flow of oxygen-rich blood to the heart muscle). Resident #44 was discharged home with services on 04/19/24. Record review of Resident #44's discharge assessment-return not anticipated MDS assessment dated [DATE] indicated Resident #44's discharge date was 04/19/24. The MDS indicated Resident #44's observation end date was 04/19/24. The MDS revealed no RN signature in section Z, which was the signature of RN assessment coordinator verifying assessment completion. During an interview on 08/20/24 at 2:38 p.m., the MDS Coordinator said she was responsible for letting the RN know when a MDS assessment needed to be signed. She said she told either the DON or Regional MDS Coordinator to review the MDS assessment and sign it. She said the RN had to sign the MDS assessment within 14 days of discharge. She said the RN reviewed and signed the MDS assessment to certify the information on the assessment was correct. During an interview in 08/20/24 at 3:56 p.m., the DON said she was still learning about what was required on MDS assessments. She said the MDS Coordinator was responsible for completing most section on the MDS. She said she checked the MDS assessment, to the best of her ability, before she signed them for submission. During an interview on 08/20/2024 at 4:30 p.m., the ADM said she expected the RN/DON to sign when MDS assessments were completed. The ADM said she expected the MDS assessment to be signed with the specified timeframe allowed. The ADM said it was important to ensure timely payment of services. Record review of a facility's MDS Assessment Coordinator revised 12/2019 indicated .a Registered Nurse (RN) shall be responsible for conducting and coordinating the development and completion of the resident assessment (MDS) .the center staff must follow the MDS 3.0 RAI manual current version .the Resident Assessment Coordinator must date and sign each assessment (MDS) to certify that the assessment has been completed . (continued on next page)

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F 0642 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the MDS 3.0 RAI Manual, dated October 2019, revealed that Federal regulation requires the RN assessment coordinator to sign and thereby certify that the assessment is complete.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44933 Based on observation, interview, and record review the facility failed to develop, and implement a comprehensive care plan to meet the medical, nursing, mental and psychosocial needs for 3 of 14 residents (Resident #15, Resident #23, and Resident #35) reviewed for care plans. 1. The facility failed to care plan Resident #15's hearing problem and use of hearing aids. 2. The facility failed to care plan Resident #23's hearing problem, impaired vision, on antidepressant (is a type of medicine used to treat clinical depression) and oral antidiabetic (used in the treatment of diabetes mellitus to control glucose levels in the blood) medication, dental issue, and shortness of breath on exertion. 3. The facility failed to care plan Resident #35's impaired vision. These failures could place residents in the facility at an increased risk of a decline in physical or functional well-being, of not receiving necessary care or services, and having personalized plans developed to address their needs. Findings included: 1. Record review of Resident #15's face sheet dated 08/18/24 indicated Resident #15 was a [AGE] year-old, female and admitted on [DATE] and readmitted on [DATE] with diagnoses including acquired stenosis of external ear canal (is a narrow ear canal), acute suppurative otitis media (is defined as an infection of the middle ear space) with spontaneous rupture of right ear drum, bilateral tinnitus (is the perception of sound that does not have an external source, so other people cannot hear it), and impacted cerumen (is the medical term for earwax blockage). Record review of Resident #15's quarterly MDS assessment dated [DATE] indicated Resident #15 was usually understood and usually understood others. Resident #15 had minimal difficulty hearing with hearing aids used, clear speech, and impaired vision with corrective lenses used. Resident #15 had a BIMS score of 10 which indicated moderately impaired cognition. Record review of Resident #15's care dated 06/20/24 did not indicate impaired hearing with hearing aids. During an observation on 08/18/24 at 10:35 a.m., Resident #15 was sitting up in bed. Resident #15's was hard of hearing and had to be spoken loud to. Unable to visualize Resident #15's hearing aids. 2. Record review of Resident #23's face sheet dated 08/18/24 indicated Resident #23 was a [AGE] year-old male and admitted on [DATE] with diagnoses including Type 2 diabetes (is a condition that happens because of a problem in the way the body regulates and uses sugar as a fuel), abnormal weight loss, and chronic respiratory failure (is a condition where there's not enough oxygen or too much carbon dioxide in your body). (continued on next page)

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	455963	A. Building B. Wing	08/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Carthage Healthcare Center	701 S Market St Carthage, TX 75633

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #23's admission MDS assessment dated [DATE] indicated Resident #23 was usually understood and usually understood others. Resident #23 had minimal difficulty hearing, clear speech, impaired vision without corrective lenses. Resident #23's BIMS score was 10 which indicated moderately impaired cognition. The MDS indicated Resident #23 experienced shortness of breath or trouble breathing with exertion. Resident #23 had taken antidepressant and hypoglycemic medication during the last days. Resident #23 had broken or loosely fitting full or partial denture. The MDS assessment, Section V, Care Assessment Area triggered visual function, communication, and dental care to be addressed in Resident #23's care plan. Record review of Resident #23's care plan dated 06/14/24 did not indicate minimal difficulty hearing, impaired vision without corrective lenses, shortness of breath or trouble breathing with exertion, use of antidepressant and hypoglycemic medication, and broken or loosely fitting full or partial denture. Record review of Resident #23's consolidated physician order dated 07/01/24-08/20/24 indicated: *Januvia (is an oral diabetes medicine that helps control blood sugar levels) tablet 50 mg 1 tablet oral, Diagnosis: Type 2 diabetes mellitus, once a day. Start date: 06/14/24-open ended. *Mitrazapine (is an antidepressant used to treat major depressive disorder) tablet 15 mg 1 tablet oral, Diagnosis: abnormal weight loss, once an evening. Start date: 06/14/24-open ended. Record review of Resident #23's MAR dated 07/01/24-07/31/24 indicated: *Januvia (is an oral diabetes medicine that helps control blood sugar levels) tablet 50 mg, Amount to Administer: 1 tablet oral, Diagnosis: Type 2 diabetes mellitus, once a day. Start date: 06/14/24. Resident #23 received 30 doses. *Mitrazapine (is an antidepressant used to treat major depressive disorder) tablet 15 mg, Amount to Administer: 1 tablet oral, Diagnosis: abnormal weight loss, once an evening. Start date: 06/14/24. Resident #23 received 30 doses. During an observation on 08/18/24 at 11:02 a.m., Resident #23 was sitting in his wheelchair. Resident #23 was sitting directly in front of his television on a high volume. 3. Record review of Resident #35's face sheet dated 08/18/24 indicated Resident #35 was a 54-years-old male and admitted on [DATE] and readmitted on [DATE] with a diagnosis including dry eye syndrome (is a common condition that occurs when your tears aren't able to provide adequate lubrication for your eyes) of bilateral lacrimal glands (located above the eye, this structure produces tears). The face sheet indicated Resident #35 was on hospital leave. Record review of Resident #35's significant change MDS assessment dated [DATE] indicated Resident #35 was usually understood and usually understood others. Resident #35 had impaired vision and used corrective lenses. Resident #35's BIMS score was 11 which indicated moderately impaired cognition. The MDS assessment, Section V, Care Assessment Area triggered visual function to be addressed in Resident #35's care plan. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455963	A. Building B. Wing	08/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Carthage Healthcare Center	701 S Market St Carthage, TX 75633

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #35's care plan dated 08/10/24 did not indicate impaired vision and corrective lenses. During an interview on 08/20/24 at 2:15 p.m., LVN L said RN M was responsible for care plans. She said it would be important for diagnoses, medication, and vision/hearing problems to be on a resident's care plan. She said care plan were supposed to be individualized and specific to the resident's plan of care. She said the care plan interventions were supposed to provided treatment to address the care plan problem. She said when care plans did not have care areas addressed, staff may not know the resident's plan of care. She said this could hinder the resident's mentally and physically. She said not providing adequate care could limit the resident independence and progress. During an interview on 08/20/24 at 2:36 p.m., RN M said she completed acute care plans. She said care plans were done during MDS assessment periods and changes. She said the MDS Coordinator also did care plans. She said she would expect vision, hearing, and dental problems and diagnoses to be addressed in the resident's care plan. She said the care plan was based off information coded on the MDS assessment. She said the care plan problems was then developed from other information acquired. She said a care plan was developed to accommodate the resident and ensure the resident was independent as possible. She said care plan were important to implement goals and target dates. She said the care plan informed staff who was responsible to work towards the outcomes. During an interview on 08/20/24 at 2:38 p.m., the MDS Coordinator said she was responsible for certain care plans. She said care plans were a shared responsibility with RN M and the DON. She said developing care plans was a team effort. She said she reviewed different type of documents to gather information for a resident's care plan. She said diagnosis and medications should be on Resident #15, Resident #23, and Resident #35's care plans. She said the care plan intervention let you know what monitoring the medication needed. She said care plans were important, so everyone knew how to care and treat the residents. She said she did not know why those care areas were not added to Resident #15, Resident #23, and Resident #35's care plans. She said Resident #35 had poor vision and it should have been on his care plan. During an interview on 08/20/24 at 3:56 p.m., the DON said she, RN M, and the MDS Coordinator completed care plans. She said she expected care area on the MDS to be addressed on the resident's care plan. She said care plans gave a lot of knowledge about the residents and how to care for them. During an interview on 08/20/24 at 4:30 p.m., the ADM said RN M did resident's care plans. She said the DON should ensure the care plan accuracy. She said the care plan was important to know how to care for the residents. She said when a care plan was not accurate then residents' needs could not be met. Record review of a facility's Care Plans, Comprehensive Person-Centered policy revised 12/2020, indicated . to meet the resident's physical, psychosocial and functional needs is developed and implemented for each residents .the care planning process will .include an assessment of the resident's strengths and needs . incorporate identified problem areas .incorporate risk factors associated with identified problems .reflect currently recognized standards of practice for problem areas and conditions .areas of concern that are identified during resident assessment .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455963	A. Building B. Wing	08/20/2024

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Carthage Healthcare Center	701 S Market St Carthage, TX 75633

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44933 Based on interview and record review, the facility failed to ensure residents receive treatment and care in accordance with professional standards of practice and the comprehensive person-centered care plan for 1 of 5 (Resident #23) residents reviewed for quality of care. The facility failed to ensure Resident #23 had daily blood sugar glucose checks due to being on an antidiabetic (help manage blood sugar (glucose) levels in people who have Type 2 diabetes) medication. This failure could place residents of risk for not receiving appropriate care and treatment for hyperglycemia (when there's too much sugar (glucose) in your blood) or hypoglycemia (when your blood sugar (glucose) level falls too low for bodily functions to continue). Findings included: 1. Record review of Resident #23's face sheet dated 08/18/24 indicated Resident #23 was a [AGE] year-old male and admitted on [DATE] with diagnoses including Type 2 diabetes (is a condition that happens because of a problem in the way the body regulates and uses sugar as a fuel) and abnormal weight loss. Record review of Resident #23's admission MDS assessment dated [DATE] indicated Resident #23 was usually understood and usually understood others. Resident #23 had minimal difficulty hearing, clear speech, impaired vision without corrective lenses. Resident #23's BIMS score was 10 which indicated moderately impaired cognition. Resident #23 had taken a hypoglycemic medication during the last days. Record review of Resident #23's care plan dated 06/14/24 did not indicate, use of hypoglycemic/antidiabetic medication or Type 2 diabetes mellitus diagnosis. Record review of Resident #23's consolidated physician order dated 07/01/24-08/20/24 indicated: *Januvia (is an oral diabetes medicine that helps control blood sugar levels) tablet 50 mg 1 tablet oral, Diagnosis: Type 2 diabetes mellitus, once a day. Start date: 06/14/24-open ended. Record review of Resident #23's prescription order dated 06/13/24 indicated .Januvia tablet; 50 mg; 1 tablet; oral .frequency: once a day .Task (s) to record: Before: Blood Sugar (measures the level of glucose (sugar) in your blood) .physician order . Created by: LVN O .Signed by MD U . Record review of Resident #23's Medication Administration Record dated 07/01/24-07/31/24 indicated Januvia tablet 50 mg 1 tablet oral, other test, Diagnosis: Type 2 diabetes mellitus, once a day. Start date: 06/14/24. Received prescribed dose daily except for 07/19/24. No documented BSGs noted. Record review of Resident #23's Medication Administration Record dated 08/01/24-08/20/24 indicated Januvia tablet 50 mg 1 tablet oral, other test, Diagnosis: Type 2 diabetes mellitus, once a day. Start date: 06/14/24. Received all doses. Documented BSGs on 08/11/24-08/20/24. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455963	A. Building B. Wing	08/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Carthage Healthcare Center	701 S Market St Carthage, TX 75633

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #23's Vital Signs: Blood Sugar dated 06/14/24-08/20/24 indicated documented BSGs for 08/12/24, 08/13/24, 08/14/24, 08/15/24, 08/16/24, 08/18/24, and 08/19/24. During an interview on 08/20/24 at 2:15 p.m., LVN L said she thought Resident #23 had BSG checks. She said resident on oral diabetic medication had to get at least weekly BSG checks. She said the resident's TAR informed staff if BSGs were required. She said BSG checks were important to know if the resident was hyperglycemic or hypoglycemic before the medication was administered. She said if BSGs were not checked then staff would not know if the MD needed to be contacted. She said if BSGs were not checked then staff would not know the oral diabetic medications were not working. She said BSGs needed to be checked because the resident could need to be on insulin instead of oral medication. She said if a resident experienced unknown hypo or hyperglycemia then they could suffer brain damage, stroke, or coma. She said resident could also die from untreated hypo or hyperglycemia. During an interview on 08/20/24 at 2:36 p.m., RN M said when a resident was on oral diabetic medication they at least had as needed order for blood sugar checks. She said the blood glucose checks should be on the medication order. She said sometimes adding blood sugar checks to the medication order was missed. She said she thought Resident #23 had blood sugar checks ordered on his medication order. She said sometimes nursing staff missed the order to do a BSG before administration. She said when blood sugars were not checked on a resident taking oral diabetic medication, it placed them at risk for hypo (occurs when your blood glucose (sugar) levels are too low) and hyperglycemic (occurs when the level of blood glucose gets too high) episode. During an interview on 08/20/24 at 3:56 p.m., the DON said a resident on an oral medication should have bsg checks at least daily. She said the nurse who received the oral diabetic medication order should add daily bsg checks to the order. She said bsg checks were important to know if the medication was needed. She said oral diabetic medication was not as known but they could cause hypoglycemia. She said it was important to check bsgs to ensure the tablet form was treating the hyperglycemia. She said the resident could need a stronger diabetic medication. She said the DON was responsible to ensure residents on oral diabetic medication had bsg checks ordered by a nurse. She said RN M and the DON pulled activity reports daily. She said they looked at new orders to see if monitoring was ordered. She said Resident #23 was supposed to get his blood sugar checked before administering his medication. During an interview on 08/20/24 at 4:30 p.m., the ADM said she expected nursing staff to follow the diabetes policy. She said the DON should ensure the diabetic policy was being followed. She said blood sugar checks were important to make sure the medication was needed and effective. Record review of a facility's Nursing Care of the Older Adult with Diabetes Mellitus policy revised 11/2020 indicated .for the resident on oral medication (s) who is well controlled, monitor blood glucose levels at least twice weekly .for the resident receiving oral medication(s) who is poorly controlled .monitor blood glucose levels twice to four times daily as needed .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455963	A. Building B. Wing	08/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Carthage Healthcare Center	701 S Market St Carthage, TX 75633

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44933 Based on observation, interview, and record review, the facility failed to ensure a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible for 2 of 2 residents reviewed for urinary and bowel incontinence (Resident #18 and #32). 1. The facility failed to ensure Resident #18 was not found excessively wet on 08/19/24. 2. The facility failed to ensure CNA C performed proper incontinent care by ensuring Resident #32 was completely clean after bowel movement and before placing a new brief on 8/19/2024. These failures placed residents who required assistance with incontinent care at risk for urinary tract infections, skin breakdown, and hospitalization . Findings included: 1. Record review of Resident #18's face sheet dated 08/18/24 indicated Resident #18 was a [AGE] year-old, female and admitted on [DATE] with diagnoses including hemiplegia (paralysis of one side of the body) and hemiparesis (is one-sided muscle weakness) following cerebral infarction (stroke) affecting left non-dominant and urinary tract infection (is an infection in any part of your urinary system: kidneys, bladder, ureters, and urethra). Record review of Resident #18's quarterly MDS assessment dated [DATE] indicated Resident #18 was usually understood and usually understood others. Resident #18 had a BIMS score of 08 which indicated moderate cognitive impairment. Resident #18 did not reject care. Resident #18's admission performance was dependent for toilet hygiene. Resident #18 was always incontinent of urine and bowel. Record review of Resident #18's care plan dated 07/03/24 indicated Resident #18 had a history of chronic UTIs. Intervention included monitor for signs/symptoms of UTI. Record review of Resident #18's care plan dated 07/28/24 indicated Resident #18 experienced bladder incontinence related to cerebral vascular accident (brain attack). Intervention included provide incontinence care after each incontinent episode. Record review of Resident #18's progress note dated 08/18/24 at 3:29 a.m., indicated .resident continues to require maximum assist with ADL completion by staff .Resident is incontinent of bowel and bladder with incontinent care being provided by facility staff prn .LVN O . Record review of Resident #18's progress note dated 08/20/24 at 10:06 a.m., indicated .during assessment the resident had a large urine output with pink/red tint noted .LVN L . Record review of Resident #18's progress note dated 08/20/24 at 11:38 a.m., indicated .new order of Keflex 500 mg .for possible UTI .ADON . (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455963	A. Building B. Wing	08/20/2024

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Carthage Healthcare Center	701 S Market St Carthage, TX 75633

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #18 Bowel/Bladder ADL sheet dated 08/01/24-08/20/24 indicated Resident #18 received incontinent care on 08/18/24 at 3:31 a.m. by CNA R. During an interview and observation on 08/19/24 at 8:42 a.m., Resident #18 was lying in her bed with the call light in her hand. She said last night she had to wait about 25 minutes to be changed. She said she could not remember what time she was lasted changed. She said she needed to be changed right now. Resident #18 pushed her call light and CNA B answered. CNA B told Resident #18 to give him 2 minutes to finish with another resident and he would change her. During an observation on 08/19/24 at 8:56 a.m., CNA B and CNA P performed incontinent care on Resident #18. When CNA B turned Resident #18 on her side, Resident #18's brief, cloth under pad, and sheet were saturated with urine. Resident #18's mattress also had a wet spot on it. During an interview on 08/19/24 at 2:00 p.m., CNA P said she had worked at the facility since February 2023. She said Resident #18 was really wet this morning when she helped CNA B change her. She said she did not work with Resident #18 a lot. She said she did not know if Resident #18 was a heavy wetter or received a diuretic in the morning. During an interview on 08/19/24 at 2:05 p.m., CNA B said RN M told him Resident #18 needed to be changed this morning. He said RN M told him Resident #18 needed to change around 8:40 a.m. He said Resident #18 was excessively wet before he changed her this morning. He said Resident #18 being really wet could cause her to have skin breakdown. He said he had not told the charge nurse Resident #18 was found excessively wet this morning. He said he needed to tell the nurse Resident #18 had pink tinged urine when he changed her, too. During an interview on 08/20/24 at 9:00 a.m., the ADON said CNA R was assigned Resident #18's hall on 08/19/24, 10pm-6am shift. During an interview on 08/20/24 at 2:15 p.m., LVN L said residents were supposed to be changed every 2-3 hours. She said CNAs were responsible for providing incontinent care to residents. She said nurses should also be rounding on residents to ensure they were being changed every 2-3 hours. She said when residents were not provided timely incontinent care, it placed them at risk for skin breakdown and UTIs. On 08/20/24 at 2:25 p.m., called CNA R for interview regarding incontinent care on Resident #18. CNA R did not answer. Messaged left. Return not received before exit. During an interview on 08/20/24 at 3:56 p.m., the DON said CNAs were responsible for providing incontinent care to residents. She said CNAs should make rounds every 2 hours and as needed. She said if a resident was found excessively wet, it could be assumed they had not been changed in a while. She said the LVN charge nurses should be ensuring CNAs were changing residents timely. She said she had never been told Resident #18 was a heavy wetter. She said not changing residents timely placed them at risk for skin breakdown and infections such as UTIs. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455963	A. Building B. Wing	08/20/2024

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Carthage Healthcare Center	701 S Market St Carthage, TX 75633

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 08/20/24 at 4:30 p.m., the ADM said CNAs were responsible for incontinent care. She said she expected CNAs to perform incontinent care every 2 hours and as needed. She said the charge nurse and the DON should be ensuring the CNAs provided timely incontinent care. She said if a resident was found excessively wet, could indicated Resident #18 was not changed every 2 hours. She said it was important to provide timely incontinent care to prevent skin breakdown and infections. 49019 2. Record review of face sheet dated 8/20/2024, revealed Resident #32 was a [AGE] year-old female, admitted on [DATE] with the diagnoses of Alzheimer's disease (progressive disease beginning with mild memory loss and possibly leading to loss of the ability to carry on a conversation and respond to the environment), pressure ulcer of sacral region, stage 1 (non-blanchable redness of a localized area) and depression (a mood disorder that causes persistent sadness and loss of interest). Record review of an annual MDS assessment dated [DATE] revealed Resident #32 BIMS score was blank which indicated resident is rarely or never understood and was severely impaired cognitively. Resident #32 was dependent on staff for majority of activities of daily living. The MDS indicated Resident #32 was incontinent of bowel and bladder. Record review of Resident #32's care plan dated 09/03/2022 indicated Resident #32 had a history of pressure sores and DTI (deep tissue injury). Intervention included follow facility skin care protocol and report to charge nurse any redness or skin breakdown immediately. Record review of Resident #32's care plan dated 9/3/2022 indicated Resident #32 experienced bowel and bladder incontinence and requires assistance with personal care and at risk for breakdown from incontinence. Intervention included check for incontinence frequently throughout the shift, briefs, depends or pantiliners when out of bed and keep call light within reach. During an observation on 8/19/2024 at 9:28 AM, CNA C performed perineum care to Resident # 32 with CNA B assisting. CNA C used proper technique wiping from front to back and disposing of soiled wipe in a separate trash bag. CNA C assisted Resident #32 in positioning on her right side and cleansed her bottom from front to back using appropriate technique. After completing perineum care, CNA C placed a clean brief on Resident #32 and placed a new under pad on her bed. CNA C failed to inspect between Resident #32's legs to ensure she was completely cleaned before placing a new brief. CNA C said she felt she performed proper incontinent care and cleaned Resident #32 correctly. During an observation on 8/19/2024 at 9:51 AM, the DON and RN M came to Resident #32's room to follow-up on perineum care provided by CNA C. The DON was made aware of concerns of Resident #32 perineum care. RN M obtained additional supplies to perform perineum care. The DON rolled Resident #32 on her left side and started wiping from front to back removing moderate amount of feces remaining between Resident #32's perineum area. The DON rolled Resident #32 toward her and RN M assessed skin to sacrum area. RN M said Resident #32 had a blanchable red area to sacrum. During an interview on 8/19/2024 at 10:06 AM, RM M said some residents had issues with loose stools and sometimes staff will clean a resident and they were dirty again. RN M said she expected the residents to be clean prior to placing a new brief. RN M said a resident not receiving proper perineum care could result in an infection, urinary tract infection or skin breakdown if not properly cleaned after a bowel movement. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455963	A. Building B. Wing	08/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Carthage Healthcare Center	701 S Market St Carthage, TX 75633

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 8/19/2024 at 10:11 AM, the DON said she expected CNA's to clean residents from front to back and between the legs as she demonstrated. The DON said the staff has been in-serviced on incontinent care to keep them on their toes. The DON provided CNA C's checklist and provided a copy of perineum policy revised on 1/20/2023. During an interview on 8/20/2024 at 1:51 PM, CNA B said the facility has in-serviced on perineum care. CNA B said it was important to keep environment and workplace sterile. CNA B said you should put a barrier between all supplies and table and keep extra bags. CNA B said he inspects the areas to make sure all fecal matter has been removed from the resident. CNA B said a resident could be at risk for infection, get sick or the resident could get skin irritation or a bed sore. During an interview on 8/20/2024 at 1:58 PM CNA D said the facility had in-serviced on perineum care and the DON checked staff off. CNA D said it was important to inspect skin after cleaning the resident to ensure they are clean. CNA D said a resident could have skin breakdown, pressure sores or urine could saturate the skin and could cause a urinary tract infection. During an interview on 8/20/2024 at 2:19 PM, LVN K said the facility has in-serviced staff on perineum care. LVN K said it was important for residents to have good perineum care to prevent infection and prevent skin breakdown. During an interview on 8/20/2024 at 2:24 PM, LVN L said perineum care was important for men and women residents. LVN L said the resident could get an infection such as a urinary tract infection that could turn into sepsis if not caught early or a resident could get skin breakdown. LVN L said the staff member performing perineum care should inspect skin to ensure all areas are clean. During an interview on 8/20/2024 at 2:33 PM, the ADON said in-services were performed with facility staff every 6 months and performed an annual check off on perineum care. The ADON said perineum care was important to keep residents clean, prevent discomfort, skin breakdown, prevent infections and was a dignity issue. The ADON said she expected the staff to perform proper perineum care and inspect skin following care to ensure resident was clean. During an interview on 8/20/2024 at 2:49 PM, the DON said she expected the CNA's and nurses to perform proper perineum care. The DON said it could be a source for infection and skin breakdown. The DON said she expected the CNA's and nurses to inspect the resident skin after performing care to ensure the residents were clean. The DON said she expected the CNA's performing care if they observe a wound or pressure area, they should notify their charge nurse and the ADON who is also the treatment nurse so she was aware of concern and can stay on top of the issue. During an interview on 8/20/2024 at 3:30 PM, the ADM said she expected the nurses and CNAs to perform proper perineum care to the residents. She said it was important to provide timely incontinent care to prevent skin breakdown and infections. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455963	A. Building B. Wing	08/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Carthage Healthcare Center	701 S Market St Carthage, TX 75633

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the facility's check list dated 5/22/2024 titled Perineum care return demonstration checklist revealed CNA C completed demonstration of proper procedure steps performing perineum care on female and male residents. The Procedure steps revealed Use clean section for each wipe or use a new wipe each time. Use correct technique for peri-care on female verse male . Female .Spread labia, maintain serration of labia, clean center, then each groin areas to each side .dirty to clean .wipe one side then the other, and then the middle .wiping toward the rectum .Dispose of gloves and perform hand hygiene .don new gloves and roll resident to side then proceed to clean the rectal and buttock area. Review of a facility policy revised on 1/20/2023 titled Perineal Care revealed Perineal care is providing cleanliness and comfort to the resident, to prevent infections, skin irritation, and to observe the resident's skin condition. Steps in the procedure . For female resident: 1. Using the cleansing wipe, clean perineal area, wiping from front to back .2. Separate labia and wash area downward from front to back .3. Continue to clean perineum moving from inside outward to the thighs, cleanse the perineum thoroughly in the same direction . 5. Dry the perineum .6. Ask the resident to turn on her side with her top leg slightly bent .7. Using a new cleansing wipe, clean the rectal area thoroughly, wiping from the base of the labia and extending over the buttocks . Reporting .Notify the nurse if the resident refuses the perineum care and/or any concerns identified.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455963	A. Building B. Wing	08/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Carthage Healthcare Center	701 S Market St Carthage, TX 75633

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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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44933 Based on interview and record review, the facility failed to ensure that nurse aides were able to demonstrate competency in skills and techniques necessary to care for residents' needs for 1 (CNA B) of 2 staff reviewed for demonstration of skills and techniques necessary for residents' needs. The facility failed to ensure CNA B identified and addressed a change in condition and failed to report to LVN L, when Resident #18's pink tinged urine visualized during incontinent care on 08/19/24 which delayed physician notification and treatment. This failure could place residents at risk for not receiving the appropriate care and services to maintain their health and safety. Finding included: Record review of Resident #18's face sheet dated 08/18/24 indicated Resident #18 was a [AGE] year-old female and admitted on [DATE] with diagnoses including hemiplegia (paralysis of one side of the body) and hemiparesis (is one-sided muscle weakness) following cerebral infarction (stroke) affecting left non-dominant and urinary tract infection (is an infection in any part of your urinary system: kidneys, bladder, ureters, and urethra). Record review of Resident #18's 5-day MDS assessment dated [DATE] indicated Resident #18 was usually understood and usually understood others. Resident #18 had a BIMS score of 08 which indicated moderate cognitive impairment. The MDS assessment indicated Resident #18 was dependent for toilet hygiene. Resident #18 was always incontinent for urinary and bowel. Record review of Resident #18's care plan dated 07/03/24 indicated Resident #18 had a history of chronic UTIs. Intervention included monitor for signs/symptoms of UTI. During an interview and observation on 08/19/24 at 8:42 a.m., Resident #18 was lying in her bed with the call light in her hand. She said last night she had to wait about 25 minutes to be changed. She said she could not remember what time she was lasted changed. She said she needed to be changed right now. Resident #18 pushed her call light and CNA B answered. CNA B told Resident #18 to give him 2 minutes to finish with another resident and he would change her. During an observation on 08/19/24 at 8:56 a.m., CNA B and CNA P performed incontinent care on Resident #18. When CNA B turned Resident #18 on her side, Resident #18's brief, cloth under pad, and sheet were saturated with urine. Resident #18's mattress also had a wet spot on it. During an interview on 08/19/24 at 2:05 p.m., CNA B said RN M told him Resident #18 needed to be changed this morning. He said RN M told him Resident #18 needed to change around 8:40 a.m. He said Resident #18 was excessively wet before he changed her this morning. He said Resident #18 being really wet could cause her to have skin breakdown. He said he had not told the charge nurse Resident #18 was found excessively wet this morning. He said he needed to tell the nurse Resident #18 had pink tinged urine when he changed her, too. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 08/20/24 at 1:40 p.m., CNA B said on 08/19/24 during peri care on Resident #18 he noticed her urine had a pink hue. He said he did not immediately notify LVN L. He said after this surveyor interviewed him, he told LVN L about Resident #18's skin issue and urine with pink hue. He said he thought he also mentioned it to the ADON in passing. He said when he provided peri care this morning on Resident #18, he noticed again she had pink tinged urine. He said he immediately told LVN L. He said the facility had provided training on notifying the nurse of changes. He said it was important to let the nurse know changes in the resident so she could make the appropriate phone calls and provide treatment. He said not reporting could cause residents issue to be untreated. During an interview on 08/20/24 at 2:15 p.m., LVN L said yesterday (08/19/24) CNA B notified her about Resident #18's skin issue but not her having pink hued urine. She said CNA B told her about Resident #18's pink hued urine today. She said she immediately assessed Resident #18 and notified the MD. She said she expected CNA B to have notified her yesterday asap when he first noticed Resident #18's urine. She said it was important for CNAs to notify the nurses so the change of condition could be reported to the doctor. She said when the nurse was aware, then a plan of care could be made before the issue worsened. During an interview on 08/20/24 at 2:40 p.m., the ADON said CNA B had not informed her yesterday about Resident #18's urine color. She said she had validated a lot of the staff's competencies. She said CNAs competencies were checked on reporting changes upon hire and annually. She said CNA B should have informed LVN L immediately about Resident #18 urine color. She said Resident #18 was getting several tests to figure out what was going on. She said it was important for CNAs to report changes so the resident could be evaluated, assessed, and treated. During an interview on 08/20/24 at 3:56 p.m., the DON said she expected CNAs to notify the nurses of changes. She said CNAs should report changes immediately to the nurse. She said the facility had provided staff in-services on reporting changes. She said changes needed to be reported so the issues could be addressed as soon as possible. During an interview on 08/24/24 at 4:30 p.m., the ADM said staff were provided trainings on reporting changes. She said competencies were done upon hire and annually. She said she expected CNAs to report changes immediately to the charge nurse. Record review of CNA B's C.N.A Proficiency Audit by LVN T dated 02/15/24 indicated CNA B was satisfactory on reports changes in condition promptly. Record review of a facility's Competency of Nursing Staff revised 05/2019, indicated .and nursing assistants employed by the facility will .demonstrate specific competencies and skills sets deemed necessary to care for the needs of residents .competency in skills and techniques necessary to care for residents' needs included but is not limited to .identification of changes in condition .processes necessary to identify and report resident changes of condition .

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. 44933 Based on interview, and record review, the facility failed to use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week for 1 of 1 facility reviewed for RN coverage. The facility failed to provide RN coverage for 8 consecutive hours daily on 01/07/24, 01/13/24, 01/20/24, 1/21/24, 02/03/24, 02/04/24, 02/10/24, 02/24/24, 03/02/24, 03/03/24, 03/16/24, 03/17/24, 03/31/24, and 07/13/24. This failure had the potential to affect residents in the facility by leaving staff without supervisory coverage for RN specific nursing activities and for coordination of events such as an emergency care and disasters. Findings included: Record review of the facility's PBJ Staffing Data Report for Quarter 2 2024 (January 1-March 31) indicated the facility triggered for No RN Hours. The PBJ reported indicated, No RN Hours for 01/07, 01/13, 01/20, 01/21, 02/03, 02/04, 02/10, 02/24, 03/02, 03/03, 03/16, 03/17, and 03/31. Record review of the facility's January 2024 Staff Schedule provided on 08/18/24 indicated that the facility did not have an RN in the facility or did not work 8 consecutive hours on 01/07/24, 01/13/24, 01/20/24, and 01/21/24. Record review of the facility's February 2024 Staff Schedule provided on 08/18/24 indicated that the facility did not have an RN in the facility or did not work 8 consecutive hours on 02/03/24, 02/04/24, 02/10/24, and 02/24/24. Record review of the facility's March 2024 Staff Schedule provided on 08/18/24 indicated that the facility did not have an RN in the facility or did not work 8 consecutive hours on 03/02/24, 03/03/24, 03/16/24, 03/17/24, and 03/31/24. Record review of the facility's July 2024 Staff Schedule provided on 08/18/24 indicated that the facility did not have an RN in the facility or did not work 8 consecutive hours on 07/13/24. Record review of the facility's Time Punch Sheets provided 08/19/24 indicated: *01/07/24- No punch time for RN noted. *01/13/24- No punch time for RN noted. *01/20/24- No punch time for RN noted. *01/21/24- No punch time for RN noted. (continued on next page)

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	*02/03/24- No punch time for RN noted. *02/04/24- No punch time for RN noted. *02/10/24- No punch time for RN noted. *02/24/24- No punch time for RN noted. *03/02/24- No punch time for RN noted. *03/16/24- No punch time for RN noted. *03/17/24- No punch time for RN noted. *03/31/24- No punch time for RN noted. *07/13/24- No punch time for RN noted. During an interview on 08/19/24 at 4:45 p.m., the ADM said at the beginning of the year, the facility had problems getting RN coverage, 7 days a week. She said the facility hired two RNs to cover the weekends. She said unfortunately, one of the RNs, had a family issue and could not work as planned. She said RN M had adjusted her hours to cover weekend shifts not covered. She said there was certain task RNs were trained on. During an interview on 08/20/24 at 2:36 p.m., RN M said the facility had two other RNs rotating RN weekend coverage. She said one of the RNs had to back out. She said now she covered weekend RN coverage when there was a gap in the schedule. She said RN coverage was important for managing, supervising, and educating. She said anything could affect the residents and situation outcome. During an interview on 08/20/24 at 3:56 p.m., the DON said the facility used have an issue for weekend RN coverage. She said the facility hired two RN to cover the weekends. She said when the two other RNs were unable to cover the weekend, RN M worked instead. She said lack of RN coverage at the facility during weekends could affect the resident's care and nursing supervision. Record review of a facility's Staffing policy revised 09/28/23 indicated, .the facility utilizes the services of a registered nurses for at least 8 consecutive hours a day, 7 days a week .

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46929 Based on interview and record review the facility failed to provide pharmaceutical services, including the accurate acquiring, administering, and receipt of all drugs and biologicals, to meet the needs of 1 of 14 residents (Resident #9) reviewed for pharmacy services. The facility failed to ensure MA A signed off on the Narcotic Drug Record for Resident #9's lacosamide (a medication used to reduce the number and severity of seizures) medication when the last dose on the medication card was administered. This failure could place residents who received medications at risk of missing medications or missing doses of medications and staff being unable to reconcile controlled substance counts. Findings included: Record review of Resident #9's face sheet, dated 08/20/24, indicated she was a [AGE] year-old female, admitted to the facility on [DATE]. Her diagnoses included pseudobulbar affect (a neurological disorder that causes people to have sudden, uncontrollable, and inappropriate episodes of crying or laughing), diffuse traumatic brain injury (a brain injury caused by an outside source), and convulsions (medical condition where a person's muscles contract and relax rapidly and repeatedly, causing uncontrolled shaking). Record review of Resident #9's quarterly MDS assessment, dated 08/01/24, indicated she had a BIMS score of 10, which indicated moderate cognitive impairment. Record review of Resident #9's physician's orders, dated 08/20/24, indicated she had this order: *Vimpat (lacosamide) - Schedule V (a medication that is the least likely of the controlled substances to be misused) tablet; 100mg ; 1 tablet; oral, twice a day. The start date was 06/02/22. Record review of Resident #9's Narcotic drug record for Lacosamide, dated 07/02/24 through 08/01/24, indicated each dose of the medication was signed for except the last dose in the card, which was the evening dose on 08/01/24. Record review of Resident #9's MAR for August 2024 indicated that MA A administered lacosamide to Resident #9 both doses on 08/01/24. Record review of the controlled drug card count record, dated August 2024, indicated the narcotic count of cards and sheets were correct on 08/01/24. The record further indicated that 1 medication card and 1 narcotic sheet of Resident #9's medication was removed from the cart. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 08/19/24 at 03:25 PM, MA A said she counted the narcotic medications with MA N on the evening of 08/01/24. She said she wrote on the sheet minus 1 card, minus 1-sheet [Resident #9]. She said this meant that she pulled Resident #9's lacosamide medication card and sheet because she had administered the last dose in the card. She said she signed the Narcotic drug record for the morning dose of lacosamide and did not sign the sheet for the evening dose. she said it was a mistake and she forgot to sign the sheet. She said she should have signed out the last pill on the sheet. During an interview on 08/20/24 at 01:56 PM, the ADON said she expected MA A to sign for the last dose on the narcotic sheet. During an interview on 08/20/24 at 02:01 PM, the DON said MA A failed to sign out the last dose of the lacosamide medication on the drug sheet. She said she expected the medication aides to ensure the controlled medication sheets are signed when given. She said she did speak with MA N on 08/19/24 and MA N told her that the narcotic count was correct on 08/01/24. During an interview on 08/20/24 at 02:09 PM, the Administrator said she expected the MA A to sign for each dose of the lacosamide medication on the controlled medication sheet. Record review of the facility's policy, Controlled Substances, last revised April 2019, stated: .10. Upon Administration: a. The nurse administering the medication is responsible for recording: . .(5) Quantity of the medication remaining; and (6) Signature of nurse administering medication .

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44933 Based on interview, and record review, the facility failed to ensure each resident's drug regimen was free from unnecessary medications (a medication used in excessive doses and including duplicate therapy or for excessive duration; or without adequate monitoring, or without adequate indications for its use; or in the presence of adverse consequences which indicated the dose should be reduced or discontinued) for 1 of 5 residents reviewed for unnecessary medications. (Resident #35) The facility failed to ensure Resident #35 did not receive Minocycline, an antibiotic, without an indication of use and an excessive duration. The facility failed to ensure Resident #35 did not receive Acidophilus, a type of probiotic (good bacteria) found in the human gut, mouth, and vagina, and also in certain foods, for an excessive duration. This failure could place residents receiving antibiotics at risk for unnecessary antibiotic use, inappropriate antibiotic use, and increased antibiotic-resistant infections (happens when germs like bacteria and fungi develop the ability to defeat the drugs designed to kill them). Findings included: Record review of Resident #35's face sheet dated 08/18/24 indicated Resident #35 was a [AGE] year-old male and admitted on [DATE] and readmitted on [DATE] with diagnosis including local infection of the skin and subcutaneous tissue. The face sheet indicated Resident #35 was on hospital leave. Record review of Resident #35's significant change MDS assessment dated [DATE] indicated Resident #35 was usually understood and usually understood others. Resident #35 had impaired vision and used corrective lenses. Resident #35's BIMS score was 11 which indicated moderately impaired cognition. The MDS did not indicate a diagnosis of an infection. Resident #35 had received an antibiotic during the last 7 days of the assessment period. Record review of Resident #35's care plan dated 07/11/24 indicated Resident #35 was at risk for complications with gut health related to antibiotic use requiring medication. Intervention included med as prescribed: Acidophilus. Record of Resident #35's consolidated physician order dated 07/01/24-08/20/24 indicated: *Minocycline capsule 100 mg, 1, oral. Special instructions: prophylactic until MD V confirms infection is present. Diagnosis: Local infection of the skin and subcutaneous tissue, unspecified. Twice a day. Start date 06/25/24- open ended. Ordered by MD W. *Acidophilus capsule, 2 capsule, oral. Diagnosis: Long term (current) use of antibiotics. Once a day. Start date 07/11/24- open ended. Ordered by MD W. Record review of Resident #35's MAR dated 07/01/24-07/31/24 indicated: (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	*Minocycline capsule 100 mg, 1, oral. Special instructions: prophylactic until MD V confirms infection is present. Diagnosis: Local infection of the skin and subcutaneous tissue, unspecified. Twice a day. Start date 06/25/24- open ended. *Acidophilus capsule, 2 capsule, oral. Diagnosis: Long term (current) use of antibiotics. Once a day. Start date 07/11/24- open ended. Record review of Resident #35's MAR dated 08/01/24-08/20/24 indicated: *Minocycline capsule 100 mg, Amount to administer: 1, oral. Special instructions: prophylactic until MD V confirms infection is present. Diagnosis: Local infection of the skin and subcutaneous tissue, unspecified. Twice a day. Start date 06/25/24. Resident #35 received scheduled doses. *Acidophilus capsule, Amount to administer: 2 capsules, oral. Diagnosis: Long term (current) use of antibiotics. Once a day. Start date 07/11/24. Resident #35 received scheduled doses. Record review of Resident #35's Progress note dated 01/01/24-08/18/24 indicated: *06/25/24 at 8:33 a.m. by LVN L- This SN [LVN L] and ADON noted a raised area on left hip incision and notified MD W no new orders at time. *06/25/24 at 8:42 a.m. by LVN L- New orders received to call surgeon and have resident [Resident #35] evaluated. *06/25/24 at 11:09 a.m. by LVN L- New orders received from MD W/ MD V to start Minocycline 100 mg by mouth for 2 weeks. Prophylactic until confirmed by MD V on 06/28/24. *06/28/24 at 12:00 p.m. by LVN L- Resident [Resident #35] returned to facility, no new orders. Staples removed at facility. *07/10/24 at 11:30 a.m. by ADON- Incision closed no redness, no drainage. *07/11/24 at 11:56 a.m. by ADON- New order received for Acidophilus Probiotic 2 capsules by mouth every day for 30 days for diagnosis Z79.2 current use of antibiotics. During an interview on 08/20/24 at 2:40 p.m., the ADON said Resident #35's wound incision looked red, so she contacted MD W. She said an antibiotic was started prophylactic. She said she did not know why Resident #35's antibiotic had not been discontinued. She said she or the nurses should have contacted MD V's office. She said staff should have contacted MD V's office to clarify continuation or discontinue the antibiotic after Resident #35's appointment. She said Resident #35's order for his probiotics should have been discontinued 30 days after it started. She said stop dates should have been placed on both orders. She said it was her responsibility to ensure the orders had stop dates. She said when residents received unnecessary medications it affected their quality of care. She said when residents received antibiotics without indication of use, it built up resistance to other antibiotics. She said residents should only get medications that were needed and had indication of use. (continued on next page)

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	455963	A. Building B. Wing	08/20/2024

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 08/20/24 at 3:56 p.m., the DON said the ADON should have followed up on Resident #35's antibiotic order and an end date placed on the probiotic order. She said she personally would not have started prophylactic antibiotics on Resident #35. She said both medication orders should have end dates, especially an antibiotic. She said receiving unnecessary antibiotics may cause residents to build up a resistance which was not beneficial to the resident. She said the facility requested the consulting notes from MD V's office today from Resident #35's visit. She said the facility had a hard time getting notes from MD V's office. During an interview on 08/20/24 at 4:30 p.m., the ADM said the DON should have followed up with MD V's office about Resident #35 antibiotic order. She said the DON should have ensured stop dates were placed per the physician specified order. She said it was the facility's antibiotic stewardship policy not to prescribe unnecessary antibiotic. Record review of a facility's Medication Administration- General Guideline policy dated 01/2021 indicated . medications are administered in accordance with written orders of the prescriber .a medication order seems to be unrelated to the resident's current diagnosis or condition, the nurse calls the provider pharmacy for clarification prior to the administration of the medication .the nurse contacts the prescriber for clarification . Record review of a facility's Antibiotic Stewardship policy revised 12/2023 indicated .the Infection Preventionist and Director of Nursing (DON) are responsible for the Infection Control and oversight of the Antibiotic Stewardship Program .avoid long-term antibiotic prophylaxis for prevention infections .ordering practitioner will provide complete orders, including .duration of treatment, including a stop date .antibiotics orders obtained from consulting, specialty, or emergency providers will be reviewed for appropriateness .

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49019 Based on observation, interview and record review the facility failed to ensure, in accordance with State and Federal laws, store all drugs and biologicals in locked compartments under proper temperature controls, and permitted only authorized personnel to have access to the keys for 2 of 14 residents (Resident # 23 and Resident #33) reviewed for pharmacy services. The facility failed to safely store wound cleanser in a locked compartment in a clean, safe, and sanitary manner for Resident #23 and Resident #33. This failure could place residents at risk for misuse of medication and overdose, adverse reactions of medications, and not receiving the therapeutic benefit of medications. Findings included: 1. Record review of Resident #23's face sheet dated 08/18/24 indicated Resident #23 was a [AGE] year-old male and admitted on [DATE] with diagnoses including pressure ulcer (an injury that breaks down the skin and underlying tissue) of sacral region, stage 4, pressure ulcer and pressure ulcer of other site, stage 3. Record review of Resident #23's admission MDS assessment dated [DATE] indicated Resident #23 was usually understood and usually understood others. Resident #23 had minimal difficulty hearing, clear speech, impaired vision without corrective lenses. Resident #23's BIMS was 10 which indicated moderately impaired cognition. Resident #23 used a wheelchair for mobility. Resident #23 required partial assistance for eating, oral hygiene, upper body dressing, substantial assistance for personal hygiene, and dependent for shower/bathe self and lower body dressing on admission performance. Resident #23 had pressure ulcer/injury, a scar over bony prominence, or a non-removable dressing device. Record review of Resident #23's care plan dated 06/13/24, edited 07/24/24, indicated Resident #23 had pressure ulcer Stage 4. Resident #23 was at risk for associated complications. Intervention included treatment as prescribed. Record review of Resident #23's consolidated physician order dated 08/19/24 indicated Wound Treatment Order: Location: Left Lateral AKA (stump) PU IV, clean with normal saline/wound cleanser, apply collagen particles, cover with dry dressing. Diagnosis: Pressure ulcer of unspecified site, stage 4. Once a day. During an observation on 08/19/24 at 3:17 p.m., the ADON, with the assistance of LVN L provided wound and incontinent care on Resident #23. After wound and incontinent care were provided, the ADON placed Resident #23' spray bottle of wound cleanser in the dresser underneath his television. (continued on next page)

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	455963	A. Building B. Wing	08/20/2024

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview in 08/19/24 at 4:36 p.m., the ADON said there the facility did not have a policy on storage of wound cleanser. She said she should have stored the wound cleanser in a bag and locked it on the treatment cart. She said storing wound cleanser in the resident's room was improper storage. She said she looked up the ingredients in wound cleanser and did not see anything harmful. She said the wound cleanser still needed to be stored away from residents. 2. Record review of dated face sheet revealed Resident #33 was a [AGE] year-old male, was readmitted on [DATE] with the diagnoses of Cerebral Infarction (also called ischemic stroke occurs as a result of disrupted blood flow to the brain resulting in brain cells being deprived of oxygen and vital nutrients which can cause the brain to die off) cerebrovascular disease (condition that affects blood flow to your brain) , pressure ulcer sacral region, stage 4 (a sore that extends below the subcutaneous fat into the deep tissues, including muscle, tendons and ligaments) and extended spectrum beta lactamase resistance (an enzyme produced by some bacteria that makes them resistant to many antibiotics). Record review of a quarterly MDS assessment dated [DATE] revealed Resident #33's BIMS score was 12 which indicated resident was moderately cognitively impaired. Resident #33 was dependent on staff for majority of activities of daily living. The MDS indicated Resident #33 was occasionally incontinent of bladder. During an observation on 8/19/2024 at 1:30 PM, the ADON performed wound care to Resident #33's Stage IV Sacral wound. The ADON placed the wound cleanser in Resident #33's top dresser drawer and left the room. During an observation on 8/19/2024 at 2:28 PM, Resident #33 gave permission to open his top dresser drawer and the wound cleanser remained in the top drawer, unsecure behind a locked cabinet away from other potential staff of residents passing by room. During an interview on 8/19/2024 at 3:55 PM, the ADON said Resident #33 was not able to get out of bed to obtain the wound cleanser she placed in his top dresser drawer. The ADON said Resident #33's wound care supplies were in his top dresser drawer due to his insurance pays for the wound care supplies. The ADON said she did not know the facility policy on storing wound cleanser. The ADON said there were other residents and visitors passing by who walk the halls and could wander in Resident #33's room and use the wound cleanser in an improper manner making it harmful to them. During an interview in 08/19/24 at 4:36 p.m., the ADON said there the facility did not have a policy on storage of wound cleanser. She said she should have stored the wound cleanser in a bag and locked it on the treatment cart. She said storing wound cleanser in the resident's room was improper storage. She said she looked up the ingredients in wound cleanser and did not see anything harmful. She said the wound cleanser still needed to be stored away from residents. During an interview on 8/20/2024 at 8:18 AM, the ADON said she removed all the wound cleanser from resident's rooms. The ADON said she did not have the policy on medication storage for wound cleanser and it should not be stored in a resident's room. During an interview on 8/20/2024 at 2:19 PM, LVN K said wound care supplies such as wound cleanser should not be in a resident room. LVN K said a resident could get ahold of it and cause them harm. LVN K said wound care supplies were to be stored in the medication room or on the medication cart. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455963	A. Building B. Wing	08/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Carthage Healthcare Center	701 S Market St Carthage, TX 75633

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 8/20/2024 at 2:24 PM, the LVN L said the wound cleanser should be stored in the medication cart but was told wound cleanser could remain in a resident's room if the supplies were charged to Medicaid. LVN L said someone could drink it or use it improperly and make them sick. During an interview on 8/20/2024 at 2:33 PM, the ADON said wound care supplies should be in the resident's drawer. The ADON said she it would be fraud if Medicaid purchased the wound care supplies, and those supplies were stored outside the resident room. The ADON said if a passerby obtained wound cleanser, they could spray it in their eyes, drink it, or cause injury. During an interview on 8/20/2024 at 2:49 PM, the DON said the wound care supplies should be stored in the supply room. The DON said there were residents who had insurance covering their wound care supplies and the wound care supplies were to be stored in the resident's room. The DON said if it were gauze, she would be ok with it going in the resident's dresser drawer. The DON said the staff should not store a chemical or wound cleanser in a resident's room and was to be stored in the main supply room and labeled with resident's name. The DON said she expected wound cleanser, or any liquid medication needed to be stored in the supply room. During an interview on 8/20/2024 at 3:06 PM, the ADM said wound care supplies was to be stored like mouthwash and away from resident's access. The ADM said it could be potentially harmful to resident if they did not know what wound cleanser was. The ADM said someone could ingest it and it could make them sick. The ADM said she expected the nurses to keep the wound cleanser locked up either on the medication cart, in the storage room or locked in the resident's drawer. During record review of the facility's policy revised November 2020 titled Storage of Medication revealed . The facility stores all drugs and biologicals in a safe, secure, and orderly manner .Policy Interpretation and Implementation .1 .Drugs and biologicals used in the facility were stored in locked compartments under proper temperatures. Only persons authorized to prepare and administer medications have access to locked medications. 2 Drugs and biologicals were stored in the packaging, containers, or other dispensing systems in which they are received .3. The nursing staff are responsible for maintaining medication storage and preparation areas in a clean, safe, and sanitary manner . 44933

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 49019 Based on observation, interviews and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety for 1 of 1 kitchen reviewed for kitchen sanitation in that: 1. The facility failed to ensure ice machine was functioning properly and preventing ice from spilling out onto the floor. 2. The facility failed to ensure minimal black carbon buildup on iron gas stovetop and debris cleared from under burner. 3. The facility failed to ensure food was properly labeled, dated, and stored in a resident personal refrigerator. These failures could place residents who received meals from the kitchen at risk for chemical contamination and food-borne illness. The findings were: During an observation on 8/18/2024 at 9:00 AM, the ice machine in the dining hall had a beige/brown blanket absorbing melting ice cubes laying directly in front of ice machine where residents and staff navigate. During an observation on 8/18/2024 at 10:44 AM, Resident #16 had a green, moldy undated, unlabeled sandwich stored in her mini refrigerator. Resident #16 said she needed to throw the sandwich away. During an observation on 8/18/2024 at 9:10 AM, observed black carbon buildup on gas stove in kitchen. During an observation on 8/19/2024 at 8:15 AM, observed iron gas stove with shiny black build up along the edges of the iron stove top. During an interview on 8/20/2024 at 1:21 PM, Dietary Aide F said the cook was responsible for cleaning the stove and oven. Dietary Aide F said a fire could occur if there was grease build up on the stove. Dietary Aide F said the Dietary Manager was the cook for tonight. Dietary Aide F said she does not know who was responsible for cleaning out resident's mini refrigerators and said she was not sure if sandwiches should be dated. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 8/20/2024 at 1:30 PM, the Dietary Manager said all the kitchen staff were responsible for cleaning the kitchen. The Dietary Manager said the cook was responsible for cleaning the stove and oven and said it was maintained regularly . The Dietary Manager said the ice machine does not have the guard on it causing ice to spill out onto the floor, so the aides put down a blanket to catch the ice. The Dietary Manager said the blanket could be a trip hazard and anyone could fall and hurt themselves. The Dietary Manager said she tries to keep the black grim off the stove and the kitchen has a strapper and brush to clean the stove and oven. The Dietary Manager said they were doing the best they can and use to get hours to help clean them more thoroughly. The Dietary Manager said the staff would stay until 3 AM and they currently do not have enough time during working hours. The Dietary Manager said the staff date the sandwiches leaving the kitchen to resident rooms. The Dietary Manager said she was not for sure but thought the aides and maintenance were responsible for cleaning resident's personal refrigerators. During an interview on 8/20/2024 at 1:44 PM, Hospitality Aide E said staff check and make sure the resident's refrigerators were clean. The Hospitality Aide said she was not sure who was responsible for checking the refrigerators or keeping the temperature logs. She said residents were good about keeping their refrigerators cleaned out. Hospitality Aide E said she does not know the facility policy on in room refrigerators. She said a resident could get sick if they ate something that went bad in their refrigerator. During an interview on 8/20/2024 at 1:47 PM, the Maintenance Supervisor said he was responsible for small appliances and changing air filters. He said he was not responsible for cleaning the oven or stove in the kitchen. The Maintenance Supervisor said he was responsible for thawing the resident's refrigerators if they were frozen up. He said he was not responsible for checking the refrigerator temperatures or removing food. During an interview on 8/20/2024 at 1:51 PM, CNA B said everyone was supposed to clean out the refrigerators in the resident's room. CNA B said housekeeping keeps temperature logs. CNA B said he was not sure who was responsible for the routine cleaning of the resident's refrigerators. During an interview on 8/20/2024 at 1:58 PM, CNA D said she has observed the maintenance person and ADON cleaning out resident's refrigerators. CNA D said there was a schedule and a list with a signature on the side of resident's refrigerator was how they kept up with it. CNA D said the kitchen staff date and label sandwiches in resident's rooms. She said a resident could get sick if they ate something that was out of date. CNA D said if they find something out of date, they take it out and throw it away. During an interview on 8/20/2024 at 2:08 PM, Housekeeper J said the nurse aides were responsible for wiping out the refrigerators. She said maintenance was responsible for monitoring the refrigerator temperatures. Housekeeper J said she was responsible for removing outdated food. She said a resident could get sick if consumed and the food should have a date on it. Housekeeper J said she has a deep clean schedule every 3 weeks, and said she checks the resident's refrigerator and performs a deep clean. During an interview on 8/20/2024 at 2:19 PM, LVN K said she was not sure who was responsible for resident's refrigerators or the ice machine. LVN K said she considers the blanket in front of the ice machine a hazard and was not sure who was responsible for the ice machine. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 8/20/2024 at 2:24 PM, LVN L said the night nurses check the refrigerators, perform temperature checks, and clean them out. She said a resident could get food poisoning and experience diarrhea or severe food poisoning. She said food opened should have been dated. LVN L said food should have been labeled and dated. LVN L said the blanket on the floor in front of the ice machine was a trip hazard. She said a resident couldor fall and hit their head, get a break, or brain bleed. LVN L said she thought maintenance was responsible for the ice machine. During an interview on 8/20/2024 at 2:33 PM, the ADON said the nurses were to check the refrigerator temperatures nightly and the CNA's and Aides were supposed to clean out the refrigerators. She said the housekeepers would also check the refrigerators. The ADON said there was not a schedule the facility goes by. The ADON said a resident could become sick if they ate something that had spoiled in their refrigerator. The ADON said the residents were not responsible for cleaning out their refrigerator. The ADON said she does not expect the sandwich dates on the refrigerated foods brought from home but if the facility prepared or was provided to the resident, she said it should be labeled and dated. The ADON said she noticed the blanket in front of the ice machine and said the facility recently had someone come out and work on the ice machine. The ADON said the blanket in front of the ice machine could cause a fall resulting in a break or injury. During an interview on 8/20/2024 at 2:49 PM, the DON said Resident #16 does not like you touching her things. The CNA would often go through the resident's refrigerator and take out the outdated items. The DON said housekeeping only takes it out if it needs thawed or deep cleaned. The DON said outdated food could make the resident sick. The DON said she expected the CNAs to go through the refrigerator at least one time weekly to ensure nothing spoiled. The DON said the stove was not her department. She said they have a schedule and maintenance completes certain task. During an interview on 8/20/2024 at 3:06 PM, the ADM said the resident with the green sandwich does not let staff do for her. The ADM said everyone was responsible for ensuring refrigerators are clean. The ADM said the facility does Angel rounds. (Where staff assigned to residents and check on them). The ADM said she thought the policy was for refrigerators to check weekly if residents allow. The ADM said the night nurses check the refrigerator temperature logs. The ADM said the sandwiches would be dated if it came out of the kitchen. She said it had the potential to make a resident sick if a food was outdated or spoiled. The ADM said the blanket in front of the ice machine looked tacky, but it kept water off the floor from the ice machine. She said the ice machine guard was broken. The ADM said the facility was going to reach out to have it serviced to fix the issue. She said the blanket was used to keep water off the floor. The ADM said it was a potential for injury as well as water on the floor could cause injury. She said she expected the ice machine to have the appropriate guard on it. The ADM said the dietary staff were responsible for cleaning the stove. The ADM said she did not think it was grease on the stove and said it was part of the stove. During an observation and interview on 8/20/2024 at 3:30 PM, the ADM and the Dietary Manager revisited kitchen to inspect the iron gas stove black buildup. The Dietary Manager removed the iron stove top and observed a sugar packet under the stove top burner. The ADM removed the sugar packet and threw it in the trash. The ADM said the black buildup on the iron gas stove was part of the stove. The Dietary manager was holding the stove top and around the edges was additional black buildup on the iron top. The Dietary Manager obtained a metal brush with a metal scrapper and started scaping the edges of the stove top and black particles started falling into the sink. The ADM acknowledged the particles but was unsure of the cause of the buildup. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 8/20/2024 at 3:34 PM, the Clinical Operations brought a small sample of black particles from the stove in the palm of his hand and was informed the black particles were carbon build up on the stove and it would just come back. Record review of FDA Food code dated 2022 Chapter 4 (A) Equipment food-contact surfaces and utensils shall be clean to sight and touch. (B) The Food-contact surfaces of cooking equipment and pans shall be free of encrusted grease deposits and other coil accumulations. (C) Nonfood-contact surfaces of equipment shall be kept free of an accumulation of dust, dirt, food residue, and other debris. Record review of the facility's undated policy titled Kitchen Sanitation and Cleaning Schedules revealed All surfaces, including floors, walls, storage shelves. Prep tables, trash cans, and all food contact surfaces must be routinely cleaned and sanitized. Ceilings, vents, light fixtures, pipes, and any other potentially contaminated surface will be cleaned as needed. All equipment must be thoroughly washed and sanitized between uses, in different food preparation tasks and anytime contamination occurs or was suspected. Cleaning schedules: cleaning schedules are posted at the beginning of each day, week, or month in the kitchen depending on the type of schedule. It was the responsibility of the team member to follow the cleaning schedule and to complete as indicated. Sigh the cleaning schedule once the task was completed. Record review of the facility's policy dated 9/11/2023 titled Personal Resident Refrigerator revealed This facility does not provide a refrigerator in a resident's room. However, it was the policy of this facility to ensure safe and sanitary use of any resident-owned refrigerators. Policy explanation and compliance guidelines: 1. Dormitory-sized refrigerators are allowed in a resident's room under the following conditions: a. The refrigerator was inspected by maintenance personnel and deemed safe prior to use and upon routine inspection. b. The refrigerator maintains proper temperatures. e. The resident complies with the facility's policy for use of refrigerators. 2. Maintenance staff or designee shall record refrigerator temperatures weekly on a temperature log attached to the refrigerator. 3. Housekeeping and or nursing staff as assigned shall clean the refrigerator weekly and discard any foods that are out of compliance. 4. Residents and staff will comply with safe food handling and storage principals: Perishable foods such as dairy products, meat, and processed foods made with perishable foods or eggs will be stored immediately upon receipt. b. Leftovers shall be dated upon receipt and discarded withing three days. c. Foods with use-by dates shall be discarded accordingly.

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	455963	A. Building B. Wing	08/20/2024

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46929 Based on observations, interviews, 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 2 of 2 residents (Resident #19 and Resident #23) reviewed for incontinent care and 3 of 5 (Resident #5, Resident #18, and Resident #22) reviewed for Covid-19 infection control practices. 1.The facility failed to ensure MA A wore an N95 mask when entering Covid positive Resident #19 and #22's room. 2. The facility failed to ensure MA A changed her mask after leaving Covid positive Resident #19 and #22's room and entering another non-isolation room. 3. The facility failed to ensure CNA P and Housekeeper Q wore proper PPE in Resident #5's room on 08/18/24 and 08/19/24. Resident #5 was COVID-19 positive. 4. The facility failed to ensure CNA P changed her gloves and performed hand hygiene appropriately while providing incontinent care to Resident #18. 5. The facility failed to ensure LVN L changed her gloves and performed hand hygiene appropriately while providing incontinent care to Resident #23. These failures could place residents at risk of exposure to communicable diseases, cross-contamination, and infections. Findings included: 1. Record review of Resident #19's face sheet, dated 08/20/24, indicated he was a [AGE] year-old male, admitted to the facility on [DATE]. His diagnoses included chronic obstructive pulmonary disease (A lung disease that limits airflow and causes breathing problems), and cough. Record review of Resident #19's progress note, dated 08/15/24, indicated that Resident #19 tested positive for covid-19 on 08/15/24. Record review of Resident #19's progress note, dated 08/16/24, indicated he was placed on isolation precautions related to a positive covid-19 test. 2. Record review of Resident #22's face sheet, dated 08/20/24, indicated he was a [AGE] year-old male, admitted to the facility on [DATE]. His diagnoses included bipolar disorder (a mental illness that causes unusual shifts in a person's mood, energy, activity levels, and concentration), and Parkinson's disease (a progressive disorder that affects the nervous system and the parts of the body controlled by the nerves). Record review of Resident #22's progress note, dated 08/15/24, indicated that Resident #19 tested positive for covid-19 on 08/15/24. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #22's progress note, dated 08/16/24, indicated he was placed on isolation precautions related to a positive covid-19 test. During an observation on 08/19/24 at 08:54 AM, MA A donned a gown, gloves, and face shield. She was already wearing a surgical mask. She did not don an N95 Mask. She entered the room of Resident #19 and Resident #22. Both residents in the room were Covid positive. before leaving the room, she doffed her face shield, gown and gloves. She did not remove her surgical mask. After this MA A entered another resident's room that was not covid positive, while wearing the same surgical mask. During an interview on 08/19/24 at 09:40 AM, the DON said the staff should be wearing an N95 mask while in a covid positive resident's room. She said that was what the corporate director said they should be doing. she said she was going to conduct an in-service with the staff. During an interview on 08/19/24 at 09:49 AM, the Director of Clinical Operations said he expected the staff to wear an N95 when entering a Covid positive resident's rom. He said it was not in the policy, but it was a corporate preference. During an interview on 08/20/24 at 01:42 PM, MA A said she should have worn a N95 mask when she went into the covid positive resident's room. She said she also should have changed her mask after she left the covid room before she went into another resident's room. She said the ADON and DON monitors the staff for infection control compliance. During an interview on 08/20/24 at 01:56 PM, the ADON said she expected MA A to wear a N95 mask when going into a covid positive resident's room. She said MA A should have changed masks after being in the covid positive room. During an interview on 08/20/24 at 02:01 PM, the DON said she expected MA A to wear an N95 and change the mask after wearing it in the covid positive resident's room. During an interview on 08/20/24 at 02:09 PM, the Administrator said she expected MA A to follow the facility's policy and change her mask once she had left the room. 44933 3. Record review of Resident #5's face sheet dated 08/20/24 indicated Resident #5 was a [AGE] year-old female admitted on [DATE] with diagnosis including acute respiratory infection (is a serious infection that prevents normal breathing function). Record review of Resident #5's annual MDS assessment dated [DATE] indicated Resident #5 was usually understood and usually understood others. Resident #5 had a BIMS score of 10 which indicated moderate cognitive impairment. Record review of Resident #5's care plan dated 08/14/24 indicated Resident #5 was COVID-19 positive. Interventions included follow principles of infection control and universal/standard precautions and isolation precautions. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation and interview on 08/18/24 at 4:25 p.m., Resident #5's door had a posting on instruction for donning and doffing PPE. A sign was posted that stated, full PPE required. Resident #5 asked the surveyor what was on my face. The surveyor asked Resident #5 did staff wear face shield when the entered her room. Resident #5 paused the replied, yes. CNA P entered Resident #5's room to answer her call light. CNA P had on gown, gloves, and regular mask. CNA P did not have on a face shield/googles or N-95 mask. CNA P raised Resident #5's bed and handed Resident #5 her tumbler of water. During an observation on 08/19/24 at 9:17 a.m., Housekeeper Q stood outside of Resident #5's room. Housekeeper Q had on 2 regular face mask, gown, booties, and gloves. Housekeeper Q did not have one face shield/googles or N-95 mask. Housekeeper Q entered Resident #5's room. During an interview on 08/19/24 at 9:40 a.m., the DON said she did not know the facility's policy on which mask had to worn in COVID-19 positive rooms. She said she would look at the policy and let this surveyor know. During an interview on 08/20/24 at 2:30 p.m., Housekeeper Q said she wore a gown, gloves, regular mask, and booties when she went into Resident #5's room on 08/19/24. She said she had on a regular mask when she went into Resident #5's room. She said until today that N-95 masks had to be worn in COVID positive rooms. She said she was also told face shields were optional. She said face shields and N-95 mask were important because COVID can get into body fluids. She said it was important not spread the virus to other residents. 4. Record review of Resident #18's face sheet dated 08/18/24 indicated Resident #18 was a [AGE] year-old, female and admitted on [DATE] with diagnoses including hemiplegia (paralysis of one side of the body) and hemiparesis (is one-sided muscle weakness) following cerebral infarction (stroke) affecting left non-dominant and urinary tract infection (is an infection in any part of your urinary system: kidneys, bladder, ureters, and urethra). Record review of Resident #18's quarterly MDS assessment dated [DATE] indicated Resident #18 was usually understood and usually understood others. Resident #18 had a BIMS score of 08 which indicated moderate cognitive impairment. The MDS assessment indicated Resident #18 was dependent for toilet hygiene. Resident #18 was always incontinent for urinary and bowel. Record review of Resident #18's care plan dated 07/28/24 indicated Resident #18 experienced bladder incontinence related to cerebral vascular accident (brain attack). Intervention included provide incontinence care after each incontinent episode. During an observation on 08/19/24 at 8:56 a.m., CNA B and CNA P provided Resident #18 incontinent care. During incontinent care, CNA B accidentally knocked over the bottle of hand sanitizer on to the floor. Resident #18 had urine saturated brief, cloth under pad, and bed sheet. CNA P removed Resident #18's soiled linens and placed it in a clear bag. CNA P then attached a clean bed sheet to the top and bottom part of mattress without changing gloves. CNA P then grabbed Resident #18's cloth under pad and moved Resident #18 up in the bed with the same gloves as she removed the soiled linens. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5. Record review of Resident #23's face sheet dated 08/18/24 indicated Resident #23 was a [AGE] year-old male and admitted on [DATE] with diagnoses including pressure ulcer (an injury that breaks down the skin and underlying tissue) of sacral region, stage 4, pressure ulcer and pressure ulcer of other site, stage 3, and cerebral infarction (stroke). Record review of Resident #23's admission MDS assessment dated [DATE] indicated Resident #23 was usually understood and usually understood others. Resident #23 had minimal difficulty hearing, clear speech, impaired vision without corrective lenses. Resident #23's BIMS score was 10 which indicated moderately impaired cognition. Resident #23 used a wheelchair for mobility. Resident #23 required partial assistance for eating, oral hygiene, upper body dressing, substantial assistance for personal hygiene, and dependent for shower/bathe self and lower body dressing on admission performance. Resident #23 urinary continence was not rate and was always incontinent for bowel continence. Record review of Resident 23's care plan dated 07/02/24, edited 07/24/24 indicated Resident #23 was continent of bladder and use a urinal. Resident #23 was at risk for urinary tract infections due to history of UTIs. Intervention included keep perineal area clean and dry. During an observation on 08/19/24 at 3:17 p.m., the ADON, with the assistance of LVN L provided wound and incontinent care on Resident #23. During wound care of Resident #23, the ADON noticed he had formed stool between his buttocks. The ADON cleaned Resident #23, changed gloves and reapplied barrier cream to site. Resident #23 was on his right side facing the wall. LVN L placed a new brief under Resident #23. Resident #23 laid over the new brief. LVN L grabbed peri wipes and cleaned Resident #23's peri area. LVN L, without changing her gloves, closed the tabs on Resident #23 brief. LVN L then turned Resident #23 on his left side with the same gloves to position him for wound care on his stump. During an interview on 08/19/24 at 2:00 p.m., CNA P said she had worked at the facility since February 2023. She said yesterday (08/18/24) when she entered Resident #5's room, she only had on a regular face mask, gown, and gloves. She said she had on a regular face mask because until today, they had not been told N-95 mask had to be worn. She said when the COVID outbreak started, she had been told to use the supplies in the caddies outside of the resident's door. She said in Resident #5's caddie was only a gown, gloves, and regular masks. She said she realized yesterday when she saw the surveyor in Resident #5's room, she needed to wear a face shield. She said it was important to wear face shields and N-95 masks because of the resident's droplet from coughing could be in the air. She said those droplets could get on the face without a face shield and N-95 mask. She said when face shields or N-95 masks were not worn in a COVID positive room, it could be transmitted to yourself and other residents. She said the facility provided an in-service when the outbreak started. She said the in-service was placed on the nurse's station and she signed it. CNA P said during incontinent care on Resident #18, she recalled removing her gloves after placing the soiled linen a bag. She said she placed the gloves in the bag with the soiled linen then grabbed new gloves from the dresser. During an interview on 08/20/24 at 1:40 p.m., CNA B said he could not recall what CNA P did after she removed Resident #18's soiled linen on 08/19/24. He said if she removed her gloves after touching the soiled linens, she was supposed to use hand sanitizer or wash her hands before putting on new gloves. He said it was important to use hand sanitizer or wash her hands after gloves were removed to ensure hands were cleaned after removal. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455963	A. Building B. Wing	08/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Carthage Healthcare Center	701 S Market St Carthage, TX 75633

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 08/20/24 at 2:15 p.m., LVN L said gown, gloves, face mask, and booties were supposed to worn in COVID positive rooms. She said the facility told staff N-95 mask and face shields were optional and personal preference. She said N-95 mask and face shields were important for COVID positive residents because of the droplets. She said if proper PPE was not worn, COVID could be spread to residents and family. She said residents already had poor immune systems and impaired healing process. During an interview on 08/20/24 at 2:40 p.m., the ADON said she was the Infection Control Preventionist. She said the facility interpreted that the type of face mask and to wear a facial shield was optional in the COVID-19 policy. She said after confirming with corporate, N-95 masks and face shields were required to enter a COVID positive room. She said the facility gave 2 in-services on COVID-19 when the outbreak happened on 08/14/24. She said N-95 mask and face shields were important, so the virus was contracted and spread to residents and staff members. She said during incontinent care, staff should place dirty linen in a bag and close it. She said staff should then remove gloves, perform hand hygiene, and place new gloves on before touching clean items. She said hand hygiene was the first defense to stop the spread of infection and viruses. She said LVN L should have removed her gloves, perform hand hygiene and place on new gloves before she touched the resident and attached straps on Resident #23's brief. She said not changing gloves and touching clean items was cross contamination. She said LVN L touched urine and possible feces which could have been transferred to Resident #23's linens and other things. She said LVNs were expected to be competent performing incontinent care. She said LVNs had also had in-services on peri care. During an interview on 08/20/24 at 3:56 p.m., the DON said she expected staff to change gloves after performing a dirty task. She said staff should remove their gloves then perform hand hygiene before place on new gloves. She said when dirty gloves were not changed, or hand hygiene not performed bacteria could spread and germs placed in clean area. She said peri care and hand hygiene competencies were performed upon hire and annually. During an interview on 08/20/24 at 4:25 p.m., LVN L said during wound and incontinent care on Resident #23 she did remember cleaning his peri area then attaching his brief without changing gloves. She said she did not recall touching Resident #23 with dirty gloves. She said she should have removed the dirty gloves, washed her hands then attached his brief. She said not changing her gloves then touching things was cross contamination. During an interview on 08/20/24 at 4:30 p.m., the ADM said she expected staff to perform hand hygiene after touching dirty items. She said staff were trained on hand hygiene and performing proper peri care upon hire and annually. She said it was important for infection control. She said it was the charge nurse, DON and ADON, who was the ICP, to ensure staff were performing hand hygiene and proper peri care. Record review of LVN L's Hand Hygiene Competency Validation by the ADON dated 01/31/24 indicated LVN L was competent for hand hygiene with soap and water and hand hygiene with ABHR. Record review of CNA P's Hand Hygiene Competency Validation by the ADON dated 01/26/24 indicated CNA P was competent for hand hygiene with soap and water and hand hygiene with ABHR. Record review of CNA P's Perineal Care Return Demonstration by the ADON dated 02/01/24 indicated CNA P correctly completed. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	*This guidance applies to all U.S. settings where healthcare is delivered, including nursing homes and home health. The recommendation in this guidance continue to apply after the expiration of the federal COVID-19 Public Health Emergency . .2. Recommended infection prevention and control (IPC) practices when caring for a patient with suspected or confirmed SARS-CoV-2 infection The IPC recommendations described below .also apply to patients with symptoms of COVID-19 . .Personal Protective Equipment *HCP who enter the room of a patient with suspected or confirmed SARS-CoV-2 infection should adhere to Standard Precautions and use a NIOSH Approved particulate respirator with N95 filters or higher, gown, gloves, and eye protection . Record review of a facility's Handwashing/Hand Hygiene policy revised 01/20/23 indicated .the facility considers hand hygiene the primary means to prevent the spread of infections .all personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infection to other personnel, residents, and visitors .hand hygiene must be performed prior to donning and after doffing gloves .hand hygiene is the final step after removing and disposing of personal protective equipment .