STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	45F497	A. Building B. Wing	08/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hansford Manor	707 S Roland St Spearman, TX 79081

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48161 Based on interview and record review, the facility failed to complete an assessment that accurately reflected the resident's status for 1 of 14 residents (Resident #4) reviewed for accuracy of MDS assessments. The facility failed to complete an accurate assessment for Resident #4, the assessment indicated she received insulin and did not. This failure could affect residents by placing them at risk for not receiving adequate care and services. Findings included: Record review of Resident #4's face sheet revealed a [AGE] year-old female admitted on [DATE] with diagnoses to include but not limited to hereditary motor and sensory neuropathy (nerve damage in the arms and legs), bipolar disorder, type 2 diabetes mellitus (high blood sugar levels), and chronic pain. Record review of Resident #4's Annual MDS assessment dated [DATE] revealed Resident #4 had a BIMS score of 13 out of 15 which indicated that she was cognitively intact. The MDS indicated in Section N0300 (Injections) that Resident #4 received 1 insulin injection from the 7 days during the MDS look back period. Record review of Resident #4's physician orders revealed no order for insulin injections. Orders for Ozempic . 5 mg given subcutaneously in the afternoon every Wednesday related to type 2 diabetes mellitus dated 04/24/2024. Record review of Resident #4's Care plan dated 06/27/2024 indicated resident had Diabetes Mellitus with interventions of dietary consult for nutritional regimen and ongoing monitoring. No insulin injections were identified in the care plan. Record review of Resident #4's Medication Administration Record for June 2024 did not indicate any insulin injections were administered. (continued on next page)

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

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

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 08/20/2024 at 11:05 AM, Resident #4 stated that she does not take any insulin but was taking a medication called Ozempic for weight loss and that she was pre diabetic. Resident #4 stated that she does not get a lot of exercise being in a wheelchair, so the Ozempic was helping her lose weight. During an interview on 08/21/2024 at 9:14 AM, the ADM stated that she looked at the MDS Assessment for Resident #4 and stated that she saw where the MDS Coordinator marked insulin injections and stated that it must have been a typo. The ADM stated she could not argue that it was a mistake. During an interview on 08/21/2024 at 9:34 AM, the DON stated the MDS Coordinator was responsible for putting information in the MDS Assessment and that if that information was wrong it could affect the payrate and care of a resident. During an interview on 08/21/2024 at 9:43 AM, LVN A stated the MDS Coordinator was responsible for putting information in the MDS Assessment. LVN A stated that a possible negative outcome for putting wrong information in the MDS Assessment would be that a resident could get insulin instead of the accurate medication. During an interview on 8/21/2024 at 9:44 AM, the ADON stated the negative outcome for wrong information being in the MDS Assessment would be that the payrate for CMS would be wrong. During an interview on 08/21/2024 at 9:51 AM, the MDS Coordinator stated that the look back period for medication was 7 days for the MDS Assessment and she used the Resident Assessment Instrument for guidance. The MDS Coordinator stated that she was responsible for putting the information in the MDS Assessment and stated that she made a mistake by indicating that the resident was taking insulin when she was not. Record review of Resident Assessment Instrument (RAI) via CMS website. Section N: Medications Intent: The intent of the items in this section is to record the number of days, during the last 7 days that any type of injection, insulin, and or select medication were received by the resident. Steps for Assessment: 1. Review the resident's medication administration records for the 7-day look-back period (or since admission/entry or reentry if less than 7 days). 2. Review documentation from other health care locations where the resident may have received injections while a resident of the nursing home (e.g., flu vaccine in a physician's office, in the emergency room - as long as the resident was not admitted). 3. Determine if any medications were received by the resident via injection. If received, determine the number of days during the look-back period they were received.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 46534 Based on observation, interview, and record review the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment and describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being for 2 (Resident #28 and Resident #101) of 14 residents reviewed for care plans. The facility failed to include bed rail use in the care plans of Resident #28 and Resident #101. These failures could place residents at risk of harm due to incorrect care and/or lack of monitoring. Findings Included: 1. Record review of Resident #28's admission record dated 08/19/24 revealed a [AGE] year-old male admitted to the facility on [DATE] with diagnoses that included, but were not limited to, dementia (a group of thinking and social symptoms that interferes with daily functioning), anxiety disorder (mental disorder characterized by significant and uncontrollable feelings of anxiety and fear), osteoarthritis (degenerative joint disease), muscle weakness, hallucinations (sensory experiences that appear real but are created by your mind), and repeated falls. Record review of Resident #28's quarterly MDS completed on 08/01/24 revealed the following: Section C: Resident #28 had no BIMS score but staff assessment of resident indicated severely impaired cognition. Section GG: Resident #28 used a w/c and was dependent on staff for all ADLs. Section I: Resident #28's primary medical condition was non-traumatic brain dysfunction. Section J: Resident #28 had one fall with no injury since his previous assessment. Section N: Resident #28 received antipsychotic, antianxiety, antidepressant, and opioid medications. Section O: Resident #28 received hospice services while a resident. Record review of Resident #28's care plan completed on 07/30/24 revealed he had impaired cognitive function and was at high risk for falls. The care plan made no mention of bed rails. Record review of Resident #28's Admit/Readmit Screener dated 04/14/23 revealed it was a reentry and right and left side half rails would be used. Side Rails are indicated and serve as an enabler to promote independence. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #28's order tab in his EHR revealed the following order: Resident may use enabler for bed mobility dated 04/14/23. Record review of Resident #28's Consent for Side Rails form revealed it was signed and dated by his family member on 01/31/20. During an observation on 08/19/24 at 10:57 AM Resident #28 was lying in his bed with eyes closed. He had a bed rail in the upright position on the top left side of the bed. During an observation on 08/20/24 at 01:55 PM Resident #28 was in his bed on his back with eyes closed. HOB was raised almost to sitting. Bed rail on the left side of the bed was in upright position. The bed was against the wall on the right side of the bed. 2. Record review of Resident #101's admission record dated 08/20/24 revealed a [AGE] year-old male admitted to the facility on [DATE] with diagnoses that included, but were not limited to, dementia (a group of thinking and social symptoms that interferes with daily functioning), insomnia (problems falling and staying asleep), and muscle weakness. Record review of Resident #101's MDS face sheet in the EHR revealed and admission MDS in progress. When this record was viewed Section C was completed and indicated a BIMS score of 3 which indicated severely impaired cognition. Record review of Resident #101's care plan initiated on 08/13/24 revealed he used antianxiety medication and had limited physical mobility due to weakness. Record review of Resident #101's order summary report dated 08/20/24 revealed the following order: Resident may use enabler for bed mobility dated 08/12/24. Record review of Resident #101's Admit/Readmit Screener dated 08/13/24 revealed 1/4 rails would be utilized for bed mobility. Record review of Resident #101's Consent for Side Rails form revealed he signed and dated the form on 08/12/24. During an observation on 08/19/24 at 10:57 AM Resident #101 was lying on his back in bed with his eyes closed. Bilateral bed rails were in upright position on the top half of the bed. During an observation on 08/20/24 at 06:49 AM Resident #101 was lying on his back in bed. Bilateral bed rails were in upright position on the top half of the bed. During an observation and interview on 08/20/24 at 08:57 AM Resident #101 was seated in his w/c next to his bed. He had a friend seated on end of his bed visiting with him. Bilateral bed rails were in upright position on the top half of Resident #101's bed. When asked if he used the bed rails for mobility, Resident #101 stared at the bed rail nearest him for approximately 10 seconds. When his friend patted the rail and asked if Resident #101 used it, Resident #101 said, There could be a better one, but it is okay. When asked if the bedrail helped him move around in his bed, Resident #101 said, Yes. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 08/21/24 at 12:05 PM MDS Coordinator stated she was responsible for putting nursing information in the care plan including information regarding bed rails. She stated bed rails utilized in the facility were for mobility. She stated a possible negative outcome of not having bed rails listed in the care plan was that staff would not know they were used for mobility. During an interview on 08/21/24 at 12:15 PM ADM stated MDS Coordinator was responsible for putting bed rail use in the care plans of residents who used bed rails. She stated residents could die or could get hung up in the bed rails if they were not care planned for bed rail use. ADM stated having bed rail use in the care plan was important because, We want to keep them (residents) safe. Record review of facility policy titled Proper Use of Bed Rails and dated 10/02/24 revealed in part: . The facility will continue to provide necessary treatment and care to the resident who has bed rails in accordance with professional standards of practice and the resident's choices. Direct care staff will be responsible for care and treatment in accordance with the plan of care. The interdisciplinary team will make decisions regarding when the bed rail will be use [sic] or discontinued, or when to revise the care plan to address any residual effects of the bed rail. Record review of facility policy titled Care Plans and dated 04/12/23 revealed in part: . It is the policy of [NAME] Manor to provide care and services to each resident based on a plan of care. The plan o care is developed through the collaborative assessment of an interdisciplinary team, in conjunction with the resident, the resident's family or representative, and the attending physician. A. Baseline care plan will be: . Include the minimum healthcare information necessary to properly care for a resident including . 2. Physician orders . 3. The admitting nurse, or supervising nurse on duty, shall gather information from the admission physical assessment, . physician orders . The comprehensive care plan: 1. RAPs (Resident Assessment Protocol) provide criteria that trigger review of possible problem conditions to ensure that staff has identified the problems in a consistent and systematic manner. D. The care plan must include but is not limited to: . The care plan will attempt to manage resident risk Factors [sic] . Services that are furnished to attain or maintain the resident's highest practicable physical, mental and psychosocial well-being. E. The care plan will be periodically reviewed and revised as the resident's status changes, and services provided must be in accordance with each resident's written plan of care. Record review of facility policy title Care plans-Interdisciplinary Team and dated 01/09/18 revealed in part: . [NAME] Manor Care Planning/Interdisciplinary Team is responsible for the development of an individualized comprehensive care plan for each resident. 48161

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46534 Based on observation, interview, and record review the facility failed to attempt to use appropriate alternatives prior to installing a side or bed rail for 2 (Resident #4 and Resident #101) of 14 residents reviewed for bed rails. The facility placed bed rails on the beds of Resident #4 and Resident #101 on the day the residents were admitted without attempting other interventions. These failures could place residents at risk of entrapment or injury due to bed rails. Finding included: 1. Record review of Resident #4's admission record dated 08/20/24 revealed a [AGE] year-old female admitted to the facility on [DATE] with diagnoses that included, but were not limited to, hereditary motor and sensory neuropathy (nerve damage that can cause pain, weakness, numbness, or tingling as well as motor symptoms like muscle weakness and loss of mass in different parts of the body characterized by impact on both afferent nerve cells [carry sensory information to the central nervous system] and efferent nerve cells [carry motor information away from the central nervous system]), bipolar disease (serious mental illness characterized by extreme mood swings such as extreme excitement or extreme depressive feelings), macular degeneration (medical condition resulting in blurred or no vision in the center of the visual field), and insomnia (problems falling and staying asleep). Record review of Resident #4's annual MDS completed on 06/20/24 revealed the following: Section B: Resident #4 required corrective lenses. Section C: Resident #4 had a BIMS score of 13 which indicated intact cognition. Section GG: Resident #4 had functional limitation in range of motion in both legs and utilized a w/c. She was independent in eating and required substantial/maximal assistance or was dependent across all other ADLs. Section I: Resident #4's primary medical condition was non-traumatic brain dysfunction. Section N: Resident #4 received antianxiety, antidepressant and opioid medications. Record review of Resident #4's care plan completed on 06/18/24 revealed Resident #4 was a moderate risk for falls, used an electric w/c, and had side rails for safety during care provision, to assist with bed mobility. Record review of Resident #4's Admit/Readmit Screener dated 06/28/23 revealed right and left half rails would be in use. Side rails are indicated and serve as an enabler to promote independence. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #4's order summary report dated 08/20/24 revealed the following order: Resident may use enabler for bed mobility dated 06/26/23. Record review of Resident #4's Consent for Side Rails form revealed she signed and dated the form on 06/28/23. During an observation on 08/19/24 Resident #4's bed had bilateral bed rails in upright position on the top half of the bed. During an observation on 08/20/24 at 11:05 AM Resident #4's bed had a bed rail in upright position on the right side of the top half of the bed. 2. Record review of Resident #101's admission record dated 08/20/24 revealed a [AGE] year-old male admitted to the facility on [DATE] with diagnoses that included, but were not limited to, dementia (a group of thinking and social symptoms that interferes with daily functioning), insomnia (problems falling and staying asleep), and muscle weakness. Record review of Resident #101's MDS face sheet in the EHR revealed and admission MDS in progress. When this record was viewed Section C was completed and indicated a BIMS score of 3 which indicated severely impaired cognition. Section GG was not yet complete. Record review of Resident #101's care plan initiated on 08/13/24 revealed he used antianxiety medication and had limited physical mobility due to weakness. Record review of Resident #101's order summary report dated 08/20/24 revealed the following order: Resident may use enabler for bed mobility dated 08/12/24. Record review of Resident #101's Admit/Readmit Screener dated 08/13/24 revealed 1/4 rails would be utilized for bed mobility. Record review of Resident #101's Consent for Side Rails form revealed he signed and dated the form on 08/12/24. During an observation on 08/19/24 at 10:57 AM Resident #101 was lying on his back in bed with his eyes closed. Bilateral bed rails were in upright position on the top half of the bed. During an observation on 08/20/24 at 06:49 AM Resident #101 was lying on his back in bed. Bilateral bed rails were in upright position on the top half of the bed. During an interview on 08/20/24 at 08:22 AM Resident #101's family member stated she did not remember signing anything regarding consent for bedrails for Resident #101. (continued on next page)

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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 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and interview on 08/20/24 at 08:57 AM Resident #101 was seated in his w/c next to his bed. He had a friend seated on end of his bed visiting with him. Bilateral bed rails were in upright position on the top half of Resident #101's bed. When asked if he used the bed rails for mobility, Resident #101 stared at the bed rail nearest him for approximately 10 seconds. When his friend patted the rail and asked if Resident #101 used it, Resident #101 said, There could be a better one, but it is okay. When asked if the bedrail helped him move around in his bed, Resident #101 said, Yes. During an interview on 08/21/24 at 10:38 AM LVN B stated the RNs were responsible for bed rail assessments at admission. During an interview on 08/21/24 at 10:43 AM RN C stated RNs did monthly bed rail assessments as part of the regular monthly assessment of each resident. RN C said RN D did initial bed rail assessments prior to or at admission. During an interview on 08/21/24 at 10:46 AM RN D stated when she admitted a resident, she encouraged families and residents strongly to forego bed rails. She stated the other nurses who worked with families at admission did the same. She stated they educated families and residents on the risks of bed rails. She stated families often wanted bed rails because they felt the bed rails would keep their loved ones from falling. She stated the facility tried to follow family wishes. RN D stated alternatives to bed rails would include a concave mattress, fall mats, bed alarms, and ensuring items of importance are within reach. RN D said, I feel like if they (families and residents) have been educated properly and they still choose them (bed rails) it is their prerogative. RN D did not respond with any possible negative outcome to residents of installing bed rails prior to trying alternatives. During an interview on 08/21/24 at 11:07 AM DON stated residents could be negatively impacted if bed rails were installed prior to attempting alternatives. She said, There are a lot of negative outcomes; limits mobility, potential for entrapment, risk of them climbing out of bed over the rails and getting injured. She stated residents and their families often wanted bed rails if they came from a hospital setting where bed rails were used. During an interview on 08/21/24 at 11:28 AM ADM stated residents could be injured if bed rails were installed prior to attempting alternatives. Record review of facility policy titled, Proper Use of Bed Rails and dated 10/02/23 revealed in part: . Appropriate alternative approaches are attempted prior to using be rails. Informed consent from the resident or resident representative must be obtained after appropriate alternatives have been attempted prior to installation and use of bed rails. 48161