STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675014	A. Building B. Wing	06/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Haskell Healthcare Center	1504 North First St Haskell, TX 79521

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42515 43150 Based on observations, interviews, and record reviews, the facility failed to ensure each resident was treated with respect, dignity, and care for each resident in a manner and in an environment that promotes the maintenance or enhancement of their quality of life, recognizing each resident's individuality and the facility failed to protect and promote the rights of the resident for 3 of 15 residents (Resident #7, Resident #17, and Resident #23) reviewed for resident rights in that: 1. The facility failed to have a privacy cover over the catheter drainage bag for Residents #7 and #17. 2. CNA B failed to provide complete privacy for Resident #7 during catheter care. 3. CNA C failed to provide complete privacy for Resident #23 during incontinence care. These failures could place residents at risk for diminished quality of life and loss of dignity and self-worth. The findings included: Resident #7: Record Review of Resident #7's face sheet, dated 06/12/24, revealed a [AGE] year-old male, who was admitted to the facility on [DATE] with a primary diagnosis of a stroke, anxiety, upper respiratory infection, difficulty in walking, muscle weakness, hypokalemia (low-potassium), insomnia, constipation, dementia, psychotic disturbance, mood disturbance, hypo-osmolality (a condition where the levels of electrolytes, proteins, and nutrients in the blood are lower than normal) and hyponatremia (a condition that occurs when the level of sodium in the blood is too low), high blood pressure, atherosclerotic heart disease (the build-up of fats, cholesterol, and other substances in and on the artery wall), hyperlipidemia (a condition in which there are high levels of fat particles in the blood), fatty liver, muscle wasting and atrophy, lack of coordination. (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record Review of Resident #7's Admission MDS dated [DATE] revealed Resident #7 had a BIMS of 4 which indicated Resident #7 was severely cognitively impaired. The MDS indicated that Resident #7 used extensive assistance for toilet use with substantial and max assistance. The MDS listed Resident #7 as urinary not rated due to catheter and bowel incontinent frequently. Record review of Resident #7's active physician orders revealed an order for: Foley catheter: size (30ml) 18 French, Diagnosis: Obstructive uropathy with a start date of 04/09/24. Record review of Resident #7's comprehensive care plan, last reviewed on 05/08/24 revealed a problem area: Category: Indwelling catheter .Approach: Provide catheter care per shift and as needed Observation on 06/11/24 at 2:23 PM revealed Resident #7 was sitting up in wheelchair with the catheter drainage bag hanging on bottom side of the wheelchair. There was no privacy cover noted over the catheter drainage bag. Clear, yellow urine was noted in the catheter drainage bag. Observation on 06/12/24 at 3:12 PM revealed CNA B provide incontinent care for Resident #7. CNA B closed Resident #7's door to perform catheter care. CNA B put on clean disposable gloves. CNA B removed Resident #7's clothing from the waist down. CNA B placed a towel underneath Resident #7. CNA B removed Resident #7's brief. CNA B did not have a curtain to close at the end of the resident's bed just the curtain in between to divide the residents. CNA B left the blinds open to the back parking lot exposing Resident #7. CNA B did not cover Resident #7 during catheter care. It was observed that Resident #7 did not have a bag to cover the catheter. Interview on 06/12/24 at 4:37 PM with CNA B revealed she knew she failed to provide privacy for the resident during incontinent care. CNA B stated she did intentionally not provide privacy for Resident #7, but she was tired due to not getting any sleep the night before and just overlooked that step. CNA B stated she had been trained in providing privacy for the residents by in-services every month. CNA B stated the negative potential outcome for not providing privacy was someone could walk in and see the resident naked. Resident #17: Record Review of Resident #17's face sheet, dated 06/13/24, revealed a [AGE] year-old male, who was admitted to the facility on [DATE] with diagnoses to include non-ST elevation (NSTEMI) myocardial infarction (heart attack), chronic obstructive pulmonary disease (lung disease), and obstructive and reflux uropathy (difficulty urinating). Record Review of Resident #17's comprehensive MDS dated [DATE] revealed Resident #17 had a BIMS of 15 which indicated Resident #17's cognition was intact. The MDS indicated that Resident #17 used extensive assistance for toilet use with substantial and max assistance. The MDS listed Resident #17 as having an indwelling catheter for urination. Record review of Resident #17's active physician orders revealed an order for: Foley catheter: size (30ml) 18 French, Diagnosis: Urinary outlet obstruction with a start date of 04/09/24. Record review of Resident #17's comprehensive care plan, last reviewed on 06/09/24 revealed a problem area: Category: Indwelling catheter .Approach: Provide catheter care per shift and as needed (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 06/11/24 at 2:55 PM revealed Resident #17 was sitting up in bed with catheter drainage bag hanging on side of bed. No privacy cover noted over urine drainage bag. Yellow urine noted in catheter drainage bag. Interview on 06/13/24 at 9:23 AM, Resident #17 stated he was bothered by his catheter drainage bag being uncovered and others being able to see his urine. Resident #17 stated he had not told anyone at the facility and did not remember who last changed it. Resident #23: Record Review of Resident #23 face sheet revealed a [AGE] year-old female, who was admitted to the facility on [DATE] with a primary diagnosis of Alzheimer's disease, edema (inflammation), depression, weakness, muscle wasting and atrophy, difficulty in walking, unsteadiness on feet, heartburn, stress fracture in pelvis, chronic pain syndrome, high blood pressure, hypokalemia (low potassium), hyperlipidemia (a condition in which there are high levels of fat particles in the blood), chronic atrial fibrillation (an irregular, often rapid heart rate that commonly causes poor blood flow). Record Review of Resident #23's Annual MDS dated [DATE] revealed Resident #23 had a BIMS of 3 which indicated the resident was severely cognitively impaired. The MDS indicated that Resident #23 as urinary and bowel always incontinent. Observation on 06/12/24 at 11:10 AM revealed CNA C provided incontinent care for Resident #23. CNA C closed Resident #23's door. CNA A performed hand hygiene and put on pair of disposable gloves. CNA C laid resident in the bed and removed her clothing from the waist down. CNA C removed the wet brief. CNA C left Resident #23 uncovered from the waist down. Resident #23 did not have a front curtain to close just one in the middle to divide residents. CNA C used the blanket to cover Resident #23's top half of her body and she had a shirt on and left the exposed bottom half uncovered. CNA C proceeded in providing and completing incontinent care and did not provide privacy for the resident. Interview on 06/12/24 at 1:15 PM with CNA C revealed she knew she should have provided privacy for Resident #23. CNA C stated she had been trained in privacy by in-services approximately monthly. CNA C stated if she were to run into the issue of a resident not having a curtain again, she would make sure to contact the maintenance guy to correct the issue. CNA C stated they may have taken the curtain down because it was dirty. CNA C stated the negative potential outcome of not providing privacy for the resident could make the resident feel embarrassed if someone were to walk in or expose the resident's private areas. Interview on 06/13/24 at 9:18 AM, LVN D stated they were trained to keep privacy covers over the catheter drainage bags. LVN D stated she only worked PRN and was unsure why Resident #7 and Resident #17 did not have privacy covers over their catheter drainage bags. LVN D stated the potential negative outcomes to the residents were dignity issues. Interview on 06/13/24 at 10:11 AM with the DON revealed the DON expected staff to protect resident privacy by closing curtains, doors, and blinds. The DON stated that he did provide in-services weekly for training. The DON stated the negative potential outcome of not providing privacy was exposing residents. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 06/13/24 at 10:32 AM, the ADM and DON both stated that the catheter drainage bags should be covered. The DON stated the facility only ordered catheter bags with a cover already in place, so he was unsure why Resident's #7 and #17 had catheter drainage bags without a cover. The DON stated both residents received Hospice services and maybe they changed their bags during a visit and forgot to tell the facility staff about it. The DON stated all staff were trained to look at the catheter drainage bags and make sure they had a cover. The DON stated a potential negative outcome to the residents was it could embarrass them. Record review of the facility's policy titled; Dignity date revised February 2021 revealed: Policy Statement: Each resident shall be cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life, and feelings of self-worth and self-esteem. Policy Interpretation and Implementation: 1. Residents are always treated with dignity and respect. 5. When assisting with care, residents are supported in exercising their rights. For example, residents are: A). groomed as they wish to be groomed. 11. Staff promote, maintain, and protect resident privacy, including bodily privacy during assistance with personal care and during treatment procedures. 12. Demeaning practices and standards of care that compromise dignity is prohibited. Staff are expected to promote dignity and assist residents, for example: a). helping the resident keep the catheter bags covered. b). promptly responding to a resident's request for toileting assistance

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42515 43150 46425 Based on interviews and record review, the facility failed to ensure all residents had the right to formulate advance directives for 3 of 15 residents (Residents #12, #17, and #34) reviewed for advanced directives, in that: The facility failed to ensure Residents #12, #17, and #34, who are listed as DNR (Do Not Resuscitate), had Out-of-Hospital Do Not Resuscitate (OOH-DNR) forms that were correctly filled out and did not have missed required information on the OOH-DNR. These failures could place residents at risk for not having their end of life wishes honored and incomplete records. Findings included: Resident #12 Record review of Resident #12's undated face sheet revealed a [AGE] year-old-female who was admitted to the facility on [DATE] had diagnosis which included Cerebral infarction (lack of blood supply to the brain), muscle weakness (decreased strength in muscles) and Type 2 Diabetes (problem with blood sugar). The face sheet indicated under the advance directive section - DNR-Do Not Resuscitate. Record review of Resident #12's physician order summary dated [DATE] reflected the following order: DNR-Do Not Resuscitate dated [DATE]. Record review of Resident #12's care plan, dated [DATE], reflected care plan for DNR. Record review of Resident #12's OOH-DNR form dated [DATE] reflected there was no physician's license number associated with the physician's signature, no printed name associate with the physician's signature and the physician had not signed the bottom of the OOHDNR. Resident #17 (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #17's undated face sheet reflected a [AGE] year-old-male who was admitted to the facility on [DATE] with diagnoses to include myocardial infarction (heart attack), chronic obstructive pulmonary disease (a group of lung diseases that block airflow and make it difficult to breath), acute upper respiratory infection, cellulitis (a common and potentially serious bacterial skin infection), urinary tract infection, dysphagia (difficulty swallowing), unsteadiness on feet, asymptomatic human immunodeficiency virus (HIV), hyperlipidemia (a condition in which there are high levels of fat particles in the blood), muscle weakness, alcoholic cirrhosis of the liver without ascites, portal hypertension (increased pressure within the portal venous system), alcohol induced chronic pancreatitis (viscous secretions that block small pancreatic ducts), emphysema (a type of lung disease that causes breathlessness), heart failure, anemia, type 2 diabetes, thiamine deficiency, vitamin deficiency, hypokalemia (low potassium), schizoaffective disorder bipolar type, anxiety, post traumatic stress disorder(trauma associated with witnessing a terrifying event), insomnia (trouble sleeping), polyneuropathy (when multiple peripheral nerves become damaged). The face sheet also revealed under the advance directive section - DNR-Do Not Resuscitate. Record review of Resident #17's physician order summary dated [DATE] reflected the following order: DNR-Do Not Resuscitate dated [DATE]. Record review of Resident #17's care plan, dated [DATE], reflected a care plan for DNR. Record review of Resident #17's OOH-DNR form date retrieved on [DATE] reflected there was no date or printed name next to Resident #17's signature, physician signature was dated as of [DATE] and notary signature was dated [DATE] on the OOHDNR. Resident #34 Record review of Resident #34's face sheet, dated [DATE], reflected an [AGE] year-old-male who was admitted to the facility on [DATE] with diagnoses to include unspecified fracture of right femur (right broken leg), other specified depressive episodes (mood disorder) and nonexudative age-related macular degeneration (eye disease). The face sheet also revealed under the advance directive section - DNR-Do Not Resuscitate. Record review of Resident #34's physician order summary dated [DATE] reflected the following order: Code Status: DNR-Do Not Resuscitate with a start date of [DATE]. Record review of Resident #34's care plan, last reviewed [DATE], reflected a care plan for DNR. Record review of Resident #34's OOH-DNR form date signed by Resident #34 was [DATE], reflected there was no physician's license number associated with the physician's signature, no printed name associated with the physician's signature, and no date associated with the physician's signature. During an interview on [DATE] at 12:15pm with the DON, he stated OOH DNR was not valid if it's not filled out correctly. He stated he was responsible for ensuring OOH-DNRs were completed correctly. He verified missing information on OOH-DNRs for Residents #12, #17, and #34. He stated there was no system for monitoring OOH-DNRs for accuracy. He stated the reason the DNR's were not complete was human error. He stated there was no potential negative outcome for residents as the staff would review other forms in the Residents' record to determine if a Resident was a DNR or Full Code. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on [DATE] at 12:35PM with the ADM, she stated the OOH DNR was not valid if not filled out correctly. She stated the DON was responsible for making sure the OOH DNR was completed accurately. She stated they did not have a system in place to monitor OOH DNR for accuracy. She stated the DON should be reviewing the OOH DNRs for accuracy. She verified missing information on OOH DNR for Residents #12, #17 and #34. She stated she did not know why the information was missing. She stated the potential negative outcome was nothing as this was only a paper mistake, the nursing staff would look at the care plan, face sheet for direction regarding a resident's end of life wishes. She stated she was trained on how to complete OOH DNR and her expectations were for them to be filled out completely and be correct. Record review of the Social Services Policies and Procedures Advanced Directives (Revised [DATE]) reflected the following: Policy Residents have the right to execute an advance directive specifying how decisions about the resident's care will be made. Advance Directives include written instructions about care and treatment and include such documents as Directive to Physician, Power of Attorney for Health Care, OOH DNR, and instructions for no CPR. The facility will also ensure the Care Plan, Physician's Orders, and Resident Banner. The Social Services Director will maintain a list of Residents with an Advanced Directive on file. A code status audit will be conducted by the DON or designee on a quarterly basis or designee on a quarterly or as needed basis. Record review of the facility's undated policy titled Advance Directives reflected no information regarding the creation of a OOH DNR.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 43150 Based on observation, interview and record review the facility failed to ensure drugs and biologicals used in the facility were labeled in accordance with currently accepted professional principles and included the appropriate accessory and cautionary instructions, and the expiration date when applicable and the facility failed to ensure, in accordance with State and Federal laws, all drugs and biologicals were stored in locked compartments under proper temperature controls, and permitted only authorized personnel to have access to the keys for 2 of 2 medication carts for 5 of 8 residents (Residents #3, #4, #8, #26, and #34) reviewed for medication administration. 1. LVN B failed to ensure Resident #34's medications were properly labeled as the medications were stored in an open medication cup in the medication cart top drawer. 2. LVN A failed to ensure Resident #26's medications were properly labeled as the medications were stored an in open medication cup in the medication cart. 3. LVN B failed to properly store medications for Resident #3 by leaving medications in an open medication cup on the medication cart, while administering a medication to Resident #34. 4. LVN A failed to properly transport medication by carrying medications in an open medication cup down the hall to Resident #4. The medication was identified by LVN A as tramadol. 5. LVN A failed to properly transport medication by carrying medications in an open medication cup down the hall to Resident #4. These failures could place residents at risk of not receiving prescribed medications as ordered and drug diversions. The findings include: 1. Record review of Resident #3's, undated, face sheet reflected an [AGE] year-old male who was admitted to the facility on [DATE]. Resident #3 had diagnoses which included fracture of right femur, depression, low blood pressure, rheumatoid arthritis, pain in right knew, muscle weakness, chronic kidney disease, difficulty in walking, age related cognitive decline, edema and fracture of one rib (an injury that occurs when one of the bones in the rib cage cracks). Record review of Resident #3's quarterly MDS, dated [DATE], reflected Resident #3 had a BIMs of 13, which indicated the resident was cognitively intact. Record review of Resident #3's physician orders, dated 7/24/2013, reflected: daily multivitamin with minerals OTC tablet, 1 tablet orally once a day, 8:00 AM. Record review of Resident #3's physician orders, dated 12/29/2018, reflected: Colace (docusate sodium) OTC capsule, 1 capsule orally twice a day, 8:00 AM, 8:00 PM (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #3's physician orders, dated 2/16/2022, reflected: baclofen tablet, 10 mg, 1/2 tablet orally three times a day, 8:00 am, 12:00 PM, 8:00 PM. Record review of Resident #3's physician orders, dated 02/16/2022, reflected: Sinemet (carbidopa levodopa) tablet 25-100 mg, 2 tablets orally, three times a day, 8:00 AM, 12:00 PM, 8:00 PM. Record review of Resident #3's physician orders, dated 10/16/2023, reflected: buspirone tablet, 5 mg, 1 tablet orally, once a day, 8:00 AM. Record review of Resident #3's physician orders, dated 10/30/2023, reflected: metformin tablet extended release 500 mg, 1 tablet orally, once a day, 8:00 AM Record review of Resident #3's physician orders, dated 03/21/2024, reflected: sertraline tablet 50 mg orally, once a day, 8:00 AM. 2. Record review of Resident #4's, undated, face sheet reflected a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #4 had diagnoses which included cerebral palsy (a congenital disorder of movement muscle tone or posture), viral pneumonia (an infection of your lungs caused by a virus), dysphagia (difficulty swallowing), psychotic disorder with hallucinations (seeing or hearing things that others do not such as hearing voices telling them to do something), convulsions (a condition in which the body muscles contract and relax rapidly and repeatedly resulting in uncontrolled shaking), acid reflux (a digestive disease in which stomach acid or bile irritates the food pipe lining), difficulty in walking, alcohol abuse with intoxication, depression, anxiety, high blood pressure, neuropathy (weakness, numbness, and pain from nerve damage, usually in the hands and feet), alcoholic cirrhosis (is severe scarring of the liver), gout (a disease in which defective metabolism of uric acid causes arthritis), muscle weakness, vitamin deficiency (a deficiency of one or more essential vitamins) and asthma (a chronic disease in which the bronchial airway in the lungs become narrowed and swollen making it difficult to breathe). Record review of Resident #4's Admission MDS, dated [DATE], reflected Resident #4 had a BIMs of 15, which indicated the resident was cognitively intact. Record review of Resident #4's physician orders, dated 11/24/2023, reflected: clonazepam, Schedule IV tablet, 0.5 mg, 1 tablet orally, three times a day, 8:00 AM, 12:00 PM, 7:00 PM. Record review of Resident #4's physician orders, dated 05/09/2024, reflected: gabapentin capsule, 100 mg, 2 capsules orally, special instructions: take 2 capsules 200 mg three times a day, 8:00 AM, 12:00 PM, 7:00 PM 3. Record review of Resident #8's, undated, face sheet reflected an [AGE] year-old male who was admitted to the facility on [DATE]. Resident #8 had diagnoses which included Alzheimer's disease, adult failure to thrive, history of falling, muscle weakness, atherosclerotic heart disease (a buildup of fats, cholesterol, and other substances in and on the artery wall), reduced mobility, disorientation, edema (inflammation), insomnia, aphasia (difficulty speaking), vitamin D deficiency, contracture of muscle, osteoarthritis (type of arthritis that occurs when flexible tissue at the ends of bones wear down), hypokalemia (low potassium), low back pain, constipation, acid reflux and anemia (a problem of not having enough healthy red blood cells or hemoglobin to carry oxygen to the body's tissues). (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #8's Significant change in status MDS, dated [DATE], reflected Resident #8 was listed as a 00, which indicated severe cognitive impairment. 4. Record review of Resident #26's, undated, face sheet reflected an [AGE] year-old male who was admitted to the facility on [DATE]. Resident #26 had diagnoses which included Alzheimer's disease, dehydration, bipolar disorder, acute upper respiratory infection, nocturia (frequent night time urination), urinary tract infection, vitamin deficiency, type 2 diabetes, neuropathy, muscle wasting and atrophy, chronic obstructive pulmonary disease (a group of lung diseases that block airflow and make it difficult to breathe), high blood pressure and hyperlipidemia (a condition in which there are high levels of fat particles in the blood). Record review of Resident #26's Quarterly MDS, dated [DATE], reflected Resident #26 had a BIMS (Brief Interview of Mental Status) of 11, which indicated the resident was cognitively moderately impaired. Record review of Resident #26's physician orders, dated 10/07/2022, reflected: carvedilol tablet, 3.125 mg, 1 tablet orally, special instructions: hold if systolic blood pressure is <100 and diastolic blood pressure is <50, once a day 8:00 AM. Record review of Resident #26's physician orders, dated 10/07/2022, reflected: fenofibrate nano crystalized tablet, 145 mg one tablet orally, once a day 8:00 AM. Record review of Resident #26's physician orders, dated 10/07/2022, reflected: fish oil capsule 1,000 mg (120 mg-180 mg) one capsule orally, once a day 8:00 AM. Record review of Resident #26's physician orders, dated 11/14/2022, reflected: lisinopril tablet 40 mg one tablet orally, once a day 8:00 AM. Record review of Resident #26's physician orders, dated 1/1/2023, reflected: gabapentin capsule 100 mg one capsule orally, three times a day 8:00 AM, 12:00 PM, 7:00 PM. Record review of Resident #26's physician orders, dated 8/17/2023, reflected: memantine tablet, 10 mg one tablet orally, twice a day, 8:00 AM, 7:00 PM. Record review of Resident #26's physician orders, dated 10/16/2023, reflected: aspirin OTC tablet, delayed release, 325 mg, one tablet orally, special instructions: cardiovascular risk reduction, once a day 8:00 AM. Record review of Resident #26's physician orders, dated 2/14/2024, reflected: escitalopram oxalate tablet, 5 mg, tablet orally, once a day, 8:00 AM. Record review of Resident #26's physician orders, dated 6/03/2024, reflected: Zyrtec 10 mg by mouth once a day, 8:00 AM. (continued on next page)

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	675014	A. Building B. Wing	06/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Haskell Healthcare Center	1504 North First St Haskell, TX 79521

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5. Record review of Resident #34's, undated, face sheet reflected a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #34 had diagnoses which included Alzheimer's disease, Parkinson's disease, dysarthria and anarthria (slurred speech and complete loss of speech), dysphagia (difficulty swallowing), aphasia (a language disorder that affects a person's ability to communicate), muscle wasting and atrophy, muscle weakness, dehydration, polydipsia (excess thirst), altered mental status, contracture of muscle, hematuria (blood in urine), dysuria (discomfort when urinating), need for continuous supervision, reduced mobility, vitamin D deficiency and functional dyspepsia, chronic indigestion. Record review of Resident #34's significant change in status MDS, dated [DATE], reflected Resident #34 had a BIMS (Brief Interview of Mental Status) of a 6, which indicated the resident was moderately impaired. Record review of Resident #34's physician orders, dated 4/15/2024, reflected: doxazosin tablet, 1 mg, one tablet orally, twice a day, 8:00 AM, 7:00 PM. Record review of Resident #34's physician orders, dated 4/15/2024, reflected: gabapentin capsule, 400 mg, 2 capsules orally, twice a day, 8:00 AM, 7:00 PM. Record review of Resident #34's physician orders, dated 4/15/2024, reflected: midodrine tablet, 5 mg, 1 tablet orally, twice a day, 8:00 AM, 7:00 PM. Record review of Resident #34's physician orders, dated 4/23/2024, reflected: furosemide tablet, 40 mg, 1 tablet orally, once a day, 8:00 AM. Record review of Resident #34's physician orders, dated 4/23/2024, reflected: hydrocodone-acetaminophen Schedule II tablet, 10-325 mg, 1 tablet orally, every 4 hours 8:00 AM, 12:00 PM, 4:00 PM, 8:00 PM, 12:00 AM, 4:00 PM. Observation on 06/12/2024 at 8:12 AM revealed LVN B had left medications in a medication cup on top of the medication cart, for Resident #3 while administering a medication to Resident #34. After LVN B attempted administering medication to Resident #34, LVN B carried an open cup of medications to administer to Resident #3 in the room. Resident #3 took the medications. The medications that were carried in an open medication cup from the medication cup to the dining room for Resident #3 were identified by LVN B as: baclofen tablet 10 mg (1 tablet), buspirone tablet 5 mg (1 tablet), Colace docusate sodium OTC capsule 100 mg (1 capsule), daily multivitamin OTC tablet (1 tablet), metformin tablet extended release 500 mg. (1 tablet), Sinemet (carbidopa-levodopa) tablet 25-100 mg (2 tablets) and sertraline tablet 50 mg (1 tablet). Observation on 06/12/2024 at 8:15 AM revealed LVN B stored medications in an open medication cup in the medication cart, in the top drawer for Resident #34LVN B identified the medications that were placed in an open medication cup as: doxazosin tablet 1 mg (1 tablet), furosemide tablet 40 mg (1 tablet), gabapentin capsule 400 mg (2 capsules), midodrine tablet 5 mg (1 tablet), sertraline tablet 50 mg (1 tablet), midodrine tablet 5 mg (1 tablet) and hydrocodone/acetaminophen Schedule II tablet 10-325 mg (1 tablet). Observation on 06/12/2024 at 8:23 AM revealed LVN A carry medication in an open medication cup down the hall to Resident #8's room. The medication was identified as tramadol by LVN A. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 06/12/2024 at 8:56 AM revealed LVN A stored medications in open medication cup in the medication cart for Resident #26. LVN A administered the open cup of medications to Resident #26 by carrying the open cup of medications into the dining room. The medications that were observed in the medication cup and stored in the medication cart were identified by LVN A as: aspirin OTC tablet 325 mg (1 tablet), carvedilol tablet 3.125 mg (1 tablet), fenofibrate nano crystalized tablet 145 mg (1 tablet), fish oil capsule 1,000 mg (1 capsule), gabapentin capsule 100 mg (1 capsule), lisinopril tablet 40 mg (1 tablet), memantine tablet 10 mg (1 tablet), Zyrtec 10 mg (1 tablet), escitalopram oxalate tablet 5 mg (1 tablet). LVN A stored the medications in her medication cart for 2 hours before administering them to Resident #26. Observation on 06/12/2024 at 11:05 AM revealed LVN A carried medications in an open medication cup down the hall to Resident #4. The medications were identified by LVN A as: clonazepam Schedule IV tablet 0.5 mg (1 tablet), gabapentin capsule 100 mg (1 capsule). Resident #4 took the medications. Interview on 06/12/2024 at 4:18 PM with LVN B revealed, she understood she was not supposed to store the medications in the medication cart in an open medication cup. LVN B stated that she had stored the medications in the medication cart because the resident had refused, and she was going to reattempt administration. LVN B stated she was trained in medication storage by in-services yearly. LVN B stated the policy stated not to store medications in the medication cart in open containers. LVN B stated it could accidentally be forgotten causing a missed dose or administered to the wrong resident. LVN B stated that the negative potential outcome was missed medications for the residents, or the wrong medication could be given to the wrong resident. Interview on 06/13/2024 at 2:13 PM with LVN A revealed medications should not be stored in an open medication cup in the medication cart. Medications should not be stored in this manner because it could cause the medication to be forgotten and cause a missed dose or could be accidentally given to the wrong resident. LVN A stated she knew Resident #26 would take the medications eventually and would refuse medications sometimes. LVN A stated the policy stated medications should be destroyed and not stored in the cart. LVN A stated she was trained in medication administration and medication errors by in-services monthly. LVN A stated the negative potential outcome would be missed medications. LVN A stated that she had stored the medications because the residents had refused, and she knows that they will take them eventually. Interview on 06/13/2024 at 2:36 PM with the DON and the Administrator revealed the Administrator expected nurses to give medications as soon as they were prepared. The Administrator and the DON expected medications to be kept in pill bottles or blister packs in the medication cart. The DON expected medications to be given as soon as they were prepared, or they should be destroyed if a resident refused. The DON stated , Nurses are trained to give the medications right away and it is unknown why they didn't. The DON stated the negative potential outcome was medication errors. Record review of the facility's provided policy, labeled, Storage of Medications,, date revised November 2020, reflected: .The facility stores all drugs and biologicals in a safe, secure, and orderly manner . 1. Drugs and biologicals used in the facility are stored in locked compartments under proper temperature, light, and humidity controls. Only persons authorized to prepare and administer medications have access to locked medications. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Drugs and biologicals are stored in the packaging, containers or other dispensing systems in which they are received. Only the issuing pharmacy is authorized to otr4ansfer medications between containers. 3. The nursing staff is responsible for maintaining medication storage and preparation areas in a clean, safe, and sanitary manner. 4. Drug contains that have missing, incomplete, improper, or incorrect labels are returned to the pharmacy for proper labeling before storing. Discontinued, outdated, or deteriorated drugs or biologicals are returned to the dispensing pharmacy or destroyed. 6. Compartments (including, but not limited to, drawers, cabinets, rooms, refrigerators, carts, and boxes), containing drugs and biologicals are locked when not in use.

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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. 42515 Based on observation, interview, and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety in 1 of 1 kitchen reviewed for dietary services. 1) The facility failed to keep freezer handles and microwave handles clean. These failures could place residents at risk for food contamination and foodborne illness. The findings included: Observation during a kitchen tour on 06/11/24 at 12:40 PM revealed 5 freezer door handles that were sticky with hard substances stuck to the inside and outside of the handle. Observation during a return visit to the kitchen on 06/13/24 at 8:46 AM revealed 1 microwave handle with several spots of hard substances stuck to the inside and outside of the handle. Interview on 06/13/24 at 10:17 AM, the DM stated all the dietary staff were responsible for kitchen cleanliness. The DM stated the night kitchen crew had a checklist to follow when closing up the kitchen and the day staff were responsible to keep up with the cleanliness throughout the day. The DM stated she was unsure why the freezer handles and the microwave handle was dirty. The DM stated most of the staff were new to the kitchen, including her, but all dietary staff received training on kitchen cleanliness upon hire. The DM stated a potential negative outcome to the residents was it could make them sick. Interview on 06/13/24 at 10:38 AM, the ADM stated she expected the dietary staff to keep up with kitchen cleanliness. The ADM stated the kitchen staff had a cleaning schedule to follow and was unsure why the freezer and microwave handles were dirty. The ADM stated the DM was responsible for monitoring the kitchen staff and keeping up with the cleanliness. The ADM stated she was unsure on training for the kitchen staff as she had not worked at the facility for more than 2 weeks. The ADM stated a potential negative outcome was it could cause problems with food and infection control concerns. Record review of the facility's policy and procedure titled, Kitchen Sanitation and Schedules, undated, reflected the following: All surfaces, including floors, walls, storage shelves, prep[preparation] 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 is suspected

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43150 Based on interview and record review the facility failed to ensure in accordance with accepted professional standards and practices, medical records maintained on each resident were accurately documented for 3 of 3 residents (Residents #3, #8 and #34) reviewed for accuracy of records. LVN A and LVN B failed to protect Residents #3, #8 and #34 information by leaving the computer screen up or halfway open with the resident's information up on the screen, while administering medications, and leaving the screen unattended. This failure could place residents at risk of having medical information exposed to others. Finding include: 1. Record review of Resident #3's, undated, face sheet reflected an [AGE] year-old male who was admitted to the facility 04/15/2024. Resident #3 had diagnoses which included fracture of right femur, depression, low blood pressure, rheumatoid arthritis, pain in right knew, muscle weakness, chronic kidney disease, difficulty in walking, age related cognitive decline, edema and fracture of one rib (an injury that occurs when one of the bones in the rib cage cracks) . Record review of Resident #3's quarterly MDS, dated [DATE], reflected Resident #3 had a BIMs (Brief Interview of Mental Status) of 13, which indicated the resident was cognitively intact. Observation on 06/12/2024 at 7:58 AM revealed the MAR for Resident #3 was exposed on LVN B's computer during medication administration. LVN B left her computer screen halfway up with Resident #3's information visible on the screen, on her medication cart while she administered medications and left the screen unattended. LVN B walked away and left the screen exposed while she administered medications to Resident #3 in her room. LVN B left her medication cart by the dining room where residents were eating breakfast. The information that could be observed is Resident #3's personal information such as: medications, resident name, physician, date of birth, and room number. 2. Record review of Resident #8's, undated, face sheet reflected an [AGE] year-old male who was admitted to the facility on [DATE]. Resident #8 had diagnoses which included Alzheimer's disease, adult failure to thrive, history of falling, muscle weakness, atherosclerotic heart disease (a buildup of fats, cholesterol, and other substances in and on the artery wall), reduced mobility, disorientation, edema (inflammation), insomnia, aphasia (difficulty speaking), vitamin D deficiency, contracture of muscle, osteoarthritis (type of arthritis that occurs when flexible tissue at the ends of bones wear down), hypokalemia (low potassium), low back pain, constipation, acid reflux and anemia (a problem of not having enough healthy red blood cells or hemoglobin to carry oxygen to the body's tissues). Record review of Resident #8's Significant change in status MDS, dated [DATE], reflected Resident #8 was listed as a 00, which indicated severe cognitive impairment. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 06/12/2024 at 8:56 AM revealed Resident #8's MAR was exposed, during medication administration on LVN A's computer. LVN A left her computer screens up with Resident #8's information visible on the screen, on her medication cart while she attempted to administer medications to another resident and left the screen unattended. 3. Record review of Resident #34's, undated, face sheet reflected a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #77 had diagnoses which included Alzheimer's disease, Parkinson's disease, dysarthria and anarthria (slurred speech and complete loss of speech), dysphagia (difficulty swallowing), aphasia (a language disorder that affects a person's ability to communicate), muscle wasting and atrophy, muscle weakness, dehydration, polydipsia (excess thirst), altered mental status, contracture of muscle, hematuria (blood in urine), dysuria (discomfort when urinating), need for continuous supervision, reduced mobility, vitamin D deficiency and functional dyspepsia (chronic indigestion). Record review of Resident #34's significant change in status MDS, dated [DATE], reflected Resident #34 had a BIMS (Brief Interview of Mental Status) of a 6, which indicated the resident was moderately impaired. Observation on 06/12/2024 at 8:13 AM revealed Resident #34's MAR was exposed, during medication administration on LVN B computer. LVN B left her computer screen halfway up with Resident #34's information visible on the screen, on her medication cart while she administered medications and left the screen unattended. LVN B left her screen exposed while she took the resident's medication to her in her room on hall A. The medication cart was parked by the dining room. The medication cart was not in LVN B's line of sight. Interview on 06/12/2024 at 4:18 PM with LVN B revealed understood she should not have left her screen half-way up with Resident #3's information on the screen and unattended. LVN B stated she was trained in protecting resident information by in-services every year if not more often. LVN B stated the negative potential outcome of not protecting resident information was it could cause all kinds of problems such as: the resident information being misused or stolen identity. LVN B stated she did not know what the facility policy stated about protecting the resident's information, but she did know the state law stated that violating HIPAA was prohibited. LVN B stated that she it is too hard to have to log in and out to administer medications. Interview on 06/13/2024 at 10:11 AM with the DON revealed expectation of staff was to protect resident information by shutting and locking the screen when they were away from the medication cart. The DON stated he did provide training by means of in-services monthly and quarterly. The DON stated the negative potential outcome of not protecting a resident's information was the information could be mishandled or misused. Interview on 06/13/2024 at 2:13 PM with LVN A revealed she knew staff needed to protect resident's information. LVN A stated policy stated to keep passwords private and don't expose resident information. LVN A stated she was trained in protecting resident information. LVN A stated her training included in services, every quarter. LVN A stated the negative potential outcome of not protecting resident information was someone could misuse their information or others finding out resident information. LVN A stated that she was in a hurry and did not completely close the screen. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the facility's policy titled; Confidentiality of Information and Personal Privacy, date revised October 2017, reflected: Policy Statement: Our facility will protect and safeguard resident confidentiality and personal privacy. Policy Interpretation and Implementation: 1. The facility will safeguard the personal privacy and confidentiality of all resident personal and medical records. 2. The facility will strive to protect the resident's privacy regarding his or her . b). medical treatment . d). personal care

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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** 42515 43150 Based on observation, interview and record review the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 7 of 7 residents (Residents #4, #7, #10, #18, #20, #26, and #34) reviewed for infection control 1. The facility failed to ensure LVN B washed her hands or used hand sanitizer prior to medication preparation or administration for Residents #4 during medication administration. 2. CNA B failed to wash her hands prior to gathering supplies for incontinent care for Resident 7. CNA B failed to wash her hands properly before providing incontinent care for Resident 7. 3. The facility failed to ensure LVN A washed her hands or used hand sanitizer prior to medication preparation or administration for Residents #4 and #26. 3. The facility failed to ensure CNA A washed her hands properly before and after providing incontinent care for Resident #10. CNA A washed her hands for 7 seconds before incontinent care and 5 seconds afterwards. The policy stated to wash hands for 20 seconds. 4. The facility failed to ensure LVN B washed her hands or used hand sanitizer before medication preparation for Resident #18 for medication administration. 5. The facility failed to ensure LVN B washed her hands or used hand sanitizer before medication preparation and administration for Resident #20. 6. The facility failed to ensure LVN A washed her hands or used hand sanitizer before medication preparation for Resident #26 during medication administration. 7. The facility failed to ensure LVN B washed her hands or used hand sanitizer before medication preparation for Resident #34. 8. The facility failed to ensure LVN B washed her hands or use hand sanitizer before medication preparation or administration for Resident #3. These failures could place residents at risk for the transmission of communicable diseases and infections. Findings include: (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1, Record review of Resident #3's, undated, face sheet reflected an [AGE] year-old male who was admitted to the facility 04/15/2024. Resident #3 had diagnoses which included fracture of right femur, depression, low blood pressure, rheumatoid arthritis, pain in right knew, muscle weakness, chronic kidney disease, difficulty in walking, age related cognitive decline, edema and fracture of one rib (an injury that occurs when one of the bones in the rib cage cracks) . Record review of Resident #3's quarterly MDS, dated [DATE], reflected Resident #3 had a BIMs (Brief Interview of Mental Status) of 13, which indicated the resident was cognitively intact. 2. Record review of Resident #4's, undated, face sheet reflected a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #4 had diagnoses which included cerebral palsy, viral pneumonia, dysphagia, psychotic disorder with hallucinations, convulsions, acid reflux, difficulty in walking, alcohol abuse with intoxication, depression, anxiety, high blood pressure, neuropathy, alcoholic cirrhosis, gout, muscle weakness, vitamin deficiency and asthma. Record review of Resident #4's Admission MDS, dated [DATE], reflected Resident #4 had a BIMs of 15, which indicated the resident was cognitively intact. Record review of Resident #4's physician orders, dated 11/24/2023, reflected: clonazepam, Schedule IV tablet, 0.5 mg, 1 tablet orally, three times a day, 8:00 AM, 12:00 PM, 7:00 PM. Record review of Resident #4's physician orders, dated 05/09/2024, reflected: gabapentin capsule, 100 mg, 2 capsules orally, special instructions: take 2 capsules 200 mg three times a day, 8:00 AM, 12:00 PM, 7:00 PM Observation on 06/12/2024 at 11:05 AM revealed LVN A did not wash her hands or use hand sanitizer before medication preparation for Resident #4 during medication administration. LVN A did not wear gloves. 3. Record review of Resident #7's face sheet reflected a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #7 had diagnoses which included stroke, anxiety, upper respiratory infection, difficulty in walking, muscle weakness, hypokalemia (low-potassium), insomnia, constipation, dementia, psychotic disturbance, mood disturbance, hypo-osmolality (a condition where the levels of electrolytes, proteins, and nutrients in the blood are lower than normal) and hyponatremia (a condition that occurs when the level of sodium in the blood is too low), high blood pressure, atherosclerotic heart disease (the build-up of fats, cholesterol, and other substances in and on the artery wall), hyperlipidemia (a condition in which there are high levels of fat particles in the blood), fatty liver, muscle wasting and atrophy and lack of coordination. Record review of Resident #7's Admission MDS, dated [DATE], reflected Resident #7 had a BIMS of 4, which indicated Resident #7 was severely cognitively impaired. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 06/12/2024 at 1:43 PM revealed CNA B provided incontinent care for Resident #7. CNA B did not wash hands or use hand sanitizer before gathering supplies for incontinent care. CNA B did wash hands prior to providing incontinent care for Resident #7 but did not wash for the time specified in policy of 20 seconds. CNA B turned on the faucet, used 3 squirts of soap, used friction by rubbing hands together for 5 seconds and then rinsed hands under water. CNA B used 2 paper towels to dry hands. CNA B put on clean disposable gloves and a yellow gown due to barrier precautions. CNA B removed Resident #7's clothing from the waist down. CNA B unfastened Resident #7's brief. CNA B provided catheter care and then completed incontinent care to the front side of Resident #7. CNA B assisted resident to turn to the right side to complete incontinent care of the backside of Resident #7. CNA B removed gloves and washed hands. CNA B turned on the water, put 2 squirts of soap, used friction by rubbing hands together for 4 seconds, rinsed hands under water, used 2 paper towels to dry hands. CNA B put on clean disposable gloves. CNA B placed a clean brief underneath Resident #7 and fastened the brief and pulled up Resident #7's pants. CNA B put the call light in place and gave Resident #7 a blanket. CNA B removed and disposed of the gloves. CNA B washed hands by turning on water, using 2 squirts of soap, used friction by rubbing hands together for 9 seconds, rinsed hands, using 2 paper towels to dry hands, turned off faucet. CNA B grabbed the trash and exited Resident #7's room. 4. Record review of Resident #10's face sheet reflected a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #10 had diagnoses which included atherosclerotic heart disease (the buildup of fats, cholesterol, and other substances in and on the artery walls), acid reflux, anxiety, rheumatoid arthritis (a chronic inflammatory disorder usually affecting small joints in the hands and feet), muscle weakness, urinary tract infection, unsteadiness on feet, atrial fibrillation (an irregular, often rapid heart rate that commonly causes poor blood flow), high blood pressure, anemia and vitamin D deficiency. Record review of Resident #18's Assessment MDS, dated [DATE], reflected Resident #10 had a BIMS (Brief Interview of Mental Status) of a 09, which indicated the resident was cognitively moderately impaired. Observation on 06/12/2024 at 1:43 PM revealed CNA A provided incontinent care for Resident #10. CNA A proceeded to wash her hands by turning on the water and wetting her hands. CNA A put two squirts of soap in her hands. CNA A proceeded in rubbing her soapy hands together with friction and washed for 7 seconds. CNA A rinsed her hands with water. CNA A used two clean paper towels to dry both left and right hands. CNA A used a separate clean paper towel to turn off the faucet. CNA A gathered supplies for incontinent care. CNA A put on clean disposable gloves. CNA A set up supplies on the bedside table with a barrier. CNA A disposed of gloves and used hand sanitizer. CNA A put on clean disposable gloves. CNA A removed Resident #10's clothing from the waist down, unfastened the wet brief and rolled the brief to where it was not exposed. CNA A provided incontinent care. CNA A disposed of the dirty gloves. CNA A used hand sanitizer and put on clean disposable gloves. CNA A assisted Resident #10 in turning to the left side to clean the buttocks area. CNA A completed incontinent care. CNA A placed a clean brief underneath the resident and assisted the resident to lay back. CNA A fastened the clean brief and put clothing back on. CNA A removed the disposable gloves and used hand sanitizer. CNA A gathered trash and set by the door to carry out. CNA A washed hands by turning on the water, putting one squirt of soap, using soap/friction by rubbing together for 3 seconds, rinsing hands under water, using 2 paper towels to dry hands. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675014	A. Building B. Wing	06/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Haskell Healthcare Center	1504 North First St Haskell, TX 79521

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5. Record review of Resident #18's face sheet reflected a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #18 had diagnoses which included Alzheimer's disease, heart failure, chronic obstructive pulmonary disease (a group of lung diseases that block airflow and make it difficult to breathe), muscle wasting and atrophy, edema (inflammation), depression, candidiasis of skin and nail (yeast infection of skin and nail), gout (a disease in which defective metabolism of uric acid causes arthritis especially in the smaller bones of the feet), aphasia (a language disorder that affects a person's ability to communicate), weakness and high blood pressure. Record review of Resident #18's Annual MDS, dated [DATE], reflected Resident #18 had a BIMS of an 08, which indicated the resident was cognitively moderately impaired. Record review of Resident #18's physician orders, dated 04/27/2022, reflected: allopurinol tablet, 100 mg, one tablet orally, once a day, 8:00 AM. Record review of Resident #18's physician orders, dated 04/27/2022, reflected: Celexa (citalopram) tablet, 20 mg, one tablet orally, once a day, 8:00 AM. Observation on 06/12/2024 at 8:09 AM revealed LVN B did not wash her hands or use hand sanitizer before medication preparation for Resident #18 for medication administration. LVN B administered medications to Resident #18 without washing her hands or using hand sanitizer for preparation or administration. 6. Record review of Resident #20's face sheet reflected a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #20 had diagnoses which included Alzheimer's disease, hemiplegia and hemiparesis following stroke (affecting right side), depression, folate deficiency (a condition in which there is not enough folic acid in the body), dysphagia (difficulty swallowing), type 2 diabetes, hyperlipidemia (a condition in which there is high levels of fat particles in the blood) and acid reflux (heartburn). Record review of Resident #20's Annual MDS, dated [DATE], reflected Resident #20 had a BIMS of a 09, which indicated the resident was cognitively moderately impaired. Record review of Resident #20's physician orders, dated 04/14/2022, reflected: senna OTC tablet 8.6 mg 2 tablets orally, twice a day 8:00 AM, 8:00 PM. Record review of Resident #20's physician orders, dated 04/14/2022, reflected: folic acid OTC tablet, 1 mg, 1 tablet orally, once a morning 8:00 AM. Record review of Resident #20's physician orders, dated 04/14/2022, reflected: lisinopril tablet, 10 mg, 1 tablet orally, special instructions, hold if systolic is <100 or diastolic is <60, once a morning 8:00 AM. Record review of Resident #20's physician orders, dated 10/03/2023, reflected: MiraLAX (polyethylene glycol) OTC powder, 17 gram/dose orally, special instructions: give in 8 ounces of water, once a morning 8:00 AM. Record review of Resident #20's physician orders, dated 10/03/2023, reflected: acetaminophen tablet 325 mg 2 tablets oral, every 6 hours PRN. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675014	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Haskell Healthcare Center	1504 North First St Haskell, TX 79521

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #20's physician orders, dated 10/16/2023, reflected: Januvia (sitagliptin) tablet, 50 mg, 1 tablet orally, Special instructions: to improve glycemic control, once a morning 8:00 AM. Record review of Resident #20's physician orders, dated 02/15/2024, reflected: Depakote (divalproex) tablet, delayed release 125 mg, 1 tablet orally, twice a day 8:00 AM, 7:00 PM. Record review of Resident #20's physician orders, dated 03/11/2024, reflected: citalopram tablet, 10 mg 1 tablet orally, once a day 8:00 AM. Observation on 06/12/2024 at 7:56 AM revealed LVN B did not wash her hands or use hand sanitizer before medication preparation and administration for Resident #20. 7. Record review of Resident #26's face sheet reflected an [AGE] year-old male who was admitted to the facility on [DATE]. Resident #26 had diagnoses which included Alzheimer's disease, dehydration, bipolar disorder,(a disorder associated with episodes of mood swings ranging from depressive lows to manic highs) acute upper respiratory infection, nocturia (frequent night time urination), urinary tract infection, vitamin deficiency, type 2 diabetes, neuropathy (weakness, numbness, and pain from nerve damage), muscle wasting and atrophy, chronic obstructive pulmonary disease (a group of lung diseases that block airflow and make it difficult to breathe), high blood pressure and hyperlipidemia (a condition in which there are high levels of fat particles in the blood). Record review of Resident #26's Quarterly MDS, dated [DATE], reflected Resident #26 had a BIMS of 11, which indicated the resident was cognitively moderately impaired. Record review of Resident #26's physician orders, dated 10/07/2022, reflected: carvedilol tablet, 3.125 mg, 1 tablet orally, special instructions: hold if systolic blood pressure is <100 and diastolic blood pressure is <50, once a day 8:00 AM. Record review of Resident #26's physician orders, dated 10/07/2022, reflected: fenofibrate nano crystalized tablet, 145 mg one tablet orally, once a day 8:00 AM. Record review of Resident #26's physician orders, dated 10/07/2022, reflected: fish oil capsule 1,000 mg (120 mg-180 mg) one capsule orally, once a day 8:00 AM. Record review of Resident #26's physician orders, dated 11/14/2022, reflected: lisinopril tablet 40 mg one tablet orally, once a day 8:00 AM. Record review of Resident #26's physician orders, dated 1/1/2023, reflected: gabapentin capsule 100 mg one capsule orally, three times a day 8:00 AM, 12:00 PM, 7:00 PM. Record review of Resident #26's physician orders, dated 8/17/2023, reflected: memantine tablet, 10 mg one tablet orally, twice a day, 8:00 AM, 7:00 PM. Record review of Resident #26's physician orders, dated 10/16/2023, reflected: aspirin OTC tablet, delayed release, 325 mg, one tablet orally, special instructions: cardiovascular risk reduction, once a day 8:00 AM. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #26's physician orders, dated 2/14/2024, reflected: escitalopram oxalate tablet, 5 mg, tablet orally, once a day, 8:00 AM. Record review of Resident #26's physician orders, dated 6/03/2024, reflected: Zyrtec 10 mg by mouth once a day, 8:00 AM. Observation on 06/12/2024 at 8:58 AM revealed LVN A did not wash her hands or use hand sanitizer before medication preparation for Resident #26 during medication administration. No gloves were worn. 8. Record review of Resident #34's, undated, face sheet reflected a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #34 had diagnoses which included Alzheimer's disease, Parkinson's disease, dysarthria and anarthria (slurred speech and complete loss of speech), dysphagia (difficulty swallowing), aphasia (a language disorder that affects a person's ability to communicate), muscle wasting and atrophy, muscle weakness, dehydration, polydipsia (excess thirst), altered mental status, contracture of muscle, hematuria (blood in urine), dysuria (discomfort when urinating), need for continuous supervision, reduced mobility, vitamin D deficiency and functional dyspepsia (chronic indigestion). Record review of Resident #34's significant change in status MDS, dated [DATE], reflected Resident #34 had a BIMS of 6, which indicated the resident was moderately impaired. Record review of Resident #34's physician orders, dated 4/15/2024, reflected: doxazosin tablet, 1 mg, one tablet orally, twice a day, 8:00 AM, 7:00 PM. Record review of Resident #34's physician orders, dated 4/15/2024, reflected: gabapentin capsule, 400 mg, 2 capsules orally, twice a day, 8:00 AM, 7:00 PM. Record review of Resident #34's physician orders, dated 4/15/2024, reflected: midodrine tablet, 5 mg, 1 tablet orally, twice a day, 8:00 AM, 7:00 PM. Record review of Resident #34's physician orders, dated 4/23/2024, reflected: furosemide tablet, 40 mg, 1 tablet orally, once a day, 8:00 AM. Record review of Resident #34's physician orders, dated 4/23/2024, reflected: hydrocodone-acetaminophen Schedule II tablet, 10-325 mg, 1 tablet orally, every 4 hours 8:00 AM, 12:00 PM, 4:00 PM, 8:00 PM, 12:00 AM, 4:00 PM. Observation on 06/12/2024 at 8:12 AM revealed LVN B did not wash her hands or use hand sanitizer before medication preparation for Resident #34. Observation on 06/12/2024 at 8:15 AM revealed LVN B did not wash her hands or use hand sanitizer before medication preparation or administration for Resident #3. After LVN B attempted administering medication to Resident #34, LVN B carried an open cup of medications to administer to Resident #3 in the room. LVN B prepared medications for Resident #3 and did not wash hands or use hand sanitizer. LVN B administered medications to Resident #3 without using hand sanitizer or washing hands with soap and water. (continued on next page)

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	675014	A. Building B. Wing	06/13/2024

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 06/12/2024 at 4:18 PM with LVN B revealed policy stated she should wash her hands prior to medication preparation and administration. LVN B stated she was trained in handwashing by competency checks and in-services quarterly. LVN B stated the negative potential outcome for not washing her hands prior to medication preparation or administration would be the spread of infection. Interview on 06/12/2024 at 4:18 PM, LVN B stated she was aware of when she should wash her hands. LVN B stated that the policy stated she should wash her hands before, during, and after providing care and services to a resident. LVN B stated she was trained in handwashing and was trained at least twice a year with competency checks. LVN B stated the facility did provide in-services for handwashing every couple of weeks. LVN B stated the negative potential outcome of not washing her hands was that it could spread infections from one resident to another. Interview on 06/12/2024 at 4:37 PM, CNA A stated she was very nervous and could not focus on the steps. CNA A stated she was trained in infection control practices/handwashing by in-services monthly. CNA A stated she was not sure what the policy stated about how long to wash hands, but she though it was approximately 30 seconds. CNA A stated the negative potential outcome of not properly washing hands would be the spread of infection and germs. Interview on 06/12/2024 at 4:48 PM, CNA B stated she was really tired because she had stayed up all night the night before and she wasn't able to think correctly. CNA B stated she was trained in handwashing practices by competency checks monthly and in-services every six months. CNA B stated policy stated she should wash hands before, during, and after resident care. CNA B stated the negative potential outcome for not washing hands would be the spread of germs. Interview on 06/13/2024 at 10:11 AM with DON revealed the DON expected staff to wash their hands. The DON stated he provided in-services weekly for training. The DON stated the negative potential outcome of not washing hands would be the spread of germs. Record Review of the facility provided policy, labeled, Handwashing/Hand Hygiene, date Revised on 1/20/2023, reflected: This facility considers hand hygiene the primary means to prevent the spread of infection . 1. All personnel shall follow the handwashing, hand hygiene procedures to help prevent the spread of infection to other personnel, residents, and visitors. 3. Wash hands with soap and water, when hands are visibly soiled and after contact with resident with an infectious diagnosis. 4. Use an alcohol-based hand rub containing at least 60% to 95% ethanol alcohol or isopropyl alcohol. 5. Hand hygiene must be performed prior to donning and after doffing gloves. 6. Hand Hygiene is the final step after removing and disposing of personal protective equipment. Washing Hands: (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1. Wet hands first with water, then apply soap. 2. Lather your hands by rubbing them together with the soap. Lather the back of your hands between your fingers and under the nails. 3. Scrub your hands for at least 20 seconds. 4. Rinse your hands well under clean, running water. 5. Dry your hands using a clean towel and use a towel to turn off the faucet. Use Alcohol-Based Hand Rubs: 1. Apply generous amount of product to palm of hand and rub hands together. 2. Cover all surfaces of hands and fingers until hands are dry.