STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675058	A. Building B. Wing	09/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Homeplace Manor	425 SW Ave F Hamlin, TX 79520

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 0577 Level of Harm - Potential for minimal harm Residents Affected - Many	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. 48883 Based on observation, interview, and record review, the facility failed to post in a place readily accessible to residents, and family members and legal representative of residents, the results of the most recent survey of the facility including any plans of correction without identifying information about complainants or residents reviewed for resident rights. The facility failed to ensure the three preceding years of any surveys, certifications, and complaint investigations with plan of correction were posted for residents, family members, and visitors to review without identifying information about complainants or residents. The failure placed residents and their family members and representatives at risk for violation of the right to review the findings from State surveys and investigations conducted in the facility without asking to review the reports. Findings included: During an observation on 09/03/2024 at 2:03 PM, the last survey results dated 07/27/2023 were in a binder outside of ADMN's office. No plan of corrections was observed with survey, certifications, and investigations. Form 4060 Resident Identifier/Facility had been included in binder which identified residents to their resident identifier number listed in citations. During an interview on 09/03/2024 at 2:21 PM, the ADMN stated he was responsible for placing the results from the most recent surveys, certification, and investigations in binder outside his office. He stated that during the weekend, a resident had gotten the binder and proceeded to rip out all but 10 of the pages in the binder. He stated he was hurried in placing information back into the binder and reached out to his corporate who provided the information to him to put in the binder. He did not review the information prior to placing in binder and outside of his office. He stated the plan of correction information should have been in the binder with the citations. He stated he monitored that all items were included in binder for residents and their families or responsible parties to review. He stated resident identifiers should have not been included in the binder. He stated that no negative effect happened from plan of corrections not being included due to it had only been several days since the binder had been destroyed. He stated that including resident identifiers could violate resident's right of privacy. (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675058	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/04/2024

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F 0577 Level of Harm - Potential for minimal harm Residents Affected - Many	Review of the facility's provided document titled Survey Results, Examination of dated October 2021 revealed Copies of survey results are maintained in an accessible location. (Note: Survey results mean the Statement of Deficiencies, CMS Form 2567.) .Copies of previous survey reports and state approved plans of correction are available upon request to the public, residents or their legal representatives (sponsors), designated ombudsman representative, and staff members. The location of the survey reports will be posted in a public area of the center as required by state regulations.

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NAME OF PROVIDER OR SUPPLIER: Homeplace Manor		STREET ADDRESS, CITY, STATE, ZIP CODE: 425 SW Ave F Hamlin, TX 79520	

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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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48883 Based on interview and record review, the facility failed to develop a baseline care plan within 48 hours of a resident's admission that included the instructions needed to provide effective and person-centered care plan and provide a summary of their baseline care plan to residents for 1 (Resident #24) of 14 residents reviewed for care plan completion. 1. The facility failed to complete Resident #24's baseline care plan within the required 48-hour timeframe. 2. The facility failed to provide Resident #24 a summary of their baseline care plan after completion. This failure could place residents who were newly admitted at risk for not receiving necessary care and services or having important care needs identified. Findings included: Record review of Resident #24's electronic face sheet dated 09/04/2024 revealed the resident was a [AGE] year-old male admitted on [DATE]. Record review of Resident #24's quarterly MDS dated [DATE] revealed: BIMS score of 09 which indicated moderate cognitive impairment. Record review of Resident #24's electronic medical record on 09/04/2024 revealed no evidence that baseline care plan had been performed and no evidence that summary of baseline care plan was given to Resident #24 or his representative. During an observation on 09/02/2024 at 9:55 a.m., Resident #24 was in his room lying in bed. Had walker in form and wearing glasses. He stated that he participated in therapy and does go to care plan meetings. Not able to answer if he had baseline care plan meeting. During an interview on 09/04/2024 at 10:08 a.m., the CRN stated she was unable to find that the baseline care plan was completed or that a conversation had been done with Resident #24. She stated that she was only able to find a discussion about DNR after the resident had been admitted . During a follow up interview on 09/04/2024 at 1:26 p.m., the RCN stated her expectation would be for baseline care plans to be completed within 48 hours of admission and discussed with the resident or their representative. She stated the DON, weekend supervisor or RN should complete the baseline care plan. She stated the facility's IDT monitors that baseline care plans were completed during morning clinical meeting. The RCN stated IDT members included the DON, ADON and ADMN. She stated she did not know why baseline care plan had not been performed. She stated the effect on not completing could disrupt continuity of care. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the DON's personnel file on 09/04/2024 revealed the was hired on 06/03/2024. The DON was not present on 09/04/2024 in facility for interview. Record review of the facility policy titled Care Plans - Baseline dated July 2024 revealed: 1. Completion and implantation of the comprehensive care plan within forty-eight (48) hours of a resident's admission is intended to promote continuity of care and communication among nursing home staff, increase resident safety, and safeguard against adverse events that are most likely to occur right after admission; and to ensure the resident and representative, if applicable, are informed of the initial plan of delivery of care and services by receiving a written summary of the baseline care plan. 2. To assure that the resident's immediate care needs are met and maintained, a baseline care plan will be developed within forty-eight (48) hours of the resident's admission. 3. The Director of Nursing, RN Weekend Supervisor or a registered nurse on duty will complete the baseline care plan.

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observe each nurse aide's job performance and give regular training. 45216 Based on interview and record review the facility failed to complete a performance review of each CNA at least once every 12 months, for 1 of 3 (CNA C) reviewed for annual competency evaluations. The facility failed to complete annual CNA competency evaluations for CNA C, based on the personnel file review results. This failure could affect residents by placing them at risk of not receiving consistent, appropriate interventions necessary to meet the residents' needs. Findings included: Record review of the Personnel File Review completed on 09/04/2024, indicated CNA B, did not have a competency evaluation on file. The Personnel File Review indicated CNA B's date of hire was 03/27/2023. During an interview on 09/04/2024 at 2:25 p.m., the CRN stated the DON was responsible for conducting and documenting nursing training and staff performance reviews. She stated the effect on residents would depend the topic of the review and impact on the quality of care and life for the resident. The CRN explained the facility had recently changed from paper records to electronic records and had a nursing leadership change as the reasons the documents were not available. She stated the DON was out of state and not available for an interview. During an interview on 09/04/2024 at 2:40 p.m., the AD stated she was hired as the Business Office Manager and served as the Human Resources Director. She stated she did not know where to locate missing the records and understood reviews were a requirement. Record review of the facility's Staff Development Program, dated June 2021, revealed 6. In addition to the in-service training requirements outlined above, nurse aides (CNAs) are required to complete no less than 12 hours annually of in-service training that is sufficient to ensure the continuing competency of nurse aides and address any specific areas of weakness identified in performance and through the Center assessment. 48883

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44558 Based on observation, interview, and record review the facility failed to provide each resident with a nourishing, palatable, well-balanced diet that met his or her daily nutritional and special dietary needs, taking into consideration the preferences of each resident for 1 of 1 lunch meal reviewed. This facility failed to follow the menu when preparing lunch meal on 09/02/2024. This failure could place residents at risk for a decline in health status due to inadequate or inappropriate nutritional intake. The findings include: Record review of Resident #5's Face Sheet revealed an [AGE] year-old female who was admitted on [DATE] with Diagnoses that included: Nausea and Vomiting, Dietary Calcium Deficiency, Hypokalemia (low potassium), Vitamin D deficiency, Generalized Anxiety order. Record review of Resident #5's Physician orders dated 09/01/2024 revealed: Regular Diet with regular texture. Record review of Resident #5's Quarterly MDS dated [DATE] revealed: Section C-Cognitive Patterns BIMS score was 10 (moderately impaired cognition) Section I Active Diagnoses- Anemia (not enough red blood cells), Hyperlipidemia (excess fats in blood). Record review of Resident #5's Care Plan dated 08/08/2024 revealed: Problem: Resident's lab showed low Calcium level. Goal: Resident Calcium level will be within normal limits. Approach: Encourage resident to eat foods high. in Calcium such as milk and dairy products. Record review of Resident # 13's Face Sheet revealed an [AGE] year-old female who was admitted on [DATE] with diagnoses that included: Hyponatremia (lower than normal level of sodium in the bloodstream), Acute Kidney Failure, Hyperkalemia (low potassium), Vitamin D B12 deficiency anemia, Type 2 diabetes mellitus, Moderate protein-calorie malnutrition. Record review of Resident #13's Physician orders dated 09/01/2024 revealed: Diet: Regular, LCS (low concentrated sweets) Record review of Resident #13's Quarterly MDS dated [DATE] revealed: Section C Cognitive Patterns BIMS score was 15 (cognitively intact). Section I-Active Diagnoses: Anemia, Diabetes Mellitus, Chronic Kidney Disease. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Record review of Resident #13's Care Plan dated 06/19/2024 revealed: Problem: I am at risk for hyper/hypoglycemia episodes secondary to my diagnosis of Diabetes Type II/Insulin Dependent. Goal: My blood sugar will be within normal limits 90-150 with insulin control over the net 90 days. Approach: Encourage diet compliance. Educate and re-educate as needed on consequences of not following therapeutic diet. During an observation on 09/02/2024 at 10:55 AM revealed a posted weekly menu in the dining room with lunch menu for 09/02/2024.It read: Bake pork chop, Cheesy Grits, Broccoli and cauliflower, Cornbread, Frosted cake. The meal that was served was: Baked Pork chops, Mashed Potatoes, Biscuit, Frosted cake. No substitution list was available for residents to review. During an interview on 09/03/2024 at 11:15 AM the DM stated the weekly menus were posted outside the kitchen for the residents to be able to see what was being served that day and that week. The DM stated residents did not receive cornbread at yesterday's lunch meal due to waiting on truck delivery today. The DM stated the company they received groceries from had not been sending everything that was ordered. The DM stated that resident tickets for today's meal did not match what was being served because he did not have all those items. The DM stated the ADM told him what to serve. The DM did not know if anyone had told the residents about the change. During an interview on 09/03/2024 at 11:30 AM Resident #5 stated the residents did not know what would be served at meals until the meals were placed in front of them. Resident #5 stated she would like to know what was being served before the meal arrives in case, she wanted something else to eat. During an interview on 09/03/24 at 9:26 AM Resident #13 stated, the food doesn't taste or look good. Some food wasn't served hot. I have told facility I don't like pork. Resident #13 stated she was offered a sandwich, but she didn't want the sandwich without Mayonnaise. Resident #13 stated the sandwich was the substitution. Resident #13 stated they (dietary staff) do not serve the foods on her ticket and that pisses me off. Resident #13 stated no menu was provided to her in advance. During a phone interview on 09/04/2024 at 12:17 PM the Dietician stated that menus should be followed. The dietician stated the DM should contact the dietician to get changes to the menu approved. The Dietitian asked if she could call back after consulting with her supervisor. The Dietician did not call back before survey exit. During an interview on 09/04/2024 at 1:23 PM the ADMN stated the menus should be followed. The ADMN stated the facility does not always receive what was ordered for the kitchen. The ADMN stated residents could ask staff what was on the menu for any meal before it is served. The ADMN stated the weekly menus were posted by the kitchen door. The ADMN stated he did not communicate with the dietician about changing lunch menu that was served on Tuesday. The ADMN stated the meal served on Tuesday was one the residents really liked. The ADMN stated he did not think he needed to call the dietician about menu change. Record review of the facility's policy titled: Menu Substitutions dated 2018: The menu will be served unless an emergency situation arises. If a specific item is not available, the cook with consult with the Nutrition & Food Service Manager or consultant RND/DTR regarding an appropriate substitution. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	All changes to the menu will be recorded on the Menu Substitution Approval Form. The menus are reviewed and approved by the Consultant Dietician. Intermittent changes must also be reviewed and approved by the 48883

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 44558 Based on observation, interviews, and record reviews, the facility failed to properly store, prepare, distribute, and serve food in accordance with professional standards for food service safety of 1of 1 kitchens reviewed. The facility failed to ensure items stored in 1 of 1 freezer were properly stored and labeled. The facility failed to ensure current temperature logs of 1 of 1 freezer and 2 of 2 refrigerators were maintained daily. The facility failed to ensure dietary staff (1 of 2) wore hair nets when preparing, serving meals. These failures could place resident that eat out of the kitchen at risk for food borne illnesses. The findings include: During an observation on 09/02/2024 at 09:55 AM in the kitchen revealed temperature logs for 1 of 1 freezer and 2 of 2 refrigerators were not up to date. There were no temperature logs for September 2024. During an observation on 09/02/2024 at 09:58 AM dietary staff were not wearing a hair net. During an observation on 09/02/2024 at 10:00 AM revealed in the freezer 1 box of tamales not sealed, dated. One package of what appeared to be breaded meat patties with plastic bag opened with no labels or dates. One bag of Oatmeal Raisin cookie dough 3/4 full, not sealed or dated. One box of egg rolls opened, not sealed with no label or dates. During an observation on 09/02/2024 at 10:05 AM revealed the walk-in refrigerator had yellow cheese slices with no date or label. One bag of lettuce with no date or label. During an interview on 09/02/2024 at 9:55 AM the DM stated the temperature logs for the freezer and refrigerators had not been printed for September. The DM stated all products in the freezer, refrigerators and dry storage should be labeled with received date, date opened and best but date. During an interview on 09/02/2024 at 09:56 AM the dietary aide stated she did not have on a hair net due to the facility did not have any. The dietary aide stated not wearing a hair net could lead to hair falling into a resident's meals. The dietary aide stated this could cause the resident to not want to eat and could lead to resident weight loss. During an interview on 09/03/2024 at 11:20 AM the DM stated the dietary staff were without hairnets for a couple of days. The DM stated he did not know why the dietary aide did not have a hair covering, but she had her hair pulled up and out of her face. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 09/04/2024 at 01:23 PM the ADMN stated the temperature logs for freezers and refrigerators should be up to date. The ADMS stated if the temperatures were not documented the staff might not notice if the refrigerator or freezer was not working properly. The ADMN stated this would lead to spoiled food. The ADMN stated the dietary staff were responsible for ensuring the temperature logs were kept up to date. The ADMN stated he did not know what caused this failure. The ADMN stated the dietary staff should wear hair nets, or head covering when in the kitchen. The ADMN stated the facility had run out of hair nets, but they were available today. Review of the facility's policy dated Revised June 2019: Policy: to ensure that all food served by the facility is of good quality and safe for consumption, all food will be sorted according the state, federal and US Food Codes and HACCP guidelines. Refrigerators: Date, label and tightly seal all refrigerate foods using clean, nonabsorbent, covered containers that are approved for food storage. Place a thermometer inside refrigerators near the door where temperature is warmest. Check the temperature of all refrigerators using the internal thermometer to make sure the temperature stays at 41-degree Fahrenheit or below. Temperature should be checked each morning and again on the PM shift. Record the temperature on a lob that is kept near the refrigerator. Freezers: Store frozen foods in moisture-proof wrap or containers that are labeled and dated. Place a thermometer inside freezer near the door where the temperature is warmest. Check the temperature of all freezers using the internal thermometer to make sure the temperature stays at 0 degrees Fahrenheit or below. Temperatures should be checked each morning and again on the PM shift. Record temperatures on a log that is kept near the freezer. Review of the facility's policy titled Employee Sanitation dated 2018: Employee Cleanliness Requirements . Hairnets, headbands, caps, beard coverings or other effective hair restraints must be worn to keep hair from food and food-contact surfaces.

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F 0941 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop, implement, and/or maintain an effective training program that includes effective communications for direct care staff members. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45216 Based on interview and record review, the facility failed to ensure employees received the required training effective communications mandatory training was completed for 7 of 19 employees (DON, DM, MAINT, CNA C, TRNS, COTA, and HSKP F) reviewed for training. The facility did not ensure effective communication training was completed by the DON, MAINT, TRNS, and COTA during orientation. The facility did not ensure effective communication training was completed by the DM, CNA C, and HSKP F annually. These failures could place residents at risk of miscommunication and social isolation due to lack of staff training. Findings included: Record review of the employee files revealed no evidence the following staff had completed effective communications training during orientation: * DON hire date 06/03/2024; * MAINT, hire date 09/28/2023; * TRNS, hire date 03/27/2024; * COTA, transferred from a sister facility on 08/23/2024 Record review of the employee files revealed no evidence the following staff had completed effective communications training annually: * DM, hire date 08/03/2022; * CNA C, hire date 03/27/2023; * HSKP F, hire date 04/01/2023 During an interview on 09/04/2024 at 12:17 p.m., the TRNS stated she had worked for the facility for 5-6 months. She stated she completed the online training on communication during her orientation period but did not have documentation of completion. During an interview on 09/04/24 at 12:24 p.m., the ADMN stated the DON was out of state for a court hearing. Did not attempt to contact DON about missing training records. (continued on next page)

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F 0941 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 09/04/24 at 12:32 p.m., the DM stated training was done online. He explained that staff received email notices and group text when trainings were available and due. The DM stated he had done all the training listed with the exception of the annual HIV training. He stated the ADON was responsible for tracking completed trainings. The DM was not able to provide an answer on how not completing trainings would affect the residents. During an interview on 09/04/24 at 1:00 p.m., the Maint. stated he recalled completing training on Communication within the past year. He did not know who or where the records were kept or how lack of training could affect the residents. During a phone interview on 09/04/24 at 1:12 p.m., Hskp F Stated she had worked in the facility for 3 years and had completed all required training every year. She stated she did not know who was responsible for the training records or where the records would be found. During an interview on 09/04/24 at 1:13 p.m., COTA stated she transferred from a sister facility last month and her records had not been transferred. She stated she received notification of training due and was scheduled to take all required trainings by the end of the week. During an interview on 09/04/24 at 2:25 p.m., the CRN stated the HR director was responsible for tracking completed training. She explained the effect on residents would depend on the topic of the training and how it related to care or quality of life. The CRN stated the reason documentation was not available was because the facility recently transitioned from paper records to electronic records. She also stated the facility had 2 employees that have been working at facility for more than [AGE] years and records were archived. The CRN added that a recent change in leadership was a factor in trainings not getting done or documented. During an interview on 09/04/2024 at 2:40 p.m., the AD stated she was hired as the Business Office Manager and served as the Human Resources Director. She stated she did not know where to locate missing the records and understood trainings were a requirement. Record review of the facility's Staff Development Program, dated June 2021, revealed 1. Staff development is defined as initial orientation, followed by regularly scheduled in-service training programs. 2. The primary objective of our Center's Staff Development Program is to ensure that staff have the knowledge, skills and critical thinking necessary to provide excellent resident care. 5. Training topics may include: a. Effective communication with residents and family. 48883

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F 0942 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that staff members are educated on resident rights and facility responsibilities to properly care for its residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45216 Based on interview and record review, the facility failed to ensure the staff members were educated on the rights of the resident and the responsibilities of the facility to properly care for its residents for 5 of 19 staff (DM, LVN G, HSKP E, TRNS, and HSKP F) reviewed for training requirements in that: The facility failed to ensure five staff which included: DM, LVN G, HSKP E, TRNS, and HSKP F received the required training on resident rights timely. This failure could place residents at risk of receiving care from staff who were insufficiently trained. The findings included: Record review of the DM's employee file revealed a hire date of 08/03/2022. The file did not contain any record of training on resident's rights. Record review of LVN G's employee file revealed a hire date of 09/04/2023. The file did not contain any record of training on resident's rights. Record review of HSKP E's employee file revealed a hire date of 08/05/2024. The file did not contain any record of training on resident's rights. Record review of TRNS's employee file revealed a hire date of 08/23/2024. The file did not contain any record of training on resident's rights. Record review of HSKP F's employee file revealed a hire date of 04/01/2023. The file did not contain any record of training on resident's rights. During an interview on 09/04/24 at 12:32 p.m., the DM stated the training was done online. He explained that staff received email notices and group text when trainings were available and due. The DM stated he had done all the training listed with the exception of the annual HIV training. He stated the ADON was responsible for tracking completed trainings. The DM was not able to provide an answer on how not completing trainings would affect the residents. On 09/04/2024 at 9:07 a.m. and 1:05 p.m., attempted to contact LVN G for a phone interview. No answer. Voice message left with purpose of call and detailed return call information. During a phone interview on 09/04/2024 at 1:12 p.m., HSKP F stated she had worked in the facility for 3 years and had completed all required training every year. She stated she did not know who was responsible for the training records or where the records would be found. On 09/04/2024 at 01:58 p.m. attempted to contact HSKP E for a phone interview. The number provided was not correct and no other contact numbers were provided. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675058	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Homeplace Manor	425 SW Ave F Hamlin, TX 79520

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 0942 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 09/04/24 at 2:25 p.m., the CRN stated the HR director was responsible for tracking completed training. She explained the effect on residents would depend on the topic of the training and how it related to care or quality of life. The CRN stated the reason documentation was not available was because the facility recently transitioned from paper records to electronic records. She also stated the facility had 2 employees that have been working at facility for more than [AGE] years and records were archived. The CRN added that a recent change in leadership was a factor in trainings not getting done or documented. During an interview on 09/04/2024 at 2:40 p.m., the AD stated she was hired as the Business Office Manager and served as the Human Resources Director. She stated she did not know where to locate missing the records and understood reviews were a requirement. Record review of the facility's Staff Development Program, dated June 2021, revealed 1. Staff development is defined as initial orientation, followed by regularly scheduled in-service training programs. 2. The primary objective of our Center's Staff Development Program is to ensure that staff have the knowledge, skills and critical thinking necessary to provide excellent resident care. 5. Training topics may include: b. Resident rights and responsibilities; 48883

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675058	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/04/2024
NAME OF PROVIDER OR SUPPLIER Homeplace Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 425 SW Ave F Hamlin, TX 79520	

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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 0943 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Give their staff education on dementia care, and what abuse, neglect, and exploitation are; and how to report abuse, neglect, and exploitation. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45216 Based on interview and record review the facility failed to provide training to their staff that at a minimum educates staff on activities that constitute abuse, neglect, exploitation, and misappropriation of resident property and procedures for reporting incidents of abuse, neglect, exploitation, or the misappropriation of resident property and dementia management for 2 (DM and HSKP F) of 19 employees reviewed for staff training. The facility failed to have documentation for DM and HSKP F on what constitutes abuse, neglect, exploitation, misappropriation of resident property and how to report the above. These failures could place residents at risk of injury or harm due to being cared for by untrained staff. Findings included: Record review of the DM's employee file revealed a hire date of 08/03/2022. The file did not contain any record of training on abuse, neglect, exploitation, misappropriation of resident property. Record review of HSKP F's employee file revealed a hire date of 04/01/2023. The file did not contain any record of training on abuse, neglect, exploitation, misappropriation of resident property. During an interview on 09/04/24 at 12:32 p.m., the DM stated training was done online. He explained that staff received email notices and group text when trainings were available and due. The DM stated he had done all the training listed except for the annual HIV training. He stated the ADON was responsible for tracking completed trainings. The DM was not able to provide an answer on how not completing trainings would affect the residents. During a phone interview on 09/04/24 at 1:12 p.m., Hskp F Stated she had worked in the facility for 3 years and had completed all required training every year. She stated she did not know who was responsible for the training records or where the records would be found. During an interview on 09/04/24 at 2:25 p.m., the CRN stated the HR director was responsible for tracking completed training. She explained the effect on residents would depend on the topic of the training and how it related to care or quality of life. The CRN stated the reason documentation was not available was because the facility recently transitioned from paper records to electronic records. She also stated the facility had 2 employees that have been working at facility for more than [AGE] years and records were archived. The CRN added that a recent change in leadership was a factor in trainings not getting done or documented. During an interview on 09/04/2024 at 2:40 p.m., the AD stated she was hired as the Business Office Manager and served as the Human Resources Director. She stated she did not know where to locate missing the records and understood trainings were a requirement. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675058	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Homeplace Manor	425 SW Ave F Hamlin, TX 79520

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F 0943 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	*Record review of the facility's Staff Development Program, dated June 2021, revealed 1. Staff development is defined as initial orientation, followed by regularly scheduled in-service training programs. 2. The primary objective of our Center's Staff Development Program is to ensure that staff have the knowledge, skills and critical thinking necessary to provide excellent resident care. 5. Training topics may include: c. Preventing abuse, neglect, exploitation, and misappropriation of resident property including: (1) Activities that constitute abuse, neglect, exploitation or misappropriation of resident property; (2) Procedures for reporting incidents of abuse, neglect, exploitation or misappropriation of resident property; and (3) Dementia management and resident abuse prevention. 48883

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 0945 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Include as part of its infection prevention and control program, mandatory training that includes written standards, policies, and procedures for the program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45216 Based on interview and record review, the facility failed to ensure standards, policies, and procedures for an infection prevention and control program was completed for 3 of 19 staff (DM, HSKP E, and HSKP F) reviewed for training. The facility failed to ensure five staff which included the DM, HSKP E, or HSKP F received the required training on infection control timely. These failures could place residents at risk of illness due to lack of staff training. Findings included: Record review of the DM's employee file revealed a hire date of 08/03/2022. The file did not contain any record of training on infection control. Record review of HSKP E's employee file revealed a hire date of 08/05/2024. The file did not contain any record of training on infection control. Record review of HSKP F's employee file revealed a hire date of 04/01/2023. The file did not contain any record of training on infection control. During an interview on 09/04/24 at 12:32 p.m., the DM stated training was done online. He explained that staff received email notices and group text when trainings were available and due. The DM stated he had done all the training listed with the exception of the annual HIV training. He stated the ADON was responsible for tracking completed trainings. The DM was not able to provide an answer on how not completing trainings would affect the residents. During a phone interview on 09/04/2024 at 1:12 p.m., Hskp F Stated she had worked in the facility for 3 years and had completed all required training every year. She stated she did not know who was responsible for the training records or where the records would be found. On 09/04/2024 at 01:58 p.m. attempted to contact HSKP E for a phone interview. The number provided was not correct. During an interview on 09/04/24 at 2:25 p.m., the CRN stated the HR director was responsible for tracking completed training. She explained the effect on residents would depend on the topic of the training and how it related to care or quality of life. The CRN stated the reason documentation was not available was because the facility recently transitioned from paper records to electronic records. She also stated the facility had 2 employees that have been working at facility for more than [AGE] years and records were archived. The CRN added that a recent change in leadership was a factor in trainings not getting done or documented. (continued on next page)

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	675058	A. Building B. Wing	09/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 0945 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 09/04/2024 at 2:40 p.m., the AD stated she was hired as the Business Office Manager and served as the Human Resources Director. She stated she did not know where to locate missing the records and understood reviews were a requirement. Record review of the facility's Staff Development Program, dated June 2021, revealed 1. Staff development is defined as initial orientation, followed by regularly scheduled in-service training programs. 2. The primary objective of our Center's Staff Development Program is to ensure that staff have the knowledge, skills and critical thinking necessary to provide excellent resident care. 5. Training topics may include: e. The infection prevention and control program standards, policies and procedures;