STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675061	A. Building B. Wing	05/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Munday Nursing Center	421 West F St Munday, TX 76371

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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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46425 Based on interviews and record reviews the facility failed to ensure the residents had the right to participate in, his or her treatment which included the right to be informed in advance, by the physician or other practitioner or professional, of the risks and benefits of proposed care, of treatment and treatment alternatives or treatment options and to choose the alternative or option he or she preferred, for 1 of 15 residents (Residents #1) reviewed for resident rights. The facility failed to obtain a signed informed consent based on information of the benefits, risks, and options available for Residents #1 prior to administering Celexa, Lorazepam, and Seroquel, psychotropic medications, (a psychoactive drug taken to exert an effect on the chemical make-up of the brain and nervous system). This failure could place residents at risk of receiving medications without their prior knowledge or consent, or that of their responsible party or being aware of the benefits and risks of the medications prescribed. Findings included: Record review of Resident #1's face sheet, dated 05/15/24, revealed a [AGE] year-old-female was admitted to the facility on [DATE] with diagnoses to include anxiety disorder (fears that are strong enough to interfere with daily life), muscle weakness, insomnia (trouble sleeping), pain, and difficulty walking. Record review of comprehensive MDS assessment dated [DATE] revealed Resident #1 was rarely to never understood. The MDS revealed Resident #1 had a BIMS score of 00 which indicated the resident's cognition was severely impaired. Record Review of Section N0415 indicate Resident #1 was taking antidepressants, antipsychotics, and antianxiety medications. Record review of a care plan for Resident #1 dated 06/14/23 revealed a focus area of depression: Resident will take antidepressant medication as prescribed to assist with this area of concern. Record review of Resident #1's order summary report dated 05/15/24 revealed the following orders: Celexa 10mg 2 tablets by mouth once a day as related to depression and explosive disorder dated 1/25/23. Lorazepam 1mg give by mouth twice a day related to anxiety dated 03/22/23. Seroquel 25mg give 1 tablet by mouth at bedtime related to hallucinations. (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #1's electronic medical record of scanned consents on 5/15/24 revealed a consent for Seroquel and a consent for Lorazepam; however, these consents were not signed by the resident or the resident's representative. These consents stated verbal consent per phone; however, there was no date, time, or a name of the residents' representative providing verbal consent. During an interview on 05/16/24 at 12:10PM with the DON, she verified both consents for Resident #1 for Seroquel and Lorazepam do not indicate who provided verbal consent for either medication, no time for the verbal consent, and no date for the verbal consent. The DON stated she understood the need for the name of the resident representative who provided the consent as well as the time and date the verbal consent was received. She stated all staff had been trained on obtaining consents. She stated the nurses are responsible for obtaining consent for medications when they receive the order. She stated the potential negative outcome could be medications being distributed against the residents' or family wishes. During an interview on 5/16/24 at 12:28PM, the ADM stated the admitting nurse or the nurse receiving the order for the psychotropic medication is responsible for obtaining the consent for the psychotropic medication from the resident or their responsible party on the same day it is received from the physician. The ADM stated the consent should have been obtained prior to the residents being given psychotropic medications. The ADM stated the nurses have all been trained on medication consents. The ADM stated a potential negative outcome to the residents was the resident would receive a medication without consent. Policy Interpretation and Implementation: Policy was not provided prior to the exit date of 5/16/2024 at 1:15pm. The Policy for Informed Consent was requested by this surveyor from the ADM on 5/16/2024 at 12:28pm.

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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 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 46425 Based on interview and record review, the facility failed to ensure all residents had the right to formulate an advance directive for 3 of 15 residents (Residents #5, #13, and #30) reviewed for advanced directives, in that: Residents #5, #13, and #30 were listed as a DNR (Do Not Resuscitate) but had Out-of-Hospital Do Not Resuscitate (OOH-DNR) forms that were incorrectly filled out or missing required information. These failures could place residents at risk for not having their end of life wishes honored and incomplete records. Findings included: Resident #5 Record review of Resident #5's current undated face sheet revealed an [AGE] year-old-female who was admitted to the facility on [DATE] with a primary diagnosis of dementia. Additionally, the advance directive was listed as OOH-DNR. Record review of Resident #5's physician order summary dated [DATE] revealed physician orders listed as do not resuscitate, dated [DATE]. Record review of Resident #5's care plan dated [DATE] revealed a care plan goal for OOH-DNR. Record review of Resident #5's OOH-DNR form dated [DATE] revealed it was completed by the Resident, contained two witnesses, Physician's Statement, and signed by a physician. However, the form was incomplete as it did not contain the date for the physician's signature. Resident #13 Record review of Resident #13's face sheet, dated [DATE], revealed a [AGE] year-old-female was admitted to the facility on [DATE] with diagnoses to include degeneration of the brain (decline and death of brain cells), major depressive disorder (mental health condition that causes a persistently low or depressed mood and loss of interest in activities) and lack of coordination (poor muscle control). The face sheet also revealed under the advance directive section - DNR-Do Not Resuscitate. Record review of Resident #13's physician order summary dated [DATE] revealed the following order: DNR-Do Not Resuscitate dated [DATE]. Record review of Resident #13's care plan, dated [DATE], revealed care plan for DNR. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #13's Out of Hospital Do Not Resuscitate form dated [DATE] revealed there was no date associated with the physician's signature and revealed missing guardian/agent/proxy/relative signature on the signature lines required at the bottom of the Out of Hospital Do Not Resuscitate. Resident #30 Record review of Resident #30's face sheet, dated [DATE], revealed an [AGE] year-old-male was admitted to the facility on [DATE] with diagnoses to include unspecified dementia (loss of cognitive skills and functioning), cellulitis of right lower limb (infection), and neuromuscular dysfunction of bladder (loss of bladder control). The face sheet also revealed under the advance directive section - OOH-DNR. Record review of Resident #30's physician order summary dated [DATE] revealed the following order: OOH-DNR dated [DATE]. Record review of Resident #30's care plan, last reviewed on [DATE], revealed a care area for OOH-DNR. Record review of Resident #30's OOH-DNR form, signed by Resident #30 on [DATE], revealed there was no printed name or license number associated with the physician's signature that was dated [DATE]. During an interview on [DATE] at 12:10PM with the DON, she stated OOH DNR was not valid if it's not filled out correctly. She stated the social worker was usually the one who obtained the OOH DNR and then she reviews them. She verified missing information on OOH DNR for Residents #5, #13, and #30. She stated there was no system for monitoring OOH DNR for accuracy. She stated the reason the DNR's were not complete was human error. She stated the potential negative outcome could be a resident's end of life wishes may not be followed. During an interview on [DATE] at 12:28PM with the ADM, she stated the OOH DNR was not valid if not filled out correctly. She stated the social worker was responsible for making sure the OOH DNR was completed accurately. She stated they do not have a system in place to monitor OOH DNR for accuracy. She stated she should be reviewing OOH DNRs for accuracy. She verified missing information on OOH DNR for Residents #5, #13 and #30. She stated she does not know why the information was missing. She stated the potential negative outcome was a resident's end of life wishes may not be honored. She stated she had been trained on how to complete OOH DNR and her expectations were for them to be filled out completely and be correct. The Social Worker was not interviewed as she was out of the office and not reachable by phone. Record review of the Social Services Policies and Procedures Advanced Directives (Revised [DATE]) revealed the following: Policy Residents have the right to execute an advance directive specifying how decisions about the resident's care will be made. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. INSTRUCTIONS FOR ISSUING AN OOH-DNR ORDER PURPOSE Section A - If an adult person is competent and at least [AGE] years of age, he/she will sign and date the Order in Section A. Section B - If an adult person is incompetent or otherwise mentally or physically incapable of communication and has either a legal guardian, agent in a medical power of attorney, or proxy in a directive to physicians, the guardian, agent, or proxy may execute the OOH-DNR Order by signing and dating it in Section B. In addition, the OOH-DNR Order must be signed and dated by two competent adult witnesses, who have witnessed either the competent adult person making his/her signature in section A, or authorized declarant making his/her signature in either sections B, C, or E, and if applicable, have witnessed a competent adult person making an OOH-DNR Order by nonwritten communication to the attending physician, who must sign in Section D and also the physician's statement section. Optionally, a competent adult person or authorized declarant may sign the OOH-DNR Order in the presence of a notary public. However, a notary cannot acknowledge witnessing the issuance of an OOH-DNR in a nonwritten manner, which must be observed and only can be acknowledged by two qualified witnesses. Witness or notary signatures are not required when two physicians execute the OOH-DNR Order in section F. The original or a copy of a fully and properly completed OOH-DNR Order or the presence of an OOH-DNR device on a person is sufficient evidence of the existence of the original OOH-DNR Order and either one shall be honored by responding health care professionals. Record review of the facility's policy titled Advance Directives, undated revealed no information regarding the OOH DNR. 49927

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46425 48275 49927 Based on interviews and record review, the facility failed to ensure all Pre-Admission Screening and Resident Review (PASRR) Level I residents with mental illness were provided with a PASRR Evaluation assessment for 4 of 40 residents (Residents #7, #17, #19, and #23) reviewed for PASRR screening, in that: Residents #7, #17, #19, and #23 did not have an accurate PASRR Level 1 assessment when they have a diagnosis of mental illness. These failures could place residents with an inaccurate PASRR Level 1 and no PASRR Level 2 Evaluation at risk for not receiving care and services to meet their needs. The findings were as follows: Resident #7: Record review of Resident #7's electronic face sheet dated 5/15/2024 revealed an [AGE] year-old female, admitted to the facility on [DATE]. The face sheet indicated, under Diagnosis Information, a diagnosis of Major Depressive Disorder. Record review of Resident #7's Quarterly MDS assessment dated [DATE], revealed under Section C Cognitive Patterns, a BIMS score of 10 indicating the resident was moderately, cognitively impaired. Record review of Resident #7's most recent care plan, undated, revealed a diagnosis of Major Depressive Disorder. Resident #7's care plan indicated a focus area for psychoactive medications and indicated Resident #7 was prescribed Ativan and Elavil for anxiety and depression to assist with this area of need. This focus area began on 9/5/2023. Record review of Physician order summary for Resident #7, dated 5/14/2024, revealed, under pharmacy, Resident #7 was prescribed Ativan 1 mg, at bedtime, related to anxiety disorder and Zoloft 25 mg, once a day, related to Life Management Difficulty. Record review of Resident #7's PL1 form dated 1/7/2019 revealed under section C0100 Mental Illness an answer of NO, indicating the resident does not have a mental illness. Resident #17: (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #17's electronic face sheet, dated 5/15/2024, revealed a [AGE] year-old female, admitted to the facility on [DATE]. The face sheet listed under Diagnosis Information a diagnosis of Major Depressive Disorder. Record review of Resident #17's Quarterly MDS assessment, dated 10/1/2023, revealed under Section C Cognitive Patterns, a BIMS score of 10 indicating the resident was moderately, cognitively impaired. Record review of Resident #17's most recent care plan, dated 5/13/2024, revealed a diagnosis of Major Depressive Disorder. Resident #17's care plan had focus areas of anxiety, depression, and mood. This focus area began on 8/10/2022. Record review of Physician order summary for Resident #17, dated 5/14/2024, revealed, under pharmacy, Resident #17 was prescribed Zoloft 100mg, 1.5 tablet, at bedtime, related to Major Depressive Disorder. Record review of Resident #17's PL1 form, dated 7/29/2022, revealed under section C0100 Mental Illness an answer of NO, indicating the resident does not have a mental illness. Resident #19: Record review of Resident #19's electronic face sheet dated 5/15/2024 revealed an [AGE] year-old female, admitted to the facility on [DATE]. The face sheet listed, under Diagnosis Information, a diagnosis of Major Depressive Disorder. Record review of Resident #19's Quarterly MDS assessment dated [DATE], revealed, under section I Active Diagnoses, a diagnosis of Major Depressive Disorder. Additionally, under Section C Cognitive Patterns, the MDS revealed a BIMS score of 10 indicating the resident was moderately, cognitively impaired. Record review of Resident #19's most recent care plan, undated, revealed a focus area and diagnosis of Major Depressive Disorder. This problem started 9/27/2023. Resident #19 was prescribed Cymbalta 30mg once a day to assist with this area of need. Record review of Physician progress notes for Resident #19 dated 5/15/2024 revealed, under current medications, Resident #19 was prescribed Cymbalta 30mg once a day for depression. Record review of Resident #19's PL1 form dated 9/10/2021 revealed, under section C0100 Mental Illness, an answer of NO, indicating the resident does not have a mental illness. Resident #23 Record review of Resident #23's electronic face sheet dated 5/15/2024 revealed a [AGE] year-old female most recently admitted to the facility on [DATE]. The face sheet listed, under Diagnosis Information, a diagnosis of Major Depressive Disorder. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #23's Annual MDS assessment dated [DATE], revealed, under section I Active Diagnoses, a diagnosis of Major Depressive Disorder. Additionally, under Section C Cognitive Patterns, the MDS revealed a BIMS score of 10 indicating the resident was moderately cognitively impaired. Record review of Resident #23's most recent care plan, undated, revealed a focus area and diagnosis of Major Depressive Disorder. This problem started 2/19/2024. Record review of Physicians orders for Resident #23 dated 5/15/2024 revealed Resident #23 was prescribed Xanax 0.5 mg three times a day to assist with anxiety. Record review of Resident #23's PL1 form dated 8/25/2022 revealed under section C0100 Mental Illness an answer of NO, indicating the resident does not have a mental illness. During an interview conducted on 5/16/2024 at 10:30 AM with the ADM and DON, it was verified Residents #7, #17, #19, and #23, had a diagnosis of mental illness. It was verified with the DON, Residents #7, #17, #19, and #23 did not have PASRR 2 Evaluations as their PASRR 1's were negative. The ADM stated the purpose of the PASRR 1 was to identify Residents who required additional services. She stated if the PASRR 1 is positive, the PASRR 1 should be referred to the local mental health authority for completion of a PASRR 2 Evaluation. The ADM and DON stated the DON is responsible for entering the PASRR 1 into the system, and she would be responsible for ensuring they are accurate by comparing them to medical records. The ADM and the DON stated they were not aware a diagnosis of Major Depressive Disorder would require a positive PASRR 1. The DON stated the potential harm if a resident with a diagnosis of a mental illness had a negative PASRR 1, and no subsequent level PASRR 2 evaluation was, the residents could potentially go without services. The DON confirmed this and stated the Resident could miss out on necessary services. Record review of facility policy, titled, Preadmission Screening and Resident Review (PASRR) Policy Revised July 2023: The facility policy for PASARR states all applicants admitted to a Medicaid-certified nursing facility are evaluated for mental health prior to admissions and offered the most appropriate setting for their needs. If the PASARR level one screening indicated the individual may have an Intellectual Disability or a Mental Illness diagnosis the facility will confer with local mental health providers to complete a PASARR level two screening. Following the completion of the level two screening a care plan will be developed by the facility to meet the needs of a resident with an Intellectual Disability or a Mental Illness diagnosis.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42515 Based on observation, record review and interview, the facility failed to develop a comprehensive care plan that includes measurable objectives and timeframes to meet a resident's medical, nursing, mental, and psychosocial needs for 4 of 15 residents (Residents #11, #13, #14, and #23) reviewed for care plans as follows: The facility failed to develop a care plan for vision for Resident #11. The facility failed to develop a care plan for smoking and psychotropic medications for Resident #13. The facility failed to develop a care plan for advanced directives for Resident #14. The facility failed to develop a care plan for smoking for Resident #23. These failures could place residents at risk of not receiving the care required to meet their physical, mental, and psychosocial needs to attain or maintain their highest practicable physical, mental, and psychosocial outcome. Findings include: Resident #11 Record review of the admission record for Resident #11 dated 05/15/24 revealed an [AGE] year-old female who was admitted to the facility on [DATE] with the following diagnoses: inappropriate sinus tachycardia (heart problems), major depressive disorder (mood disorder), and type 2 diabetes mellitus (problems with blood sugar). Record review of the comprehensive MDS assessment dated [DATE] revealed that Resident #11 was understood and had a BIMS score of 10 indicating that the resident's cognition was moderately impaired. Section V Care Areas triggered revealed: 3. Visual Function was checked with the remarks vision declining. Record review of the current care plan for Resident #11, undated, revealed there was no focus area for Visual function. Resident #13 Record review of Resident #13's face sheet, dated 05/15/24, revealed a [AGE] year-old-female was admitted to the facility on [DATE] with diagnoses to include degeneration of the brain (decline and death of brain cells), major depressive disorder (mental health condition that causes a persistently low or depressed mood and loss of interest in activities) and lack of coordination (poor muscle control). (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #13's physician order summary dated 05/15/24 revealed the following order: Cymbalta 30 milligrams one capsule a day in the morning related to Major Depressive Disorder. Record review Resident #13's of comprehensive MDS assessment dated [DATE] revealed the following: Section C - Cognitive Patterns - C0500. BIMS Summary Score= 06 which was rated as severely cognitively impaired (not alert and oriented to time, place, and person). Section I- Active Diagnosis- I5800. Depression (conditions associated with lowering of a person's mood). Section N- Medications-N0415 indicates the resident is taking an antidepressant (medications used to improve mood). MDS does not indicate the resident is a smoker. Record review of the facility's undated list of active smokers, provided on 5/14/24 revealed Resident #13's name. Record Review of Resident #13's Care Plan dated 02/24/24 revealed the care plan did not address smoking. In addition, the care plan did not indicate the resident is prescribed an anti-depressant. Observation on 05/14/24 at 2:15 PM, Surveyor witnessed Resident #13 smoking. Resident #14 Record review of the admission record for Resident #14, dated 05/14/24 revealed a [AGE] year-old male who was admitted to the facility on [DATE] with the following diagnoses: hypertensive heart disease (heart disease), primary generalized osteo arthritis (bone and joint disease), and muscle weakness. Record review of the comprehensive MDS assessment dated [DATE] revealed that Resident #14 was understood and had a BIMS score of 04 indicating that the resident's cognition was severely impaired. Record review of the order summary report for Resident #14, dated 05/14/24, revealed the following order: OOH-DNR (Out of Hospital-Do No Resuscitate) with a start date of 02/14/24. Record review of the current care plan for Resident #14, last reviewed on 03/26/24, revealed there was no specific care plan regarding advanced directives. Resident #23 Record review of the admission record for Resident #23, dated 05/16/24 revealed a [AGE] year-old female who was admitted to the facility on [DATE] and readmitted on [DATE] with the following diagnoses: chronic obstructive pulmonary disease (lung disease), dementia (loss of cognitive thinking and skills), and gastro-esophageal reflux disease (stomach problems). (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the comprehensive MDS assessment dated [DATE] revealed that Resident #23 was understood and had a BIMS score of 10 indicating that the resident's cognition was moderately impaired. The MDS further revealed Resident #23 currently used tobacco. Record review of the facility document regarding residents who smoked at the facility revealed Resident #23's name was listed. Record review of the current care plan for Resident #23, undated, revealed there was no specific care plan regarding smoking. During an interview on 05/16/24 at 10:47 AM, the DON stated the SW and her were responsible for completing the care plans at the facility. The DON stated she did not know why Resident #11 was missing a care plan for vision, Resident #13 was missing a care plan for the Cymbalta (mood medication) she was taking or for smoking, Resident #14 was missing a care plan for his DNR status, or why Resident #23 was missing a care plan for smoking. The DON stated she care plans for the nursing areas and the SW care plans for the other areas. The DON stated the care areas for the residents may not have transferred over when they switched from paper to electronic charting. The DON stated she was responsible for ensuring care plans were complete. The DON stated she last did an audit on the care plans back in January 2024 but was unsure the exact date. The DON was asked about a potential negative outcome for the residents having missing care plans and she stated it was important for the nurses to know the correct information. During an interview on 05/16/24 at 11:10 AM, the ADM stated the care plans reflected the resident and how they were expected to care for them. The ADM stated the DON was responsible for ensuring the care plans were completed. The ADM stated she did not know why the care areas were missing for some residents and stated they may have been missed when the facility transferred from paper to electronic. The ADM stated the potential negative outcome to the residents was not everyone would be aware of their needs. During a phone interview on 05/16/24 at 11:58 AM, the SW stated she completed the care plan with the DON. The SW stated she did not know why Resident's #11, #13, #14, and #23 were missing care areas. The SW stated she did not know that smoking was an area that needed to be care planned. The SW stated she audits the care plans during their quarterly assessments. The SW stated the potential negative outcome to the residents was they could be neglected for care. Record review of the facility policy titled, Care Plans, Comprehensive Person-Centered, with a revised date of December 2016, reflected the following: Policy Statement: A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. Policy Interpretation and Implementation: .2. The care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment . 8. The comprehensive, person-centered care plan will: (continued on next page)

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	675061	A. Building B. Wing	05/16/2024

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Munday Nursing Center	421 West F St Munday, TX 76371

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	b. Describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well being; g. Incorporate identified problem areas; h. Incorporate risk factors associated with identified problems; m. Aid in preventing or reducing decline in the resident's functional status and/or functional levels; o. Reflect currently recognized standards of practice for problem areas and conditions 46425 48275

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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. 48275 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. The facility failed to ensure foods were labelled and dated. These failures could place residents at risk for food-borne diseases and food contamination. The findings included: - The following observation was made during a kitchen tour on 05/14/24 that began at 09:41 AM and concluded at 10:56 AM: - Dirty and sticky doors of 2 freezers and 1 refrigerator. - Undated and unlabeled hot dogs inside the freezer. - Undated and unlabeled Baloney inside the freezer. - Undated and unlabeled Ham inside the freezer. - Undated and unlabeled Fish inside the freezer. - Undated and unlabeled Pancakes inside the freezer. - Undated and unlabeled Hamburger Patties inside the freezer. - Undated and unlabeled Garlic Sticks inside the freezer. - Undated and unlabeled Mixed Vegetables inside the freezer. - Undated and unlabeled Omelets inside the freezer. - Undated and unlabeled Chicken thighs inside the freezer. - Undated and unlabeled Macaroni & Cheese inside the freezer. - Undated and unlabeled Onion rings inside the freezer. - Undated and unlabeled French fries inside the freezer. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Interview on 05/16/24 at 10:45 AM, the Dietary Manager stated all the dietary staff were responsible for ensuring food items were labelled and dated. The Dietary Manager stated it was so difficult writing on the zip lock bags and there was not enough space to put the food items inside the freezers from the container boxes. The Dietary Manager stated she was responsible for ensuring/monitoring food items were labelled and dated. The Dietary Manager stated that every staff was trained upon hire,. The Dietary Manager stated the potential negative outcomes to the residents with unlabeled and undated food items, could cause food-borne diseases since no one knows how long the food has been stored. The Dietary Manger stated that she does not have any policy for food storage/labelling, rather the ADM had the policy. Interview on 05/16/24 at 10:56 AM, the ADM stated typically, whoever was unloading the truck, mostly the Dietary Manager or the kitchen staffs or sometimes herself, were responsible for labelling and dating of the food items. The ADM stated the Dietary Manager was responsible for making sure food items were properly labelled and dated. The ADM stated kitchen staff members have all been trained on labelling/dating of food items upon hiring. The ADM stated in the past, the food comes in frozen and wet, so the marker does not work on them, and they lack enough space inside the freezer. The ADM stated the potential negative outcomes to the residents with unlabeled/undated food, could cause food-borne diseases. The ADM stated that they do have a policy on food storage. Record review of the facility policy and procedure titled, Storage of Frozen & Refrigerated Foods, dated 08/29/2005, reviewed date 12/04/2006, reflected the following: Policy: All Refrigerated and Frozen items will contain proper labeling of at least the common name of the product and dated. Items to be stored in the Refrigerator upon delivery are to be dated to delivery date and expiration date - 7 days following delivery date. The only exception to expiration dating is items containing an expiration date from the manufacturer, ex. Milk. Freezer units should be kept between minus10 degrees to zero degrees Fahrenheit .

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42515 49305 Based on observation, interview and record review the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 1 of 16 residents (Resident #30) and 1 of 3 staff (CNA A) reviewed for infection control. 1. CNA A failed to change gloves when providing incontinent care for Resident #30. This failure could place residents at risk for spread of infection and cross contamination. Findings include: 1. Record review of Resident #30's face sheet, dated 05/16/24, revealed an [AGE] year-old male admitted to the facility on [DATE] with diagnoses to include: unspecified dementia (loss of intellectual functioning), major depressive disorder (persistent low or depressed mood), neuromuscular dysfunction of bladder, (lack of bladder control due to brain or nerve problems), hypertension (elevated blood pressure), atherosclerotic heart disease (damage to the heart's major vessels), congestive heart failure (chronic condition where the heart doesn't pump as well as it should). Record review of Resident #30's MDS Annual assessment dated [DATE] revealed resident has a BIMS score of 09, indicating resident is moderately cognitively impaired. MDS section H revealed Resident #30 has an indwelling catheter and is frequently incontinent of bowel. Record review of Resident #30's care plan dated 05/02/24 revealed resident has an indwelling catheter, is incontinent of bowel and requires assistance with catheter care and incontinent care. During an observation of incontinent care on 05/15/24 at 10:35 AM for Resident #30, CNA A washed his hands and closed the door to the room. LVN A was present to provide assistance in turning the resident and was also observed to wash her hands and don gloves. CNA A donned gloves and explained the procedure to the resident. The resident gave verbal permission for the surveyor to observe care. CNA A removed the resident's brief and performed male incontinent care and catheter care using incontinent wipes. CNA A rolled the resident to his left side, with the assistance of LVN A, and cleaned the scrotum and buttocks with wipes. CNA A removed the dirty brief and incontinent wipes and placed them in the trash. CNA A picked up a clean brief and placed it on the resident. CNA A then pulled the sheet back up over the resident and used the pull cord on the over-bed light to dim the lighting. There was Nno observation of CNA A changing gloves/performing hand hygiene during the procedure. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 05/15/24 at 10:47 AM, CNA A stated he did not remove gloves or sanitize hands between performing dirty and clean aspects of incontinent care. He said the proper time to remove gloves is after performing incontinent care and before applying a clean brief or between any dirty and clean portions of incontinent care. CNA A stated he did not know why he failed to change his gloves and that he was nervous during the observation. He stated, I even put an extra set of gloves on the table, then forgot. He stated he has been trained on proper hand hygiene by in-servicing from the DON and the administrator and through annual computer training and skills checks. CNA A stated a potential negative outcome for failure to change gloves during incontinent care would be that the resident could get an infection. During an interview on 05/16/24 at 10:05 AM, The ADM stated her expectation of staff is to always follow policy. She stated staff have been trained by herself and the DON through periodic skills checks, in-servicing and annual computer-based training. The ADM stated a potential negative outcome of failure to change gloves and perform hand hygiene before, during and after incontinent care is illness. During an interview on 05/16/24 at 11:15 AM, DON stated gloves should be changed between clean and dirty aspects of incontinent care. The DON stated staff are trained by in-services done monthly and as needed, as well as through periodic skills checks done by herself or the administrator. She stated staff are also trained through annual computer-based training. The DON stated a potential negative outcome of failure to change gloves and perform hand hygiene before, during and after incontinent care would be infection. Record review of the facility's policy titled Handwashing/Hand Hygiene revised August of 2015 revealed: Policy Statement: This facility considers hand hygiene the primary means to prevent the spread of infections. Policy Interpretation and Implementation: 2. All personnel shall follow the hand washing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents and visitors. 7. Use an alcohol-based hand rub containing at least 62% alcohol; Or, alternatively, soap (antimicrobial or non-antimicrobial) and water for the following situations: b. Before and after direct contact with residents; h. Before moving from a contaminated body site to a clean body site during resident care; i. After contact with a resident'sce intact skin; m. After removing gloves; 8. Hand hygiene is the final step after removing and disposing of personal protective equipment. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	9. The use of gloves does not replace hand washing/hand hygiene. Integration of glove use along with routine hand hygiene is recognized as the best practice for preventing healthcare associated infections.