STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675066	A. Building B. Wing	09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Honey Grove Nursing Center	1303 E Main St Honey Grove, TX 75446

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46892 Based on observation, interview, and record review, the facility failed to provide a safe, clean, and comfortable homelike environment for 1 of 16 resident rooms (Resident #38) reviewed for environment. The facility failed to ensure Resident #38's door was properly functioning. This failure could place residents at risk for an uncomfortable, unhomelike environment, and a diminished quality of life. Findings included: Record review of a face sheet dated 09/24/2024, indicated Resident #38 was an [AGE] year-old female admitted to the facility on [DATE] with diagnoses which included Alzheimer's Disease with early onset (progressive disease that destroys memory and other important mental functions starting earlier in life) and heart failure (chronic, progressive condition in which the heart muscle is unable to pump enough blood to meet the body's needs for blood and oxygen). Record review of the Quarterly MDS assessment dated [DATE], indicated Resident #38 was able to make herself understood and understood others. The MDS assessment indicated Resident #38 had a BIMS score of 6, which indicated her cognition was severely impaired. The MDS assessment indicated Resident #38 required set-up or clean-up assistance for eating, oral hygiene, and partial/moderate assistance for toileting hygiene and showering/bathing self. Record review of Resident #38's care plan last reviewed 09/06/2024 indicated she had impaired cognitive function/dementia (deterioration of memory, language, and other thinking abilities) or impaired thought processes to provide the resident with a homelike environment. During an observation and interview on 09/24/2024 at 10:19 AM, Resident #38's door was dragging on the bottom and the floor had skid marks where the door was dragging. Resident #38's door was not easily opened and closed. Resident #38 said when the CNAs checked on her early in the morning when they opened the door it made loud noises, and it would wake her up. Resident #38 said the nurses and the CNAs knew the door needed to be fixed that they got frustrated with it all the time. (continued on next page)

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

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 09/25/2024 at 8:51 AM, CNA A said Resident #38's door to her room was dragging on the floor and had caused visible scrapes. CNA A said the Maintenance Director was aware that it needed to be repaired. CNA A said the door had been dragging since she started working on the floor about a month or two ago. CNA A said the door dragging on the floor startled Resident #38 in the mornings. CNA A said it was important for the residents' rooms to be repaired because it was their home, and they had the right to have as much of a comfortable home as possible. During an interview on 09/25/2024 at 9:04 AM, the Maintenance Director said he was responsible for fixing the rooms. The Maintenance Director said the staff had mentioned to him that Resident #38's door to her room needed to be fixed. The Maintenance Director said he was not sure how long ago it was mentioned to him. The Maintenance Director said he realized there was a portion of Resident #38's door rubbing on the floor, but he had not had a chance to sand it down. The Maintenance Director said he checked every room once a month. The Maintenance Director said Resident #38's door dragging on the flood could affect how she was entering and exiting the room. The Maintenance Director said it was important for the residents' rooms to be in good repairs so the residents could access their living environment and be in a safe environment. During an interview on 09/26/2024 at 11:05 AM, Administrator T said she was not aware Resident #38's door needed to be repaired. Administrator T said she expected for the Maintenance Director to be notified of any repairs that needed to be made and for him to make the required repairs. Administrator T said it was important for repairs to be made for the residents' safety and happiness just like we would like in our own home. Record review of the maintenance logs provided by the Maintenance Director dated from 04/23/24-09/25/2024 did not indicate a request for Resident 38's door to be fixed. Record review of the facility's policy titled, Resident Rights, indicated, .Safe environment - The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely .

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43047 Based on interview, and record review the facility failed to ensure assessments accurately reflected the resident status for 2 of 16 residents (Residents #42 and #43) reviewed for MDS assessment accuracy. 1. The facility did not ensure Resident #42's MDS assessment was accurately coded for wandering. 2. The facility failed to ensure Resident #43's antibiotic use was accurately coded. These failures could place residents at risk for not receiving care and services to meet their needs. Findings included: 1. Record review of Resident #42's face sheet, dated 09/26/24, indicated Resident #42 was admitted to the facility on [DATE] with diagnoses which included Alzheimer's (progressive disease that destroys memory and other important mental functions). Record review of the Admission MDS assessment, dated 06/14/24, indicated Resident #42 made himself understood and understood others. Resident #42's BIMS score was 4, which indicated his cognition was severely impaired. Resident #42 did not have disorganized thinking, behaviors, wandering, or refusal of care. Resident #42 used a wheelchair. Record review of the comprehensive care plan, revised 07/19/24, indicated Resident #42 was a at risk for wandering. The care plan interventions included, distract resident from wandering by offering pleasant diversions, structured activities, food, conversation, television, book, identify pattern of wandering, if the resident is exit seeking, stay with the resident and notify the charge nurse by calling out, sending another staff member, call system, etc., monitor my location frequently through the day while I am up & out of bed, and wear owander alert bracelet in place (on w/c) & check for placement q shift. Record review of the comprehensive care plan, revised 09/15/24, indicated Resident #42 was at risk for elopement as evidenced by: resident history of exit seeking and exiting out of door of facility. The care plan interventions included, resident moved to secure care unit, assess/record/report to MD risk factors for potential elopement such as: Wandering, Repeated requests to leave facility, statements such as I'm leaving I'm going home, attempts to leave facility, elopement attempts from previous facility, home, or hospital, supervise closely, and make regular compliance rounds whenever resident is in room, determine the reason the resident is attempting to elope. Is the resident looking for something or someone? Does it indicate the need for more exercise? Intervene as appropriate, provide structured activities: for inside and outside, reorientation strategies including signs, pictures, and memory boxes, distract resident from elopement attempts by offering pleasant diversions, structured activities, food, conversation, television, books, and if the resident is exiting seeking, stay with the resident and notify the charge nurse by calling out, sending another staff member, call system, etc. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the referral paperwork from a sister facility dated 06/05/24 revealed Resident #42 would be sent to a secure unit facility. Record review of Resident #42's elopement assessment, dated 06/05/24, reflected Resident #42 was at risk for elopement. Record review of the progress note dated 06/08/24 completed by LVN X indicated Resident #42 was wondering up and down hallway agitated and confused about why he is here in facility. Attempts to redirect unsuccessful due to confusion. 46892 2. Record review of a face sheet dated 09/26/2024 indicated Resident #43 was a [AGE] year-old female initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included Alzheimer's Disease (progressive disease that destroys memory and other important mental functions). Record review of the Quarterly MDS assessment dated [DATE] indicated Resident #43 was able to make herself understood and understood others. The MDS assessment indicated Resident #43 had a BIMS score of 2, which indicated her cognition was severely impaired. The MDS assessment indicated Resident #43 received an antibiotic during the last 7 days or since admission/entry or reentry if less than 7 days. Record review of Resident #43's Order Summary Report dated 09/25/2024 did not indicate orders for an antibiotic. Record review of Resident #43's care plan last reviewed 07/08/2024 did not indicate the use of an antibiotic. Record review of Resident #43's August 2024 MAR did not indicate Resident #43 received an antibiotic. During an interview on 09/26/2024 at 8:59 AM, Regional Reimbursement Nurse B said he had started completing MDS assessments at the facility 2 weeks ago. Regional Reimbursement Nurse B said the facility currently did not have an MDS nurse, but there was one starting 09/30/2024. Regional Reimbursement Nurse B said Resident #43 should not have been coded as taking an antibiotic because she had not taken an antibiotic in the look back period. Regional Reimbursement Nurse B said Resident #42 should have been coded as wandering for 1-3 days because it was noted in the progress notes that he wandered on 1 day in the look back period. Regional Reimbursement Nurse B said he did not know who had completed Resident #42's and #43's MDS assessment. Regional Reimbursement Nurse B said the person who signed a completed MDS signed for the accuracy of the MDS assessment. Regional Reimbursement Nurse B said it was important for the MDS assessments to be accurate because it reflected the resident. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 09/26/2024 at 11:07 AM, Administrator T said she expected for the MDS assessments to be coded accurately by the MDS nurses. Administrator T said the regional corporate person was responsible for providing oversight to the MDS nurse. Administrator T said they currently did not have a MDS nurse. The previous MDS nurse's last day was last Friday 09/20/24, and the new MDS nurse was starting 9/30/24. Administrator T said it was important for the MDS assessments to be coded accurately for billing purposes. During an attempted phone interview on 09/26/2024 at 11:24 AM, MDS Coordinator C did not answer the phone. Record review of the facility's undated policy titled, Minimum Data Set (MDS) Policy for MDS assessment Data Accuracy 2.2021 CMS RAI 10.2023, indicated, Purpose/Policy The purpose of the MDS policy is to ensure each resident receives an accurate assessment by qualified staff to address the needs of the resident who are familiar with his/her physical, mental, and psychosocial well-being . Federal regulations at 42 CFR 483.20 (b)(l)(xviii), (g), and (h) require that: 1. The assessment accurately reflects the resident's status .

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46892 Based on interviews and record review, the facility failed to implement a comprehensive person-centered care plan to meet resident's medical, nursing, mental and psychosocial needs identified in the comprehensive assessment for 1 of 16 residents (Resident #1) reviewed for care plans. The facility failed to care plan that Resident #1 was PASRR positive for mental illness and an intellectual disability. These failures could place the residents at increased risk of not having their individual needs met and a decreased quality of life. Findings included: Record review of a face sheet dated 09/25/2024 indicated Resident #1 was a [AGE] year-old female initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included schizoaffective disorder, bipolar type (mood disorder that can involve delusions, hallucinations, depression, disorganized thinking and speech) and intellectual disabilities. Record review of the Comprehensive MDS assessment dated [DATE], indicated in Section A1510 Resident #1 was considered by the state level II PASRR process to have serious mental illness and an intellectual disability. The MDS assessment indicated Resident #1 understood others and was able to make herself understood. The MDS assessment indicated Resident #1 had a BIMS score of 12, which indicated her cognition was moderately impaired. The MDS assessment indicated Resident #1 required supervision/touching assistance for toileting, showering/bathing self, and personal hygiene. Record review of Resident #1's PASRR Level 1 Screening completed on 07/16/2024 indicated in section C0100 that there was evidence or an indicator that this individual had mental illness, and in section C0200 that there was evidence or an indicator that this individual had an intellectual disability. Record review of Resident #1's PASRR Evaluation dated 07/17/2024 indicated she had an intellectual disability which manifested before the age of 18, and mental illness which included a mood disorder, schizoaffective disorder, and panic or other severe anxiety disorder. Resident #1's PASRR Evaluation indicated based on the QMHP assessment Resident #1 met the PASRR definition of mental illness. Record review of Resident #1's care plan last reviewed 09/06/2024 did not address Resident # 1's PASRR status. During an interview on 09/26/2024 at 8:59 AM, Regional Reimbursement Nurse B said he had looked at a couple care plans but he was not really completing them. Regional Reimbursement Nurse B said the care plans were being completed by the staff in the facility. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 09/26/2024 at 10:27 AM, the Regional Compliance Nurse said Resident #1's care plan should have included PASRR. The Regional Compliance Nurse said it must have been an oversight that it was not included in Resident #1's care plan. The Regional Compliance Nurse said it was the responsibility of the MDS nurse to ensure PASRR was included in the residents' care plans. The Regional Compliance Nurse said it was important for PASRR to be included in the residents' care plans so that everyone knew the specialized services they were receiving. During an interview on 09/26/2024 at 11:10 AM, Administrator T said the MDS Coordinator, and the nurses were responsible for completing the care plans. Administrator T said she expected for PASRR services to be included in the residents' care plans. Administrator T said it was important for the PASRR services to be included in the resident's care plan to ensure staff knew they received specialized services and to ensure they were providing the best care possible. During an attempted phone interview on 09/26/2024 at 11:24 AM, MDS Coordinator C did not answer the phone. Record review of the facility's policy titled, Comprehensive Care Plans, revised 02/13/2007, indicated, The facility will develop a comprehensive care plan for each resident that includes measurable short-term and long-term objectives and timetables to meet a resident=s [sic] medical, nursing, and mental and psycho-social needs that are identified in the comprehensive assessment .

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43047 Based on observations, interviews, and record review the facility failed to ensure the resident environment remained free of accident hazards as possible, and each resident received adequate supervision to prevent elopement for 1 of 5 residents (Resident #42) reviewed for accident hazards and supervision. 1. The facility did not ensure Resident #42 received adequate supervision to prevent exiting the facility without staff knowledge on 09/15/24. 2. The facility did not ensure exits accessible to residents who could exit unsupervised alarmed loud enough to allow staff to respond in a timely manner. An IJ was identified on 09/23/24. The IJ template was provided to the facility on [DATE] at 5:32 p.m. While the IJ was removed on 09/24/24, the facility remained out of compliance at a scope of isolated and a severity level of no actual harm with potential for more than minimal harm that is not immediate jeopardy due to the facility continuing to monitor the implementation and effectiveness of their Plan of Removal. These failures could place residents at risk of serious injury or harm. Findings included: Record review of Resident #42's face sheet, dated 09/26/24, indicated Resident #42 was admitted to the facility on [DATE] with diagnoses which included Alzheimer's (progressive disease that destroys memory and other important mental functions). Record review of the Admission MDS assessment, dated 06/14/24, indicated Resident #42 made himself understood and understood others. Resident #42's BIMS score was 4, which indicated his cognition was severely impaired. Resident #42 did not have disorganized thinking, behaviors, wandering, or refusal of care. Resident #42 used a wheelchair. Record review of the comprehensive care plan, revised 07/19/24, indicated Resident #42 was a at risk for wandering. The care plan interventions included, distract resident from wandering by offering pleasant diversions, structured activities, food, conversation, television, book, identify pattern of wandering, if the resident is exit seeking, stay with the resident and notify the charge nurse by calling out, sending another staff member, call system, etc., monitor my location frequently through the day while I am up & out of bed, and wear owander alert bracelet in place (on w/c) & check for placement q shift. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of the comprehensive care plan, revised 09/15/24, indicated Resident #42 was at risk for elopement as evidenced by: resident history of exit seeking and exiting out of door of facility. The care plan interventions included, resident moved to secure care unit, assess/record/report to MD risk factors for potential elopement such as: Wandering, Repeated requests to leave facility, statements such as I'm leaving I'm going home, attempts to leave facility, elopement attempts from previous facility, home, or hospital, supervise closely, and make regular compliance rounds whenever resident is in room, determine the reason the resident is attempting to elope. Is the resident looking for something or someone? Does it indicate the need for more exercise? Intervene as appropriate, provide structured activities: for inside and outside, reorientation strategies including signs, pictures, and memory boxes, distract resident from elopement attempts by offering pleasant diversions, structured activities, food, conversation, television, books, and if the resident is exiting seeking, stay with the resident and notify the charge nurse by calling out, sending another staff member, call system, etc. Record review of the referral paperwork from a sister facility dated 06/05/24 revealed Resident #42 would be sent to a secure unit facility. Record review of Resident #42's elopement assessment, dated 06/05/24, reflected Resident #42 was at risk for elopement. Record review of the electronic medical records indicated Resident #42 was admitted to the secure unit on 06/05/24 but was moved off from the secured unit on 07/01/24. Record review of the MAR dated 09/01/24-09/31/24 indicated Resident #42 had a wanderguard and had been checked every shift for placement and function with a d/c date of 09/15/24. Record review of a progress note dated 07/01/24 at 4:05 p.m., completed by LVN D indicated Resident #42 attempted to exit door at the end of hall 5. Resident #42 was redirected, and alarm reset. No acute distress noted. Record review of a progress note dated 07/01/24 at 5:45 p.m., completed by LVN D indicated Resident #42 stated his truck got stole and he has been looking for his truck. Resident #42 tried to exit through the end of hall 5 door. Resident #42 stated, I don't know what the hell happened. Record review of Resident #42's elopement assessment, dated 07/01/24, reflected Resident #42 was at risk for elopement. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record of a progress note dated 07/10/24 at 4:10 a.m., completed by LVN E indicated Resident resting quietly in bed with eyes closed. Resident has been exit seeking this shift. Resident made out the door at the end of hall 5. When the staff was trying to redirect the resident, the resident became even more upset and was cursing yelling. Resident was finally distracted enough to come back in the building, by saying that it was to hot outside and the resident could be come dehydrated. Once the resident was back in the building. The resident made four other attempts to exit the building without success. However, each time his efforts did not produce the wanted outcome the resident became more and more upset. Re-direction was very difficult, with even stating that his truck was in the shop, offering food and Dr. Pepper, resident still remained upset for about 30-45 minutes. Resident filly calmed down approximately 10 p.m, while talking to female resident in the front lobby. Resident then went to his room and took a Dr. Pepper from his fridge and then went to bed at approximately 11:30 PM. Safety precaution met and call light and fluids within reach. Record review of Resident #42's elopement assessment, dated 07/20/24, reflected Resident #42 was at risk for elopement. Record review of the event nurses' note, dated 09/15/24, revealed Resident #42 was outside in the parking lot and was seen by Housekeeping Aide H as she was entering the parking lot via vehicle. Record review of the provider investigation report dated 09/15/24 indicated Housekeeping Aide H was pulling in the parking lot and saw Resident #42 outside. RN P had gone to get gloves when she heard the front door alarm, when she returned to the nurse's station, she asked about the door alarm. At that time LVN N was headed outside to assist Housekeeping Aide H with Resident #42. Resident #42 may have been outside for 2 minutes, no injuries. Record review of Resident #42's elopement assessment, dated 09/15/24, reflected Resident #42 was at risk for elopement. Record review of the electronic medical records indicated Resident #42 was moved on the secured unit 09/15/24. During an observation on 09/23/24 at 9:15 a.m., the front door had no locking mechanism or alarming system upon entrance to the building. The facility was located on a busy highway. During an observation and interview on 09/23/24 at 2:32 p.m., RN G and the state surveyor tested the alarm at the front door area which was not heard down the hallways by the other state surveyors. The front door wanderguard alarm was only audible to the front door area. RN G stated she had observed exit seeking behaviors in the past with Resident #42 on several different occasions, but he was able to be redirected easily. RN G stated interventions for residents at risk for elopement was redirection. During an observation and interview on 09/23/24 beginning at 4:54 p.m. with the Maintenance Supervisor he performed a door alarm check on all halls. 3 out of 7 facility exit doors did not alarm when opened by the Maintenance Supervisor. 2 out of 7 facility exit doors were attached to the wanderguard system. The Maintenance Supervisor stated the alarms should sound when the door was opened but was unsure why the door alarm was not activated. The Maintenance Supervisor stated he performed weekly door alarm checks. The Maintenance Supervisor stated the risk of the door alarms not been activated when the door opened would put residents at risk for elopement. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of sheet titled Task #317502 indicated the Maintenance Supervisor performed door alarm checks on all halls 09/12/24. During an attempted interview on 09/23/24 at 11:15 a.m. with Resident #42, indicated he was non-interview able. During an interview on 09/23/24 at 11:28 a.m., CNA O stated she was the CNA for the secured unit. CNA O stated Resident #42 was admitted on the secured unit but was removed off when there was an incident between him and another resident and him required to be transferred by hoyer lift. CNA O stated Resident #42 did have exit seeking behaviors prior to being removed off the unit but was able to be redirected. CNA O stated on 09/15/24 the day Resident #42 eloped she was in the kitchen getting cereal for another resident when Housekeeping Aide H came in and stated LVN N needed assistance with getting Resident #42 back in the building. CNA O stated when she went outside Resident #42 was halfway in the parking lot. CNA O stated she assisted LVN N with getting him back in the building. CNA O stated she could not recall the reason why Resident #42 stated he was outside. CNA O stated the front door wanderguard alarm did sound when Resident #42 was brought back in the building. CNA O stated Resident #42 was placed on 1:1 until the nurse obtained an order to place him on the secured unit. CNA O stated it was unsure how Resident #42 got out the building. During an interview on 09/23/24 at 12:46 p.m., Housekeeping Aide H stated she was coming into work on 09/15/24 and saw Resident #42 sitting in his wheelchair between 2 cars which was approximately 50 feet from the front door. Housekeeping Aide H stated she tried to redirect Resident #42 back in the building but was unsuccessful. Housekeeping Aide H stated she left Resident #42 in the parking lot by himself while she went in the facility to get assistance. Housekeeping Aide H stated she grabbed LVN N and told her Resident #42 was found outside in the parking lot. Housekeeping Aide H stated LVN N told her she needed a CNA, so she went back in the building to grabbed one while LVN N stayed with Resident #42. Housekeeping Aide H stated CNA O came out to assist LVN N with getting Resident #42 back in the building. During an interview on 09/23/24 at 2:54 p.m., RN P stated the day Resident #42 eloped she was down the hallway with CNA Q attempting to find the supply closet because she was new to the facility. RN P stated during that time she thought she had heard an alarm going off but only for a short time. RN P stated she started coming up the hallway when Housekeeper Aide H had come up saying LVN N needed help with Resident #42 who was found outside in the parking lot. RN P stated she went outside, and Resident #42 was easily redirected into the facility. RN P stated the Administrator, and the Regional Compliance Nurse were notified, and she was instructed to sit 1:1 with him until an order was obtained for the secured unit. RN P stated multiple elopement drills were completed the day of the incident, in-servicing was performed on abuse/neglect and elopement prevention and response. RN P stated that no other staff members had heard an alarm during the investigation, so she assumed she was just hearing things. RN P stated that when Resident #42 was brought inside the facility the wander guard system on his wheelchair set the front door alarm off, so they knew the door alarm was working. RN P stated that when Resident #42 was back inside the facility, an assessment was completed. RN P stated Resident #42 had no visible issues. During an interview on 09/23/24 at 3:20 p.m., CNA R stated she was in a room down the hall and did not hear any door alarms going off while in the room when Resident #42 was found outside. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Honey Grove Nursing Center	1303 E Main St Honey Grove, TX 75446

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 09/23/24 at 3:53 p.m., the ADON stated Resident #42 was admitted to the facility on [DATE] to the secured unit because the facility he was at he was having exit seeking behaviors. The ADON stated Resident #42 was removed off on 07/01/24 due to an incident with another resident and requiring a hoyer lift for transfer. The ADON stated if a resident required a hoyer lift they did not meet the secured unit requirement. The ADON stated Resident #42 did have exit seeking behaviors but was easily redirected. The ADON stated he would always state he was looking for his truck. The ADON stated when Resident #42 tried to elope on 07/01/24 and 07/10/24 the only interventions she was aware was the wanderguard and redirection. The ADON stated she did not reassess Resident #42 after the attempted elopements back in July. The ADON stated the DON was on medical leave at this time and she did not know if she reassessed the resident to ensure safety. The ADON stated the ADO came in the week on 09/02/24 and saw Resident #42 exit seeking and asked her why he was not on the unit. The ADON stated after she told her the reason why he was not she stated a hoyer lift transfer could be on the unit. The ADON stated after the conversation with the ADO, Resident #42 was not placed on the because when he started to exhibit exit seeking behaviors, he was able to be redirected so putting him back on the unit was never brought back up until he eloped on 09/15/24. The ADON stated the risk for residents eloping was a serious injury. During an interview on 09/23/24 at 4:14 p.m., LVN D stated she was on the unit passing medications when Resident #42 was found outside in the parking lot. LVN D stated Housekeeping Aide H came and told her Resident #42 was outside in the parking lot and LVN N was with him. LVN D stated she was unable to leave the residents by themselves on the secured unit, so she had to wait until CNA O came back on the unit. LVN D stated once CNA O came to relieved her, she went out and completed a head-to-toe assessment on Resident #42. LVN D stated all the responsible parties were notified and Resident #42 was moved to the secure unit when an order was obtained. LVN D stated she had observed exit seeking behaviors from Resident #42 when he was on Hall 5 off the secured unit. LVN D stated Resident #42 would state he was looking for his white ford truck or his big rig. LVN D stated Resident #42 was easily redirected at times, but she has had to reset the alarm before because Resident #42 would get close to the door and set the alarm off. LVN D stated interventions for Resident #42 been at risk for elopement was redirection and the wandergaurd system. During an observation on 09/23/24 at 6:10 p.m., the speed limit sign in front of the facility changes from 45 to 55 miles per hour. During an interview on 09/24/24 at 11:38 a.m., LVN N stated she was at the end of Hall 2 when Housekeeping Aide H came in hollering Hey, Someone Help Me. LVN N stated Housekeeping Aide H stated Resident #42 was found outside in the parking lot when she arrived at work. LVN N stated when her and Housekeeping Aide H went outside Resident #42 was by a tree beside the facility that was approximately 150 feet from the front door entrance. LVN N stated when she asked Resident #42 where he was going, he stated, I'm going home. LVN N stated she was able to redirect Resident #42 back in the building. LVN N stated when Resident #42 was brought inside the facility the wander guard system on his wheelchair set the front door alarm off. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During a telephone interview on 09/25/24 at 10:21 a.m., Administrator S stated she was the Administrator for the facility when Resident #42 eloped back in July. Administrator S stated Resident #42 was moved off the unit because she was told by the DON Resident #42 was not exhibiting exit -seeking behaviors. Administrator S stated she could not remember the incidents on 07/01/24 or 07/10/24. Administrator S stated she did not remember Resident #42 exit seeking when she was there. Administrator S stated if resident tried to elope on 07/01/24 and 07/10/24 he should have gone back to the unit because he was still at risk for elopement. Administrator S stated the risk for residents eloping was a serious injury. During an interview on 09/26/24 at 11:22 a.m., Administrator T stated she had observed Resident #42 exit seeking while sitting at her desk in the front lobby, but he was easily redirected. Administrator T stated she thought the wandergard system was enough to be safe since he was easily to be redirected. Administrator T stated the front door remained unlocked all day and felt like it was just fine. Administrator T stated she monitored resident safety by discussing any incidents during morning meetings, rounds and collaborating with the DON/ADON. Administrator T stated the risk for residents eloping was a serious injury. Record review of the facility's policy titled, Elopement Prevention, revised 10/27/10, indicated, Every effort will be made to prevent elopement episodes while maintaining the least restrictive for residents who are at risk for elopement .Physical Plan (1) All facility exits that residents have access to will have a device in place to alert staff of possible elopement attempts . (2) All other exits not considered fire exits will be locked when not occupied by staff members . This was determined to be an IJ on 09/23/24 at 5:30 p.m. The Administrator was notified. The Administrator was provided with the IJ template on 09/23/24 at 5:32 p.m. The following plan of removal submitted by the facility was accepted on 09/24/24 at 1:00 p.m. and included the following: Interventions: 1. On 9/23/24, Resident #42 resides on the secure unit inside the facility. 2. All door alarms were checked for proper functioning and alarming by the maintenance director on 9/23/24. All doors are alarming properly. 2 of 2 doors with wander guard volume increased on 9/23/24. All other doors with locking mechanism are at a volume that is audible throughout the facility on 9/23/24. 3. All residents with wander guards had their devices checked for proper functioning by ADON and Charge Nurses on 9/23/24. All devices are functioning properly. Front door Wander guard alarm volume increased on 9/23/24. 4. Elopement risk assessments for all residents in the facility were completed and reviewed by the DON/ADON/Designee on 9/23/24. No additional concerns were identified. 5. All elopement risk care plan interventions were reviewed on 9/23/24 by the Regional Compliance Nurse, DON, and ADON. All interventions are in place and care planned. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The Administrator was informed the IJ was removed on 09/24/24 at 3:36 p.m. The facility remained out of compliance at a severity level with potential for more than minimal harm with a scope identified as isolated due to the facility's need to evaluate the effectiveness of the corrective systems that were put into place.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33249 Based on observation, interview, and record review, the facility failed to ensure a resident received appropriate treatment and services to prevent urinary tract infections for 2 of 2 residents (Resident #40 and Resident #42) reviewed for incontinent care. The facility failed to ensure CNA F and RN G properly cleaned the perineal/genital areas for Resident #'s 40 and 42 during incontinent care. These failures could place residents at risk for urinary tract infections. Findings included: 1)Record review of a face sheet dated 9/26/2024 indicated Resident #40 was a [AGE] year-old female who admitted on [DATE] and readmitted on [DATE] with the diagnosis of dementia (loss of memory). Record review of a comprehensive care plan dated 11/10/2022 and revised on 7/05/2024 indicated Resident #40 was incontinent of bowel and bladder and was dependent for toileting. The goal of the care plan was Resident #40 would have a decreased likelihood of skin breakdown. The care plan interventions for Resident #40 included to monitor for symptoms of a urinary tract infection, provide incontinent care as needed, and report any changes in bladder status such as low urine output, foul urine, discolored urine, pain, bladder distention, urine frequency, urgency, or fever. Resident #40's comprehensive care plan also indicated she required assistance with her ADLs related to impaired mobility, weakness, medications, and dementia. The goal of Resident #40's care plan was she would be clean, dry, and comfortable. The care plan interventions included Resident #40 required extensive assistance of 2 staff with personal hygiene and toileting. Record review of the Quarterly MDS dated [DATE] indicated Resident #40 understands and was understood. The MDS indicated Resident #40 had severe cognitive impairment. The MDS in Section E-Behavior indicated she had not rejected care. The MDS in Section GG-Functional Abilities and Goals indicated Resident #40 was dependent with the helper providing all the effort for toileting, and personal hygiene. The MDS in Section H-Bladder and Bowel indicated Resident #40 was always incontinent of bowel and bladder. Record review of a Licensed Nurse Proficiency Audit dated 7/26/2024 - 7/30/2024 indicated RN G was checked off as satisfactory in the Infection Control area including proper hand hygiene, prevention of cross contamination, and universal precautions. The audits provided failed to address perineal/incontinent care. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 9/25/2024 at 8: 57 a.m., RN G donned her PPE (disposable gown and gloves), with gloved hands RN G picked up the bedside trash can and moved it closer to her right side. RN G then obtained several pair of gloves and placed them on Resident #40's bed. RN G then removed Resident #40's brief, rolling it in on itself, then she took and wiped Resident #40's anal/buttock area twice removing urine and bowel movement. RN G removed her gloves, washed her hands, applied clean gloves, then positioned the draw sheet and the clean brief underneath Resident #40. Resident #40 was then repositioned; the clean brief was applied, and she was repositioned for comfort. RN G failed to clean Resident #40's perineal (female genital) area. During an interview on 9/25/2024 at 2:26 p.m., RN G said she done a horrible job when she provided incontinent care to Resident #40. RN G said I forgot to clean Resident #40's perineal area. RN G said failing to do incontinent care correctly placed Resident #40 at risk for infections. 2) Record review of a face sheet dated 9/25/2024 indicated Resident #42 was a [AGE] year-old male who admitted [DATE] with the diagnosis of Alzheimer's Disease (memory loss disease). Record review of the Comprehensive Care Plan dated 6/11/2024 indicated Resident #42 had a care plan problem of bladder incontinence. The goal of the care plan was Resident #42 would be free from skin breakdown due to incontinence. The comprehensive care plan interventions for Resident #42 included to provide incontinent care every 2 hours, monitor and document symptoms of urinary tract infections, increased pulse, increased temperature, urinary frequency, and foul urine. The comprehensive care plan also included bowel incontinence for Resident #42. The goal of the was Resident #42 would not have any complications related to bowel incontinence. The comprehensive care plan intervention for Resident #42 included check Resident #42 every two hours and assist with toileting, provide peri-care after each incontinent episode. The comprehensive care plan indicated Resident #42 required assistance with ADL self-care. The goal of ADL self-care care plan was Resident #42 would maintain or improve his current level of function. The care planned interventions for Resident #42 included toileting requiring 2 staff and a lifting device. Record review of the Admission MDS dated [DATE] indicated Resident #42 understands and was understood by others. The MDS indicated Resident #42 had severe cognitive impairment. The MDS in Section E-Behavior indicated Resident #42 had not demonstrated rejection of care behaviors. The MDS in Section GG-Functional Abilities and Goals indicated Resident #42 required supervision or touching assistance with toileting hygiene. The MDS in the Section H-Bladder and Bowel indicated Resident #42 was occasionally incontinent of bowel and bladder. Record review of a CNA Proficiency Audit dated 4/10/2024 indicated CNA F was checked off on the provision of incontinent care for a male and a female and passed the evaluation with a score of satisfactory. During an observation on 9/25/2024 at 7:09 a.m., Resident #42 was sitting on the edge of his bed. Resident #42 had an adult pull up and a pair of shorts on around his lower legs. CNA F Instructed Resident #42 to stand using his walker. Resident #42 after several attempts stood up, then CNA F removed his wet adult diaper and placed in the trash can. CNA F Removed her gloves, applied another pair of gloves, obtained two wipes and cleaned Resident #42's buttocks, she then pulled up his adult pull-up and shorts. CNA F Failed to cleanse Resident #42's genitals or complete hand hygiene between glove changes. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 9/25/2024 at 7:16 a.m., CNA F Said she had not done well on the incontinent care observation. CNA F said she failed to cleanse Resident #42's genitals (perineal area) and wash her hands in between glove changes. CNA F said she just forgot to cleanse Resident #42's genitals. CNA F said when not providing incontinent care to Resident #42's genitals (perineal area) could cause a risk of infection. During an interview on 9/26/2024 at 11:05 a.m., the ADON said she expected the staff to cleanse the perineal area when completing incontinent care. The ADON said she monitors the provision of incontinent care by annual checks offs and spot checks. The ADON said urinary tract infections could arise from failing to cleanse a resident's perineal area. During an interview on 9/26/2024 at 11:31 a.m., Administrator T said the DON was not available for interview due to health conditions. Administrator T said she expected the nursing staff to provide the appropriate incontinent care. Administrator T said this system was monitored with annual check offs and she expected spot checks to be performed. Administrator T said she only been in her role for 2 months but believed her staff required more training. Administrator T said there was a risk of infection when incontinent care was not performed correctly. Record review of a Perineal Care policy with an effective date of 5/11/2022 indicated an incontinent resident of urine and/or bowel should be identified, assessed, and provided appropriate treatment and services to restore as much normal bladder/bowel function as possible . The policy purpose indicated was to maintain the resident's dignity and self-worth and reduce embarrassment by providing cleanliness and comfort to the resident, preventing infections and skin irritations, and observing resident's skin condition Start: 10) perform hand hygiene, 11) apply gloves and all other PPE standard precautions, 12) soak towels in wash basin .or remove an adequate number of pre-moistened cleansing wipes, 13) reposition the resident on their back with legs flexed and separated as able, 14) limit resident exposure to the perineal area-provide privacy at all times, 15) if required, use a towel or extra incontinence pad to protect the mattress cover form being soiled, 16) wipe across the pubis area, 17) gently perform perineal care, wiping from clean, urethral area, to dirty rectal area, to avoid contaminating the urethral area. Female resident: working from front to back, wipe one side of the labia majora, the outside folds of the perineal skin that protect the urinary meatus and the vaginal opening. Continue perineal care to the inner thigh. Male resident: Pull back the foreskin on uncircumcised males. Hold the penis by the shaft, wash in a circular motion from the tip down to the base. Continue perineal care to the scrotum and inner thigh 20) Reposition the resident to their side, 21) Gently perform care to the buttocks and anal area, working from front to back without contaminating the perineal area 24) remove gloves and PPE, 25) perform hand hygiene. Record review of the Infection Control policy updated 3/2024 indicated the facility will establish and maintain an Infection Control Program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of disease and infection.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47006 Based on observation, interview, and record review the facility failed to ensure that residents requiring respiratory care were provided such care, consistent with professional standards of practices for 1 of 1 resident (Resident #10) reviewed for respiratory care. 1. The facility failed to administer Resident #10's oxygen as ordered by the physician. 2. The facility failed to ensure Resident #10's oxygen flow meter on the oxygen concentrator was functioning properly and undamaged. These failures could place residents who receive respiratory care at risk for developing respiratory complications and a decreased quality of care. The findings included: Record review of the face sheet, dated 09/24/2024, revealed Resident #10 was an [AGE] year-old male who admitted to the facility on [DATE] with a diagnosis of COPD (term for certain types of irreversible lung and airway damage that block (obstruct) your airways and make it hard to breathe). Record review of the quarterly MDS assessment, dated 08/26/2024, revealed Resident #10 had clear speech and was understood by others. The MDS revealed Resident #10 was able to understand others. The MDS revealed Resident #10 had a BIMS score of 7, which indicated severe cognitive impairment. The MDS revealed Resident #10 had no behaviors or refusal of care. The MDS revealed Resident #10 received oxygen therapy while a resident at the facility. Record review of the comprehensive care plan, last reviewed on 09/23/2024, revealed Resident #10 received oxygen therapy related to COPD. The interventions included: oxygen will be set at 2-4 LPM as needed and will check oxygen sats every shift and record. Record review of the order summary report, dated 09/24/2024, revealed Resident #10 had an order, which started on 12/22/2023, for oxygen at 2 - 4 LPM as needed via nasal cannula. During an observation and interview on 09/23/2024 at 10:45 AM, Resident #10 was laying in his bed with the head of the bed slightly elevated. Resident #10 was wearing a nasal cannula in his nose. The oxygen flow meter on the oxygen concentrator was covered in a white powdery substance that made the oxygen flow difficult to read. The silver ball, which indicated the oxygen flow in LPM, was shadowed at approximately 1 LPM. Resident #10 had no evidence of respiratory distress. Respirations were even, unlabored. Resident #10 stated he normally wore oxygen at all times. Resident #10 stated he was having no trouble breathing and the facility staff checked on his oxygen level frequently. During an observation and interview on 09/23/2024 at 10:33 AM, Resident #10 was laying in his bed with the head of the bed slightly elevated. Resident #10's oxygen tubing was laying on the bed above his head. Resident #10 stated his oxygen tubing fell off his face. The oxygen flow meter on the oxygen concentrator was covered in a white powdery substance that made the oxygen flow difficult to read. The silver ball, which indicated the oxygen flow in LPM, was shadowed at approximately 1 LPM. (continued on next page)

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	675066	A. Building B. Wing	09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Honey Grove Nursing Center	1303 E Main St Honey Grove, TX 75446

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and interview on 09/23/2024 at 10:36 AM, LVN D stated she was going into Resident #10's room to give him his medication. LVN D attempted to read Resident #10's oxygen flow meter to determine the LPM. LVN D stated it was hard to read because there was a white powdery substance inside the flow meter, but it appeared to be set at less than 1 LPM. LVN D turned the oxygen flow meter up to 2 LPM and placed the nasal cannula in Resident #10's nostrils. LVN D stated she had checked the oxygen concentrator early that morning and it was set at 2 LPM. LVN D stated his oxygen level that morning was 94%. LVN D stated the machine flow meter had been difficult to read for a while, but she had not reported it to anyone. LVN D was unable to estimate how long the machine had been difficult to read. LVN D placed the pulse oximeter onto Resident #10's finger. Resident #10's oxygen level fluctuated and decreased from 91% to 83%. LVN D asked Resident #10 if he was having trouble breathing and he explained that it was difficult for him to take a deep breath. LVN D explained the protocol was to keep oxygen levels above 90%. LVN D increased his oxygen flow meter from 2 LPM to 3 LPM to 4 LPM. The oxygen level stayed below 89%. LVN D then obtained an oxygen tank and new oxygen tubing. LVN D placed the nasal cannula in Resident #10's nostrils and set the flow at 3 LPM. Resident #10's oxygen level increased to 98% on 3 LPM. LVN D stated defected, damaged, or any issues with an oxygen concentrator should have been reported to management staff. LVN D stated it was important to ensure the oxygen concentrator was functioning properly and set at the correct settings to prevent neglect, hypoxic brain injury, or hypoxia (low oxygen levels). During an observation and interview on 09/24/2024 at 11:16 AM, LVN D stated she had changed out Resident #10's oxygen concentrator and she was continuing to monitor his oxygen levels. LVN D stated she had removed his old concentrator and placed it behind the nurses' station with a sticker that stated, does not work. The machine was a Companion Eco 5 and had no sticker to indicate the last date of service. LVN D stated as she understood, the machines were only serviced if they were not functioning properly. LVN D stated Medical Records was responsible for scheduling the serving of the oxygen concentrators. LVN D stated the Medical Records person or nursing management would have had the user manual for the oxygen machine. During an interview on 09/24/2024 at 11:22 AM, the ADON stated the Medical Records person had the user manual for the oxygen concentrators. During an interview on 09/26/2024 at 10:04 AM, CNA A stated she had a lot of titles and jobs at the facility. CNA A stated she was a CNA, medication aide, and also did medical records as well. CNA A stated the facility received the current oxygen concentrators in October 2023, when the current company took over. CNA A stated when a machine went down, she contacted corporate and sent over a requisition. CNA A stated then corporate would pick up the machine and get it fixed. CNA A stated if no concentrators were available in the facility, she was able to rent from a supply company. CNA A stated she relied on the nursing staff to tell her if an oxygen machine was defected or not functioning properly. CNA A stated she was unaware anything was wrong with Resident #10's oxygen concentrator prior to this week. CNA A stated it was important to ensure the oxygen machines were serviced and maintained to prevent decreased oxygen levels, which could cause brain damage. During an interview on 09/26/2024 at 10:38 AM, the Regional Compliance Nurse stated there was no facility policy on oxygen concentrator maintenance. The Regional Compliance Nurse stated she expected the nursing staff to ensure oxygen machines were in functioning condition. The Regional Compliance Nurse stated if the machine was not functioning properly or was damaged, the staff should have replaced the machine and sent the old one for maintenance. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 09/26/2024 at 1:28 PM, the ADON stated oxygen concentrators and oxygen flow should have been checked every day. The ADON stated anyone who noticed an issue with the oxygen concentrator should have reported it to the nursing staff. The ADON stated if the concentrator was not functioning properly or defective, the nursing staff should have replaced the oxygen concentrator. The ADON stated the nursing staff was responsible for ensuring the oxygen was set at the correct settings. The ADON stated it was important to ensure the oxygen concentrator was not defective, functioning properly, and set at the correct settings to prevent respiratory distress. During an interview on 09/26/2024 at 1:43 PM, Administrator T stated she expected staff to ensure the oxygen flow meter was clear and easy to read. Administrator T stated if there was an issue with an oxygen concentrator the machine should have been replaced. Administrator T stated she expected nursing staff to ensure the oxygen level was set at the correct settings as ordered by the physician. Administrator T stated it was important to ensure the oxygen concentrator was functioning properly and set at the correct settings to prevent any issues with the residents breathing. Record review of the Oxygen Administration policy, revised 02/13/2007, revealed . the resident will maintain oxygenation with safe and effective delivery of prescribed oxygen .become familiar with type of oxygen administration, medical diagnosis and reason for oxygen, intermittent or continuous use of oxygen, amount to be delivered .

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47006 Based on observations, interviews, and record review, the facility failed provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident, for 1 of 7 residents (Resident #40) reviewed for medication administration. 1. The facility did not ensure Resident #40 was given the correct dosage of alprazolam (antianxiety medication). 2. The facility did not ensure Resident #40's alprazolam (antianxiety medication) and Tylenol #3 (pain medication) labels from the pharmacy matched the orders placed in the electronic charting system. 3. The facility did not ensure RN G updated Resident #40's losartan potassium (blood pressure medication) order to match the clarification orders received from the physician. This failure could place residents at an increased risk for inaccurate drug administration and not receiving the care and services to meet their individual needs. The findings included: Record review of the face sheet, dated 09/26/2024, revealed Resident #40 was a [AGE] year-old female who admitted to the facility on [DATE] with diagnoses of unspecified dementia, without behaviors (group of symptoms that affects memory, thinking, and interferes with daily life), gastrostomy status (tube that is placed directly into the stomach to deliver medication and nutrients, usually from problems with swallowing), and essential hypertension (high blood pressure). Record review of the quarterly MDS assessment, dated 07/19/2024, revealed Resident #40 had clear speech, was understood by others, and was able to understand others. The MDS assessment revealed Resident #40 had a BIMS score of 2, which indicated severe cognitive impairment. The MDS revealed Resident #40 had no behaviors or refusal of care. The MDS revealed Resident #40 used a feeding tube while a resident. The MDS revealed Resident #40 was taking an antianxiety medication and an opioid medication. Record review of the comprehensive care plan, last reviewed 07/05/2024, revealed Resident #40 had a feeding tube and received her medications by the enteral route (through the feeding tube). The care plan further revealed Resident #40 received an antianxiety and pain medication. Record review of the order summary report, dated 09/25/2024, revealed Resident #40 had an order for the following: 1. Alprazolam 0.25mg - give one tablet by gastrostomy tube two times a day for anxiety, which started on 09/24/2024. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Tylenol #3 300-30mg - give 1 tablet by gastrostomy tube every 6 hours for pain, which started on 05/30/2023. 3. Losartan potassium 50 mg - give 1 tablet by gastrostomy tube one time a day related to hypertension (hold for systolic blood pressure less than 100, diastolic blood pressure less than 60, and heart rate less than 60), which started on 04/06/2024. Record review of the MAR, dated September 2024, revealed Resident #40 received alprazolam (antianxiety medication) and Tylenol #3 (pain medication) daily. The MAR further revealed Resident #40's losartan potassium (blood pressure medication) was held 10 out of 25 days for heart rate less than 60. During an observation and interview on 09/25/2024 beginning at 10:03 AM, RN G obtained Resident #40's blood pressure, which read 131/73 with a heart rate of 50. RN G then prepared Resident #40's medications which included Tylenol #3, alprazolam 0.5mg, and losartan potassium 50 mg. Resident #40's Tylenol #3 card from the pharmacy had instructions to administer the medication by mouth. Resident #40's alprazolam 0.5mg card from the pharmacy had instructions to administer the medication by mouth. Resident #40's losartan potassium 50mg card from the pharmacy had instructions to hold the medication for a heart rate less than 60. RN G stated hospice nurse and physician had given clarification regarding Resident #40's blood pressure medications a few days prior. RN G stated the hospice nurse had noticed Resident #40's blood pressure had been elevated and the losartan potassium was held. RN G stated the hospice nurse spoke with the doctor and instructed her to take the heart rate parameters off the order because the medication did not affect the heart rate. There were no order change stickers on any of the medication cards. RN G administered all medication one at a time into the gastrostomy tube. During an interview on 09/26/2024 beginning at 10:38 AM, the Regional Compliance Nurse stated the medication cards from the pharmacy should have matched the orders in the electronic charting system. The Regional Compliance Nurse stated if an order was changed in the electronic charting system, then a order changed sticker should have been placed on the medication card to alert staff . During an interview on 09/26/2024 beginning at 11:26 AM, RN G stated she did not realize the route was different from the order on Resident #40's alprazolam and the Tylenol #3. RN G stated Resident #40 only received medication by the gastrostomy tube, so she did not think to check the card to ensure the correct route was listed. RN G stated she was unsure what the protocol was for checking medication in from the pharmacy because they usually came on the night shift. RN G stated it was important to ensure the card from the pharmacy matched the orders in the electronic charting system to prevent a medication error. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 09/26/2024 beginning at 1:24 PM, RN G stated she had not realized Resident #40's order for alprazolam had changed. RN G stated it was not passed on during report that morning. RN G stated she administered the wrong dose of alprazolam to Resident #40 on 09/25/2024. RN G stated she should have checked the card to the order more closely. RN G stated Resident #40 had been receiving 0. 5mg and the order was reduced to 0.25mg to attempt a gradual dose reduction. RN G stated if the pharmacy cards did not match the orders in the computer, then the doctor should have been notified immediately, and the order clarified. RN G stated if the order was changed then a sticker should have been placed on the card to alert staff of an order change. RN G stated after an order was clarified by the physician, it should have been updated in the computer immediately. RN G stated she updated the hold orders for Resident #40's losartan potassium in the electronic charting system. RN G stated it was important to administer the correct dosage of medication and to ensure hold parameters were updated in the electronic charting system to prevent adverse effects from medication errors. During an interview on 09/26/2024 beginning at 1:43 PM, Administrator T stated she expected nursing staff to follow the physician orders and the facility protocol for medication administration. Administrator T stated the DON and the ADON were responsible for monitoring to ensure medications were administered properly, orders were updated, and medication cards matched the orders. Administrator T stated it was important to ensure medication cards matched the order, hold parameters were clarified by the physician, and the correct dosage was given to prevent medication error and to ensure accuracy . Record review of the Medication Administration Procedures policy, undated, revealed a specific order must be obtained from the physician to change the dosage form of a resident's medication .medication errors and adverse drug reactions are immediately reported .the ten rights of medication should always be adhered to . right dose .rights route .right documentation .

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. 33249 Based on observations, interviews, and record review, the facility failed to ensure the meals served met the nutritional needs of residents for 1 of 1 meal (the lunch meal) reviewed for nutritional adequacy. The facility did not service a whole egg roll with the lunch meal on 9/26/2024. This failure could affect all residents in the facility by placing them at risk of not receiving adequate nutritive food value needed to promote/maintain health. Findings included: Record review of a Weekly Menu 2024 Week 3 dated 4/10/2024 indicated on Thursday September 26, 2024, the facility menu was Teriyaki chicken, Lo Mein Noodles, Hibachi Vegetables, Egg roll, Gingerbread bar with glaze, and iced tea. Record review of a Recipes to Scale dated Thursday, September 26, 2024, indicated a serving size was 1 pork and vegetable egg roll, and the amount needed was 43 . During an observation and interview on 9/26/2024 at 12:05 p.m., the DM was cutting the egg rolls in 1/2 and then placing the 1/2 cut portion on each resident's plate with a regular or mechanical soft diet. The DM said there were no egg rolls and they had to go out and purchase these for the lunch. The DM said the egg roll was considered the resident's bread and was unsure of what the serving portion should be . During an interview on 9/26/2024 at 1:23 p.m., Administrator T said she expected the DM to follow the menu and provide the correct portion size. Administrator T said she was unsure why there were not any egg rolls available since they have received such large orders of food for the menu. Administrator T said the DM was new, needed more training, and was enrolled for the upcoming DM training course offered at a college . The Administrator said not serving the appropriate serving sizes of food items could cause weight loss. Record review of the Dietary Services policy, last revised on 2012 indicated, .Fundamental Information: A preplanned menu is provided to the facility, which has been planned or reviewed by a Registered Dietitian and includes meals that are adequate to meet the average resident's nutritional needs.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 33249 Based on observations, interviews, and record review, the facility failed to provide food that was palatable, attractive, and at a safe and appetizing temperature for 4 of 7 confidential residents reviewed for food and nutrition services. The facility failed to ensure dietary staff provided food that was palatable and had an appetizing temperature on 9/26/2024 for confidential residents. These failures could place residents at risk of decreased food intake, hunger, and unwanted weight loss. Findings included: During a confidential group interview on 9/25/2024 at 2:00 p.m., 4 residents said the food trays served on the halls and in the dining room were cold, overcooked, and not flavorful. Record review of the food temperature log dated 9/26/2024 indicated the regular meat's temperature at the time of serving was 180 degrees Fahrenheit, the cooked noodles/vegetables were 189 degrees Fahrenheit, mechanical soft chicken was 187 degrees Fahrenheit, and the purred noodles were 147 degrees Fahrenheit, and the pureed and regular eggs rolls were 165. During an observation on 9/26/2024 at 12:50 p.m., the DM after completing all the trays except one, which needed a pureed egg roll, stopped the trays, and pureed the egg roll and then completed the plating. Once the DM completed the plating the tray cart left the kitchen. During an observation on 9/26/2024 at 12:55 p.m , the tray cart with the test tray left the kitchen preparation area. The tray cart was reviewed by nurses, and they left the dining room and went to the hall at 12:59 p.m. The trays were passed starting from 12:59 p.m. and ending when the test tray arrived in the work room at 1:08 p.m. The resident trays and the test tray were prepared on warmed plates using a plate warmer. During a test tray interview with the Dietary Manager and State Surveyors on 9/26/2024 1:08 p.m., the Dietary Manager stated the following regarding the regular food diet for lunch served on 9/26/2024: agreed the plate had 1/2 an egg roll which was cool, the noodle/vegetable mix was warm and bland, the chicken teriyaki was warm and lacked the teriyaki seasoning flavor, and the gingerbread cake was moist and had flavor. The DM said she liked the meal and said she did not feel this affected the residents. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 5/09/2024 R 12:52 p.m., Administrator T said she expected the meals to be palatable regarding temperature and taste. Administrator T said palatability ensured enjoyable meals. Administrator T said she was surprised since she ate from the kitchen 2-3 times weekly and enjoyed the meals. Administrator T said she had had some food complaints in the past regarding palatability, but she had believed these were resolved. Administrator T said the dietary department was responsible for ensuring meals were palatable. Administrator T failed to provide a policy regarding palatability of meals . The Administrator said a resident could lose weight when the foods were not appetizing.

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F 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide special eating equipment and utensils for residents who need them and appropriate assistance. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43047 Based on observations, interviews, and record reviews the facility failed to provide special eating equipment and utensils for residents who need them and appropriate assistance to ensure that the resident can use the assistive devices when consuming meals for 2 of 2 (Residents #19 and #4) residents reviewed for special eating equipment and assistance when consuming meals. 1. The facility failed to provide Resident #19's physician ordered sippy cup with each meal tray. 2. The facility failed to ensure Resident #4 had a physician's ordered cup with lid and handles for drinking fluids. These failures could place residents at risk for harm by weight loss, diminished independence, and self-esteem. Findings included: 1. Record review of Resident #19's face sheet, dated 09/26/24, indicated Resident #19 was admitted to the facility on [DATE] with diagnoses which included encephalopathy (brain disease that alters brain function or structure). Record review of the quarterly MDS assessment, dated 08/20/24, indicated Resident #19 rarely/never made herself understood and rarely/never understood others. The assessment did not address the BIMS score. Resident #19 required set up or clean up assistance with eating. Record review of the comprehensive care plan, revised on 07/04/24, indicated Resident #19 had a potential for spillage during meal/snacks time. The care plan interventions included, assist Resident #19 at meal and snack times, assist with donning clothing protector at meal and snack times, and assist with serving food in small separate bowls for easy handling and a cup with lids. Record review of the order summary report, dated 09/26/24, indicated Resident #19 was ordered a 2-handle cup with lid with a start date of 01/01/24. Record review of the lunch meal ticket dated 09/23/24 for Resident #19 indicated Resident #19 was on a fortified/enhanced diet and required a sippy cup; two handle cup. During an observation and interview on 09/23/24 at 12:21 p.m., Resident #19 had iced tea in a clear regular drinking cup. An attempted interview with Resident #19, indicated she was non-interview able. During an interview on 09/23/24 at 12:25 p.m., CNA O stated Resident #19 should have her beverages in a sippy cup. CNA O stated she was told by the dietary staff that there were no lids for the sippy cup. CNA O stated Resident #19 was ordered a sippy cup to prevent spillage on her clothes because she was unable to hold a regular cup without spilling. CNA O stated this failure could cause a dignity issue. (continued on next page)

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F 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 09/25/24 at 2:27 p.m., the Dietary Manager stated Resident #19 required a sippy cup because she was unable to hold a regular cup. The Dietary Manager stated there were cups but without lids. The Dietary Manager stated when the cups go out the lids did not return with the cups. The Dietary Manager stated she had reported the issue to the Administrator. The Dietary Manager stated this issue had been going on for about 4 months. The Dietary Manager stated this failure was a dignity issue. During an interview on 09/26/24 at 11:05 a.m., the ADON stated Resident #19 required a sippy cup to prevent spillage on herself. The ADON stated she was not aware there were no cups with lids available until the state surveyor intervention. The ADON stated she could have gone to a local store or ordered them. The ADON stated the Dietary Manager was responsible for monitoring and overseeing to ensure adaptive devices were available to residents. The ADON stated this failure was a dignity issue. During an interview on 09/26/24 at 11:22 a.m., the Administrator stated it was brought to her attention on 09/26/24, that sippy cups were not available to residents. The Administrator stated she expected the dietary staff to inform her when there were not adaptive devices available. The Administrator stated the previous Dietary Manager's last day was 09/05/24. The Administrator stated the Dietary Manager was responsible for monitoring and overseeing the kitchen. The Administrator stated it was important to ensure physician orders were followed. The Administrator stated this failure was a dignity issue. 33249 2)Record review of a face sheet dated 9/26/2024 indicated Resident #4 was an [AGE] year-old female who was admitted on [DATE] and readmitted on [DATE] with the diagnoses of dementia (memory loss), and difficulty swallowing. Record review of the comprehensive care plan dated 5/30/2024 indicated Resident #4 required adaptive equipment at meals (two handled cup with lid). The goal of Resident #4's care plan was she would be able to drink coffee without spilling it on herself. The care plan interventions were thatould Resident #4 would use a sippy cup for drinking coffee and occupational therapy to evaluate as needed. Record review of an Annual MDS dated [DATE] indicated Resident #4 was understood and understood others. The MDS indicated Resident #4 had severe cognitive impairment. The MDS in section GG-Functional Abilities and Goals indicated Resident #4 required substantial/maximal assistance with eating. The MDS indicated Resident #4 had a height of 64 inches and a weight of 148 pounds with no weight loss or weight gain in the last 6 months. Record review of the consolidated physician's orders dated 9/26/2024 indicated on 6/25/2024 Resident #4 was ordered a pureed diet with thin liquids, fortified foods, and an adult cup with a lid and handles due to weight loss. During an observation on 9/23/2024 at 12:25 p.m., the ADON asked the Dietary Aide K for a lid to the sippy cups. Dietary Aide K said to the ADON there were 5 cups without lids. Dietary aide K informed the ADON the cups returned to the kitchen but not the lids. (continued on next page)

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	675066	A. Building B. Wing	09/26/2024

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Honey Grove Nursing Center	1303 E Main St Honey Grove, TX 75446

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F 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and interview on 9/23/2024 at 12:44 p.m., Resident #4 had iced tea in her drinking cup with handles but without a lid. RN G said Resident #4 could not use a straw therefore would have to drink her liquids from the cup without the lid. RN G said Resident #4 lets the fluids run out of her mouth and the sippy cup with the lid and handles helps to prevent spillage. RN G said when the device was not available a result of dehydration or weight loss could occur. During an interview on 9/26/2024 at 11:05 a.m., the ADON said the dietary department had the cups without enough lids. The ADON said if they had of known the cups with lids were unavailable, they could have attempted to purchase locally in order to have the sippy cups with lids. The ADON said Resident #4 had been ordered the cup due to her arm dropping and causing spills. The ADON said Resident #4 was at risk for dehydration and loss of dignity when the cup with lid was unavailable. During an interview on 9/26/2024 at 11:28 a.m., Administrator T said she was unaware of the sippy cups not having lids available. Administrator T said she expected the dietary department to inform her of needed devices. Administrator T said the sippy cups with lids should be available for the resident to use. Administrator T said when the assistive device sippy cup was not available it places the resident at risk for dignity issues related to spills of fluids on their clothing. Administrator T said the DON was unavailable for interview due to health conditions. Record review of the facility's titled Adaptive Eating Devices, dated 2012, indicated . we will enable residents to achieve and maintain their highest practicable level of eating independence and provide appropriate equipment to the residents . Dietary Manager: ensures that the resident tray card states the specific adaptive device needed. The nutritional documentation in the resident's chart reflects the need for the desired results and the success of the self-feeding device .

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33249 Based on observation, interviews, and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety in the facility's only kitchen reviewed for food safety requirements. The facility failed to ensure the can opener blade was free of a black substance. The facility failed to ensure the steam table wells were clean and free of food debris. The facility failed to ensure the fryer was cleaned after use and free of food debris, and the fryer baskets free from hard cooked on food on the bottom of the baskets appearing to be French fries. The facility failed to ensure 3 skillets were free from carbon build up on the cooking surface of the pan. The facility failed to ensure the stove top was free from black burned on material in the burner wells. The facility failed to ensure a bag of [NAME] were dated and labeled in the walk-in cooler. The facility failed to ensure a large plastic container of pudding, and a large plastic container of Oreo cheesecake was properly covered. Cook M failed to effectively clean the food processor after pureeing green peas before pureeing meatloaf. The facility failed to ensure DM, 2 cooks, and 1 dietary aide wore their hair nets effectively covering all their hair. Cook L failed to glove her hand when she used the resident beverage cup to scoop ice in a large pot of ice then filled the same cup with the beverage of choice. These failures could place residents at risk of foodborne illness, and food contamination. Findings included: During the initial tour observation on 9/23/2024 at 9:59 a.m. to 10:19 a.m. included: 1)The can open blade had black substance on the triangle part that punctures the can. 2)The steam table wells had cloudy water with food particles floating in the water. 3)The fryer had dark brown oil with food particles floating in the oil. The fryer baskets had hard cooked food on the bottom resembling French fries. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4)The hanging dish rack had three skillets of varying sizes with carbon build up on the outside and on the inside cooking surface. 5)The stove top burner wells had a black cooked on food spills. 6) The walk-in cooler had an unlabeled and undated large gallon sized bag of [NAME], and 2 large plastic containers one with pudding and one with Oreo cheesecake filling, covered with aluminum foil paper and not a sealing lid. 7) The DM, [NAME] M, and the Dietary Aide K were wearing their hair nets leaving their hair uncovered in the temple area of the side of their head, and around the neck area. During an interview on 9/23/2024 at 10:19 a.m., [NAME] M said the fryer was normally cleaned after each use. [NAME] M said the fryer was used on last Friday 9/20/24 to fry fish. [NAME] M said, I am pregnant and cleaning the fryer was hard, so she was waiting on help. [NAME] M said the stove top was cleaned monthly. [NAME] M said the stove top had burned on food material and was not clean. [NAME] M said the can opener had gunk on the blade. [NAME] M said the can opener should be cleaned after each use . During an observation and interview on 9/23/2024 at 11:32 a.m., [NAME] M was pureeing the meatloaf for lunch. When the state surveyor asked [NAME] M what the bright green material in the blender was, she replied by saying green peas. [NAME] M went on to say after she blended the green peas, she just rinsed the bowl of the food processor, and what the state surveyor saw was the remnants of green peas not washed out of the food processor. [NAME] M said she often rinsed not washed the blender between foods. [NAME] M said this gives the food more nutrients and would be beneficial to the resident. [NAME] M's hair was outside of her hair net around the temporal area and the back of her neck . During an observation and interview on 9/23/2024 at 11:30 a.m., the DM said she had recently been promoted to the DM role. The DM said she had not been enrolled yet in the training course. The DM had her hair out around her hair net in the temporal region, and around her neck. DA K was preparing the rolls with the DM for serving. DA K also had his hair exposed from underneath his hair net around his neck. During an observation on 9/24/2024 at 11:23 a.m., the DM's hair was out around the temporal region and the back of the neck. During an observation and interview on 9/24/2024 at 11:32 a.m., [NAME] L was preparing resident drinking cups. [NAME] L handled the drinking cups with an ungloved hand, used the cup as a scoop while she scooped out of a large pan of ice filling each resident cup with ice and then the beverages. [NAME] L said she normally filled the resident drinking cups in this method. During an observation and interview on 9/24/2024 at 11:58 a.m., a DM U said she was from another facility and was there to help today. DM U took the 3 skillets from the pot hanging rack. DM U then took two skillets in the dish room and indicated the skillets should be cleaned using a degreaser and threw one in the trash indicating the skillet could not be used . DM U said the skillets could not be cleaned well and this could cause food borne illness. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 9/24/2024 at 12:33 p.m., [NAME] L was preparing a grilled cheese sandwich while her hair was out of her hair net around the temporal region and the back of her neck region. During an interview on 9/26/2024 at 1:00 p.m., the DM said she had not been trained yet and was aware of needed training in the kitchen. The DM said the fryer, stove, and the can opener should have been cleaned after each use. The DM said items in the walk-in cooler should be labeled, dated, and covered with a sealing lid. The DM said the blender should be run through the dish machine after each use. The DM said she was unaware of a failure with using the resident's drinking cup for scooping into the ice container while barehanded. The DM said hair nets should be worn to cover all the exposed hair. The DM said kitchen sanitation was important to prevent food borne illness . During an interview on 9/26/2024 at 11:34 a.m., Administrator T said she expected the cleanliness of the kitchen to meet requirements. Administrator T said although the kitchen has some need for improvement overall there had been improvement since she arrived. Administrator T said she expected sanitary food practices were followed to prevent food borne illness. Record review of a Food Storage and Supplies policy dated 2012 indicated all facility storage areas will be maintained in an orderly manner that preserves the condition of food and supplies. We will ensure stage areas are clean, organized, dry and protected from vermin, and insects 4. Open packages of food are stored in closed containers with covers or in sealed bags and dated as to when opened. Record review of an Equipment Sanitation policy dated 2012 indicated we will provide clean and sanitized equipment for food preparation. The facility will clean all food services equipment in a sanitary manner. 1. Equipment must be thoroughly sanitized between use in different food preparation task, salad preparation, raw meat cutting and cooked meat cutting. 8. Blenders and food processor bowls should be inverted after cleaning to drain dry on shelves or trays with vented slots or bar netting. 9. Large equipment is to be sanitized by spraying or wiping with a chemical sanitizing solution at least twice the minimum strength of solutions needed form immersion sanitizing. Record review of an Infection Control policy dated March 2012 indicated we will ensure that all employees practice infection control in Food and Nutrition Services Department and maintain sanitary food preparation. All dietary service employees will follow Infection Control Policies as established and approved by the Infection control committee. 1. Personal cleanliness is required in sanitary food preparation b. Clean hair is required. It is to be covered with an effective hair restraint. 5. Equipment Sanitation: a. All kitchenware and food contact used in the preparation and/or serving of food are cleaned and sanitized before use and cleaned after each meal preparation. Sanitizing agents are used for cleaning all surfaces https://www.dshs.texas.gov/sites/default/files/foodestablishements/pdf/GuidanceDoc/TFER-2021_August-2021.pdf: accessed on 9/30/2024 indicated: TITLE 25 HEALTH SERVICES PART 1 DEPARTMENT OF STATE HEALTH SERVICES CHAPTER 228 RETAIL FOOD ESTABLISHMENTS SUBCHAPTER A GENERAL PROVISIONS (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	S228.1. Purpose and Regulations. (a) The purpose of this chapter is to implement Texas Health and Safety Code, Chapter 437, Regulation of Food Service Establishments, Retail Food Stores, Mobile Food Units, and Roadside Food Vendors. (b) The department adopts by reference the U.S. Food and Drug Administration (FDA) Food Code 2017 (Food Code) and the Supplement to the 2017 Food Code. TFER S228.43 states that food employees shall wear hair restraints such as hats, hair coverings or nets, beard restraints, and clothing that covers body hair, that are designed and worn to effectively keep their hair from contacting exposed food; clean equipment, utensils, and linens; and unwrapped single-service and single-use articles. It does not apply to food employees such as counter staff who only serve TEXAS DEPARTMENT OF STATE HEALTH SERVICES DIVISION FOR REGULATORY SERVICES ENVIRONMENTAL AND CONSUMER SAFETY SECTION POLICY, STANDARDS, AND QUALITY ASSURANCE UNIT PUBLIC SANITATION AND RETAIL FOOD SAFETY GROUP PSRFSGRC - No.19 Hair Restraints April 1, 2016 (Revised February 21, 2017) Page 2 Public Sanitation and Retail Food Safety Group ? PO Box 149347, Mail Code 1987 ? [NAME], Texas 78714-9347 (512) [PHONE NUMBER] ? Facsimile: (512) [PHONE NUMBER] ? According to the TFER, the container of ready-to-eat TCS food shall be marked to indicate the date by which food shall be consumed on the premises, sold, or discarded. The ready-to-eat TCS food if held at 41 F can only be held for a maximum of 7 days, with day of preparation being day 1. https://www.fda.gov/media/164194/download?attachment accessed on 9/30/2024 indicated: 2-402 Hair Restraints 2-402.11 Effectiveness. (A) Except as provided in (B) of this section, FOOD EMPLOYEES shall wear hair restraints such as hats, hair coverings or nets, beard restraints, and clothing that covers body hair, that are designed and worn to effectively keep their hair from FDA Food Code 2022 Chapter 2. Management and Personnel Chapter 2 - 22 contacting exposed FOOD; clean EQUIPMENT, UTENSILS, and LINENS; and unwrapped SINGLE-SERVICE and SINGLE-USE ARTICLES. (L) EMPLOYEES are properly SANITIZING cleaned multiuse EQUIPMENT and UTENSILS before they are reused, through routine monitoring of solution temperature and exposure time for hot water SANITIZING, and chemical concentration, pH, temperature, and exposure time for chemical SANITIZING; Preventing contamination from the premises 3-305.11 Food Storage. 3-305.12 Food Storage, Prohibited Areas. Pathogens can contaminate and/or grow in food that is not stored properly. Drips of condensate and drafts of unfiltered air can be sources of microbial contamination for stored food. Shoes carry contamination onto the floors of food preparation and storage areas. Even trace amounts of refuse or wastes in rooms used as toilets or for dressing, storing garbage or implements, or housing machinery can become sources of food contamination. Moist conditions in storage areas promote microbial growth. Refer also to the public health reasons for S 2-501.11

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33249 Based on interviews and record review, the facility failed to collaborate with hospice representatives and coordinate the hospice care planning process for each resident receiving hospice services, to ensure quality of care for the resident, ensuring communication with the hospice medical director, the resident's attending physician, and others participating in the provision of care for 1 of 3 residents (Resident #40) reviewed for hospice services. The facility failed to obtain Resident #40's most recent updated hospice plan of care. The facility failed to ensure Resident #40's hospice plan of care accurately reflect his medication regimen. The deficient practices could place residents who receive hospice services at-risk of receiving inadequate end-of-life care due to a lack of documentation, coordination of care, and communication of resident needs. Findings included: Record review of a face sheet dated 9/26/2024 indicated Resident #40 was a [AGE] year-old female who admitted on [DATE] and readmitted on [DATE] with the diagnosis of dementia (loss of memory). Record review of the Quarterly MDS dated [DATE] indicated Resident #40 understands and was understood. The MDS indicated Resident #40 had severe cognitive impairment. Section O- Special Treatments, Procedures, and Programs indicated Resident #40 received hospice services. Record review of the consolidated physician orders dated 9/25/2024 indicated Resident #40 was ordered on 2/10/2023 that she may admit to hospice services. The consolidated physician's orders indicated acetaminophen 650 milligrams every 4 hours as needed for pain/temperature; alprazolam 0.25 milligrams give one tablet two times daily for anxiety; bisacodyl suppository 10 milligrams as needed; levothyroxine 75 micrograms one time daily on Monday, Tuesday, Wednesday, Thursday, and Friday; levoxyl 88 micrograms on Saturday and Sunday; loperamide 2 milligrams one tablet every 6 hours as needed; losartan potassium 50 milligrams once daily; milk of magnesia 30 milliliters every 24 hours as needed; apply skin prep to heels every shift; MiraLAX 17gm by mouth every 24 hours, multivitamin/minerals one tablet once daily; nebivolol 5 mg once at bedtime; promethazine 25 milligrams one tablet every 6 hours as needed; sertraline 25 milligrams once daily; sodium chloride 1 gram three times daily; and Tylenol with Codeine #3 300-30 milligrams one tablet every 6 hours. Record review of the comprehensive care plan dated 3/06/2023 and revised on 6/13/2024 indicated Resident #40 had a terminal diagnosis related to Alzheimer's dementia (memory loss disease) and was admitted to a hospice provider. The goal of this care plan was Resident #40 would remain comfortable. The care plan interventions for Resident #40 included to work cooperatively with the hospice team to ensure Resident #40's spiritual, emotional, intellectual, physical, and social needs were met. (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 9/23/2024 at 11:13 a.m., Resident #40 was lying in the bed visiting with her spouse. Resident #40 was not able to be interviewed. Record review of a Hospice Certification of Terminal Illness with a printed date of 4/07/2023 indicated on 2/10/2023 Resident #40 began the hospice benefit period with the benefit period ending on 5/10/2023 of her first benefit period. Record review of the hospice plan of care dated 2/20/2023 indicated Resident #40 would receive an RN visit once weekly, a LVN nurse visit once weekly, a Chaplain visit once monthly, and a SW visit once monthly. The plan of care indicated Resident #40 would receive hospice aide services, but the visit frequency was not indicated. The plan of care indicated Resident #40's medications included Vistaril 50 milligrams every 6 hours, Klonopin 0.5 milligrams one tablet twice daily, and nebivolol 5 milligrams one tablet daily. There were no other medications listed for Resident #40. The physician's orders included in the plan of care indicated Resident #40 would have skilled nurse visits 2 times weekly, hospice aide 5 times weekly, chaplain once to evaluate, and the Social Worker once for evaluate. During an interview on 9/24/2024 at 10:59 a.m., RN G said Resident #40 received hospice services. RN G said Resident #40's hospice nurse visited two times weekly although she had not always communicated with her unless there was something she had to know. RN G said Resident #40 was seen daily by the hospice aide. RN G said she was unaware if Resident #40 received a chaplain, social work services, or bereavement services. During an interview on 9/25/2024 at 9:54 a.m., the hospice DON said Resident #40 had a nurse visit scheduled weekly since 7/29/2024; the hospice aide visited 5 times weekly; and the Social Worker, Chaplain, and Bereavement coordinator provided visits monthly. The hospice DON said she expected the hospice provider to provide the facility with the plan of care with each certification period. The DON said when the plan of care was not current there was a risk of Resident #40 not receiving the desired comfort care. The hospice DON said she would provide the state surveyor a current copy of Resident #40's plan of care . The hospice DON said the hospice staff were responsible for ensuring Resident #40's medical records were current and accurate for the coordination of car. Record review of the hospice plan of care dated 6/04/2024 provided after state surveyor intervention indicated the form was printed on 9/25/2024. The plan of care indicated Resident #40 received no bereavement services, chaplain and SW were one time a month visits, hospice aide visited 5 times weekly, and the nurse visited twice a week. The plan of care included the medication regimen of Vistaril 50 milligrams every 6 hours; klonopin 0.5 milligrams twice daily; losartan potassium 50 milligrams once daily; alprazolam 0.25 milligrams twice daily; alprazolam 0.25 milligrams every 8 hours as needed, Tylenol 300-30 milligrams every 6 hours, and alprazolam 0.25 milligrams twice daily. Record review of the Hospice Certification of Terminal Illness dated 6/04/2024 - 8/02/2024 provided after state surveyor intervention indicated Resident #40 was in her 8th benefit period. During an interview on 9/26/2024 at 11:05 a.m., the ADON said she expected Resident #40's hospice documentation to be current and available. The ADON said she was unsure how the system was being monitored to ensure continuity of care with the hospice provider and the facility. The ADON said this system was not assigned to her to manage. The ADON said there was a risk of Resident #40 not receiving the desired services when the coordination of care was not current and available. (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 9/26/2024 at 11:34 a.m., Administrator L said she expected the hospice providers to supply the facility with the current plans of care at least two times monthly to ensure the coordination of care. Administrator L said when the plans of care were not current there could be a breakdown in care needs. Administrator L said the DON was out with health conditions and unavailable for interview . The Administrator said nursing management was responsible for ensuring the hospice records were available and accurate for the coordination of care. Record review of a Hospice Services policy dated 2/13/2003 indicated as an end- of- life measure, the resident or responsible family member may choose to sue hospice services within the facility .11. The DON or designee will be responsible for ensuring that documentation is a part of the current clinical record. At a minimum, the documentation is a part of the current clinical record. At a minimum will include: the current and past Texas Medicaid Hospice Recipient Election/Cancellation Form, Texas Medicaid Hospice-Nursing Facility Assessment form, physician Certification of Terminal Illness; Medicare Election Statement, Verification that the recipient does not have Medicare Part A, Hospice Plan of Care, and Current interdisciplinary notes to include nurses notes/summaries, physician orders and progress notes, and medications and treatment sheets during the hospice certification.

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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** 33249 Based on observations, interviews, and record review, the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 2 of 2 (Resident #40 and #42) and 1 of 1 laundry cart reviewed for infection control practices. 1)The facility failed to ensure CNA F and RN G properly cleaned the perineal/genital areas for Resident #'s 40 and 42 during incontinent care . 2)The facility did not ensure Housekeeper H covered the clean linen cart while passing out clean linens on 09/23/2024. These deficient practices could place residents at risk for infection due to improper care practices. Findings included: 1)Record review of a face sheet dated 9/26/2024 indicated Resident #40 was a [AGE] year-old female who admitted on [DATE] and readmitted on [DATE] with the diagnosis of dementia (loss of memory). Record review of a comprehensive care plan dated 11/10/2022 and revised on 7/05/2024 indicated Resident #40 was incontinent of bowel and bladder and was dependent for toileting. The goal of the care plan was Resident #40 would have a decreased likelihood of skin breakdown. The care plan interventions for Resident #40 included to monitor for symptoms of a urinary tract infection, provide incontinent care as needed, and report any changes in bladder status such as low urine output, foul urine, discolored urine, pain, bladder distention, urine frequency, urgency, or fever. Resident #40's comprehensive care plan also indicated she required assistance with her ADLs related to impaired mobility, weakness, medications, and dementia. The goal of Resident #40's care plan was she would be clean, dry, and comfortable. The care plan interventions included Resident #40 required extensive assistance of 2 staff with personal hygiene and toileting. Record review of the Quarterly MDS dated [DATE] indicated Resident #40 understands and was understood. The MDS indicated Resident #40 had severe cognitive impairment. The MDS in Section E-Behavior indicated she had not rejected care. The MDS in Section GG-Functional Abilities and Goals indicated Resident #40 was dependent with the helper providing all the effort for toileting, and personal hygiene. The MDS in Section H-Bladder and Bowel indicated Resident #40 was always incontinent of bowel and bladder. Record review of a Licensed Nurse Proficiency Audit dated 7/26/2024 - 7/30/2024 indicated RN G was checked off as satisfactory in the Infection Control area including proper hand hygiene, prevention of cross contamination, and universal precautions. The audits provided failed to address perineal/incontinent care. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675066	A. Building B. Wing	09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Honey Grove Nursing Center	1303 E Main St Honey Grove, TX 75446

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 9/25/2024 at 8: 57 a.m., RN G donned her PPE (disposable gown and gloves), with gloved hands RN G picked up the bedside trash can and moved it closer to her right side. RN G then obtained several pair of gloves and placed them on Resident #40's bed. RN G then removed Resident #40's brief, rolling it in on itself, then she took wiped Resident #40's anal/buttock area twice. RN G removed her gloves, washed her hands, applied clean gloves, then positioned the draw sheet and the clean brief underneath Resident #40. Resident #40 was then repositioned; the clean brief was applied, and she was repositioned for comfort. RN G failed to clean Resident #40's perineal (female genital) area. During an interview on 9/25/2024 at 2:26 p.m., RN G said she done a horrible job when she provided incontinent care to Resident #40. RN G said I forgot to clean Resident #40's perineal area. RN G said failing to do incontinent care correctly placed Resident #40 at risk for infections. 2) Record review of a face sheet dated 9/25/2024 indicated Resident #42 was a [AGE] year-old male who admitted [DATE] with the diagnosis of Alzheimer's Disease (memory loss disease). Record review of the Comprehensive Care Plan dated 6/11/2024 indicated Resident #42 had a care plan problem of bladder incontinence. The goal of the care plan was Resident #42 would be free from skin breakdown due to incontinence. The comprehensive care plan interventions for Resident #42 included to provide incontinent care every 2 hours, monitor and document symptoms of urinary tract infections, increased pulse, increased temperature, urinary frequency, and foul urine. The comprehensive care plan also included bowel incontinence for Resident #42. The goal of the was Resident #42 would not have any complications related to bowel incontinence. The comprehensive care plan intervention for Resident #42 included check Resident #42 every two hours and assist with toileting, provide peri-care after each incontinent episode. The comprehensive care plan indicated Resident #42 required assistance with ADL self-care. The goal of ADL self-care care plan was Resident #42 would maintain or improve his current level of function. The care planned interventions for Resident #42 included toileting requiring 2 staff and a lifting device. Record review of the Admission MDS dated [DATE] indicated understands and was understood by others. The MDS indicated Resident #42 had severe cognitive impairment. The MDS in Section E-Behavior indicated Resident #42 had not demonstrated rejection of care behaviors. The MDS in Section GG-Functional Abilities and Goals indicated Resident #42 required supervision or touching assistance with toileting hygiene. The MDS in the Section H-Bladder and Bowel indicated Resident #42 was occasionally incontinent of bowel and bladder. Record review of a CNA Proficiency Audit dated 4/10/2024 indicated CNA F was checked off on the provision of incontinent care for a male and a female and passed the evaluation with a score of satisfactory. During an observation on 9/25/2024 at 7:09 a.m., Resident #42 was sitting on the edge of his bed. Resident #42 had an adult pull up and a pair of shorts on around his lower legs. CNA F Instructed Resident #42 to stand using his walker. Resident #42 after several attempts stood up, then CNA F removed his wet adult diaper and placed it in the trash can. CNA F Removed her gloves, applied another pair of gloves, obtained two wipes, and cleaned Resident #42's buttocks, she then pulled up his adult pull-up and shorts. CNA F Failed to cleanse Resident #42's genitals or complete hand hygiene between glove changes. (continued on next page)

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Honey Grove Nursing Center	1303 E Main St Honey Grove, TX 75446

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 9/25/2024 at 7:16 a.m., CNA F Said she had not done well on the incontinent care observation. CNA F said she failed to cleanse Resident #42's genitals (perineal area) and wash her hands in between glove changes. CNA F said when not providing incontinent care to Resident #42's genitals (perineal area) it could cause a risk of infection. During an interview on 9/26/2024 at 11:05 a.m., the ADON said she expected the staff to cleanse the perineal area when completing incontinent care. The ADON said she monitored the provision of incontinent care by annual checks offs and spot checks. The ADON said urinary tract infections could arise from failing to cleanse a resident's perineal area . The ADON said the staff should wash their hands when visible soiled. The ADON said hand sanitizer could be used between glove changes. During an interview on 9/26/2024 at 11:31 a.m., the Administrator said the DON was not available for interview due to her own health conditions. The Administrator said she expected the nursing staff to provide the appropriate incontinent care. The Administrator said this system was monitored with annual check offs and she expected spot checks to be performed. The Administrator said hand hygiene should be completed according to their policy. The Administrator said she had only been in her role for 2 months but believed her staff required more training. The Administrator said there was a risk of infection when incontinent care was not performed correctly . 47006 3) During an observation on 09/23/2024 at 10:37 AM, Housekeeper H was passing out clothing from her clean linen cart on Hall 5. The metal linen cart had no cover for the basket that was filled with clean linen. The purple linen cover was rolled up in the basket beside the clean linens. The metal linen cart had a rack to hang up clothing. Clothing was hanging on the rack with the purple linen cover pulled back, which exposed the clean clothing. During an interview on 09/26/2024 beginning at 11:47 AM, the Housekeeping Supervisor stated linen carts should have been covered while passing out clean linens. The Housekeeping Supervisor stated she expected the housekeeping staff to ensure the linen carts were kept covered. The Housekeeping Supervisor stated Housekeeper H could have been nervous. The Housekeeping Supervisor stated the purple linen covers were what the facility used to cover the clean linens. The Housekeeping Supervisor stated she was going to talk to the white glove company when they came to the facility about new linen carts and covers but had not talked to them yet. The Housekeeping Supervisor stated she was responsible for monitoring to ensure linen cart covers were used. The Housekeeping Supervisor stated it was important to ensure clean linen cart covers were used to prevent cross contamination. During an interview on 09/26/2024 beginning at 12:33 PM, Housekeeper H said she was always taught only one linen cart cover needed to be used. Housekeeper H said she was unaware the bottom of the metal linen cart basket needed to be covered as well. Housekeeper H said she was aware the top rack of the clean linen cart should have been covered completely but she was used to leaving it open while she was in the resident rooms. Housekeeper H said it was important to ensure the linen cart covers were used properly to prevent contamination. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 09/26/2024 beginning at 1:28 PM, the ADON stated she was the infection control preventionist at the facility. The ADON stated the clean linen cart should have been kept covered while passing out laundry. The ADON stated the Housekeeping Supervisor was responsible for ensuring the clean linen carts were kept covered but she was responsible for ensuring infection control education was provided to the housekeeping staff. The ADON was unsure when the last education had been provided to the housekeeping staff. The ADON stated it was important to ensure clean linens were kept covered to prevent the spread of infection and contamination of clean linens. During an interview on 09/26/2024 beginning at 1:43 PM, Administrator T stated she expected the housekeeping staff to ensure clean linens were kept covered while passing out laundry. Administrator T stated the Housekeeping Supervisor was responsible for monitoring to ensure the linen carts were kept covered. Administrator T stated new linen cart covers had been ordered after the Housekeeping Supervisor had told her about the incident. Administrator T stated it was important to ensure clean linen carts were covered properly for infection control. Record review of the in-service training attendance roster, dated 09/26/2024, revealed the Housekeeping Supervisor initiated an in-service training on Proper Handling and Distribution for Clean Linen. Housekeeper H was listed on the signage sheet for being called. Record review of the Infection Control Plan: Overview, updated March 2024, revealed Personnel will handle, store, process, and transport linens so as to prevent the spread of infection . Record review of a Perineal Care policy with an effective date of 5/11/2022 indicated an incontinent resident of urine and/or bowel should be identified, assessed, and provided appropriate treatment and services to restore as much normal bladder/bowel function as possible . The policy purpose indicated was to maintain the resident's dignity and self-worth and reduce embarrassment by providing cleanliness and comfort to the resident, preventing infections and skin irritations, and observing resident's skin condition Start: 10) perform hand hygiene, 11) apply gloves and all other PPE standard precautions, 12) soak towels in wash basin .or remove an adequate number of pre-moistened cleansing wipes, 13) reposition the resident on their back with legs flexed and separated as able, 14) limit resident exposure to the perineal area-provide privacy at all times, 15) if required, use a towel or extra incontinence pad to protect the mattress cover form being soiled, 16) wipe across the pubis area, 17) gently perform perineal care, wiping from clean, urethral area, to dirty rectal area, to avoid contaminating the urethral area. Female resident: working from front to back, wipe one side of the labia majora, the outside folds of the perineal skin that protect the urinary meatus and the vaginal opening. Continue perineal care to the inner thigh. Male resident: Pull back the foreskin on uncircumcised males. Hold the penis by the shaft, wash in a circular motion from the tip down to the base. Continue perineal care to the scrotum and inner thigh 20) Reposition the resident to their side, 21) Gently perform care to the buttocks and anal area, working from front to back without contaminating the perineal area 24) remove gloves and PPE, 25) perform hand hygiene. Record review of the Infection Control policy updated 3/2024 indicated the facility will establish and maintain an Infection Control Program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of disease and infection.