STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675096	A. Building B. Wing	11/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Homestead Nursing and Rehabilitation of Hillsboro	1725 Old Brandon Rd Hillsboro, TX 76645

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47065 Based on observation, interviews, and record review, the facility failed to ensure that residents received treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices for 1 (Resident #1) of 6 residents reviewed for incidents. The facility failed to identify a purple bruise observed on Resident #1's forearm on 11/19/24. This deficient practice could place residents at risk of abuse, neglect, and untreated and unassessed injuries. Findings included: Review of Resident #1's face sheet, dated 11/19/24, reflected she was a [AGE] year-old female who was admitted to the facility on [DATE] and had diagnoses including type 2 diabetes mellitus, unsteadiness on feet, muscle wasting and atrophy, generalized muscle weakness, other lack of coordination, unspecified protein-calorie malnutrition, mild cognitive impairment, and weakness. Review of Resident #1's quarterly MDS assessment, dated 10/10/24, reflected she had a BIMS score of 8, which indicated moderate cognitive impairment. Review of Resident #1's care plan, dated 10/04/24, reflected no notes related to Resident #1's bruise on her forearm. Review of Resident #1's orders, from 10/01/24 through 11/19/24, reflected there were no orders related to Resident #1's bruise on her forearm. Review of Resident #1's Treatment Administration Record, from 09/19/24 through 11/19/24, reflected no treatment orders related to Resident #1's bruise on her forearm. Review of Resident #1's clinical documents, from 11/16/24 through 11/19/24, reflected there were no notes related to Resident #1's bruise on her forearm. Review of Resident #1's event history, from 10/01/24 through 11/19/24, reflected there were no skin assessments and events related to Resident #1's bruise on her forearm. (continued on next page)

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

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

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #1's wound management reports, from 10/01/24 through 11/19/24, reflected no reports related to Resident #1's bruise on her forearm. Review of Resident #1's progress notes, from 10/01/24 through 11/19/24, reflected no notes related to Resident #1's bruise on her forearm. During an observation and interview of Resident #1 on 11/19/24 at 11:13 AM, Resident #1 was sitting in the dining area. Resident #1 had a baseball sized purple-colored bruise on her right forearm. Resident #1 stated she didn't know how and when she got the bruise on her forearm at the time of the interview. Resident #1 stated she didn't know if staff knew she had a bruise on her forearm. During an observation and interview on 11/19/24 at 11:21 AM, the DON stated she didn't know Resident #1 had a bruise at the time of the interview. The DON stated she didn't know how and when Resident #1 got the bruise on her forearm. The DON stated her staff didn't report to her that Resident #1 had a bruise on her forearm at the time of the interview. During an interview on 11/19/24 at 11:42 AM, LVN A stated she didn't know if she was in-serviced on injury of unknown origin. LVN A stated she was trained on change in condition. LVN A stated CNAs and LVNs were responsible for rounding (checking on) on residents every two hours. LVN A stated CNAs were responsible for reporting bruises to nurses. LVN A stated she worked on Resident #1's hall at the time of the interview. LVN A stated she didn't know Resident #1 had a bruise at the time of the interview. LVN A stated Resident #1 didn't have her weekly skin round yet on 11/19/24. LVN A stated CNA B worked on Resident #1's hallway on 11/19/24. LVN A stated no CNAs reported any bruises observed on Resident #1 at the time of the interview. LVN A stated she didn't receive any information from the prior shift about Resident #1 having a bruise on her forearm. LVN A stated she knew it was important to report bruises observed on residents to ensure residents were not being abused and condition was not worsening. During an interview on 11/19/24 at 11:50 AM, CNA B stated she was trained on change in condition. CNA B stated she was last in-serviced on injury of unknown origin the month of November 2024. CNA B stated CNAs were responsible for checking on residents every two hours unless they were responding to a call light. CNA B stated if she observed a bruise on a resident, she would notify her nurse. CNA B stated she worked on Resident #1's hall at the time of the interview. CNA B stated she last rounded on Resident #1 before lunchtime on 11/19/24. CNA B stated she didn't observe any bruises on Resident #1 at the time of the interview. CNA B stated she didn't see that Resident #1 had a bruise the morning of 11/19/24. CNA B stated Resident #1 didn't complain of any bruises or pain on 11/19/24. CNA B stated she didn't know if Resident #1 had a bruise before because she didn't work at the facility from 11/15/24 through 11/18/24. CNA B stated LVN A and LVN C were Resident #1's nurses on 11/19/24. CNA B stated she didn't have to report any new skin issues to LVN A and LVN C on 11/19/24. CNA B stated she knew it was important to residents' health and safety to report injuries of unknown origin. CNA B stated residents could be abused if staff didn't observe and report injury of unknown origin. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/19/24 at 12:37 PM, MA D stated she was trained on change in condition and injury of unknown origin. MA D stated she was trained to notify a nurse if she observed a change in condition. MA stated if a resident had a bruise, she would notify the nurse. MA stated she would also report it to the ADM if the nurse didn't know the resident had a bruise. MA stated if a resident's bruise was purple, it would be documented in the residents' chart because purple-colored bruises were older. MA D stated LVNs and wound care were responsible for checking residents' skin. MA D stated CNAs, Nurses and MAs were responsible for rounding on residents every two hours. MA D stated she didn't work on Resident #1's hall at the time of the interview. MA D stated she knew it was important to report injury of unknown origin because staff need to know where the injury came from. MA D stated residents could go downhill if their injury of unknown origin went unreported and unobserved. During an interview on 11/19/24 at 3:23 PM, the DON stated she couldn't recall when she last reviewed injury of unknown origin with her staff. The DON stated she expected her nurses to notify her whenever they observed an injury of unknown origin. The DON stated she expected her CNAs to report to the nurse whenever they observed an injury of unknown origin. The DON stated she in-serviced staff on abuse and neglect and reporting on 11/18/24. The DON stated all staff were responsible for rounding on residents. The DON stated residents' skin assessments were completed every seven days. The DON stated weekly skin assessments were due to be completed on 11/19/24. The DON stated that staff didn't report any skin issues to her on 11/19/24. The DON stated Resident #1 was scheduled to have her skin assessed every Tuesday. The DON stated she observed a purple-colored bruise on Resident #1, which meant that Resident #1's bruise was new. The DON described Resident #1's bruise was purple and blotchy. The DON stated she didn't believe Resident #1's bruise was a handprint. The DON stated the incident that could have resulted in Resident #1's bruise could have occurred within the last couple of days. The DON stated she asked the CNA who cared for Resident #1 last week and the CNA told her that she didn't see anything on Resident #1's forearm. The DON stated she spoke with Resident #1 and asked her if someone did something to her that resulted in her sustaining a bruise and Resident #1 told her no. The DON stated Resident #1 was on aspirin, which she explained was an anticoagulant that could thin blood and cause a bruise. The DON stated she went to check if Resident #1 had any bed rails that could've resulted in her sustaining a bruise and Resident #1 didn't have any bed rails. The DON stated Resident #1 does move around the building a lot and could've bumped her forearm on something. The DON stated she notified the MD about Resident #1's bruise on 11/19/24. The DON stated the ADM was responsible for reporting injury of unknown origin to the SA. The DON stated the ADM was required to report within 24 hours of an injury of unknown origin. The DON stated she knew it was important to report injury of unknown origin to ensure abuse to residents didn't occur. The DON stated anything could happen to the residents if injury of unknown origin was left unreported and unobserved. During an interview on 11/19/24 at 4:17 PM, the MD stated he received a couple text messages on 11/19/24 at 12:02 PM that Resident #1 had a small bruise on her right forearm and staff were unable to say how she got it. The MD stated a purple-colored bruise meant the incident happened within the first few days. The MD stated bruises were reported all the time and there was nothing particular about Resident #1's bruise. The MD stated he last visited the facility on 11/13/24 and didn't observe any bruises on Resident #1. The MD stated he guessed Resident #1's bruise was an injury of unknown origin, but he assumed Resident #1 bumped into something. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/19/24 at 4:30 PM, the ADM stated she wasn't notified of any bruises observed on Resident #1 on 11/19/24. The ADM stated Resident #1 had good memory and said no one hurt or abused her and she believed she hit her arm on something. The ADM stated Resident #1 had an intellectual disability. The ADM stated she went over injury of unknown origin with her staff on 11/18/24 and sometime in September 2024. The ADM stated she expected staff to assess a resident, ensure resident's safety, determine what happened, report to the charge nurse, and the charge nurse was to report to the DON and her if they observed an injury of unknown origin. The ADM stated her and the DON report injuries of unknown origin to the SA. The ADM stated she reported to the SA within 24 hours if there were no serious bodily injuries and within 2 hours if there were serious bodily injuries. The ADM stated she knew it was important to report injuries of unknown origin because the staff needed to conduct a full investigation. The ADM stated residents could be in pain, be scared and hurt themselves again if injury of unknown origin was left unreported and unobserved. Review of the facility's event summary report, from 10/01/24 through 11/19/24, reflected there were no incidents related to Resident #1's bruise listed. Review of the facility's in-services, from 10/01/24 through 11/19/24, reflected no in-services related to quality of care, change in condition, and injury of unknown origin .