STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675098	A. Building B. Wing	09/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Farwell Care and Rehabilitation Center	305 Fifth St Farwell, TX 79325

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46534 Based on observation, interview, and record review the facility failed to treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality for 1 (Resident #18) of 12 Residents reviewed for resident rights. The facility failed to ensure LVN C was seated while she fed Resident #18. This failure could lead to residents' dignity being adversely affected. Findings Included: Record review of Resident #18's admission record dated 09/18/24 revealed an [AGE] year-old female admitted to the facility on [DATE] with diagnoses that included, but were not limited to, dementia (a group of thinking and social symptoms that interferes with daily functioning), vitamin deficiency (low levels of essential vitamins which may result in disease), and anorexia (eating disorder characterized by inordinately low body weight and fear of gaining weight). Record review of Resident #18's quarterly MDS completed on 06/28/24 revealed the following: Section C: Resident #18 had a BIMS score of 3 which indicated severely impaired cognition. Section GG: Resident #18 required supervision or touching assistance for eating which was defined as, Helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity. Assistance may be provided throughout the activity or intermittently. Section I: Resident #18's primary medical condition was non-traumatic brain dysfunction. Section K: Resident #18 had not experienced any weight loss or gain of 5% or more and had not required parenteral/IV feeding, feeding tube, mechanically altered diet, or therapeutic diet. (continued on next page)

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

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #18's care plan completed on 07/16/24 revealed staff were to converse with resident while providing care. Resident #18 was to sit at the assist table in the dining room and receive assistance with eating by one person. The care plan indicated Resident #18 had impaired cognition and needed staff to face her and speak directly to her to provide necessary cues. Resident #18 was at risk for nutritional problems related to several of her diagnoses and staff were to provide and serve her diet as ordered. Resident #18 was at risk for decrease in ability to feed herself, weight loss, and further decline. To address these risks staff was to assist/cue/reinforce OT/ST instructions for improving/maintaining skills, minimize distractions during meal-time, and provide only the assistance necessary to ensure adequate meal intake. Record review of Resident #18's order summary report dated 09/18/24 revealed the following dietary order with start date of 05/16/23: Regular diet Regular texture, Regular consistency, Fortified foods w/ meals, cut up meat, 3 compartment plate. During an observation on 09/18/24 at 07:34 AM Resident #18 was seated at a table in the dining room with a clothing protector on and a coffee cup in front of her. During an observation on 09/18/24 at 07:50 AM LVN C was standing behind and to the right of Resident #18 while Resident #18 was seated at a table in the dining room. Resident #18 had a sectioned plate with edges in front of her and LVN C was feeding Resident #18 a bite of breakfast from a fork. During an observation on 09/18/24 at 07:53 AM LVN C was standing behind and to the right of Resident #18 while Resident #18 was seated at a table in the dining room. LVN C was feeding Resident #18 a bite of her scrambled eggs. During an observation on 09/18/24 at 07:55 AM LVN C was standing behind and to the right of Resident #18 who was seated at a table in the dining room. LVN C was holding a fork with a bite of sausage on it in front of Resident #18's mouth. Resident #18 was holding her coffee cup in her right hand and attempting to take a drink. LVN C fed the bite of sausage to Resident #18. LVN C immediately scooped up a bite of what appeared to be scrambled eggs, approximately the size of half a credit card on the fork and held it in the air to the right side of Resident #18's mouth. Resident #18 was drinking from her coffee cup and still chewing the last bite. During an observation on 09/18/24 at 07:57 AM LVN C fed Resident #18 the next bite by holding fork in front of her mouth as she was still chewing the last bite. LVN C then walked away from Resident #18. During an interview on 09/18/24 at 07:59 AM Resident #18's family member, who was also a resident of the facility, stated Resident #18 usually feeds herself. During an interview on 09/18/24 at 08:04 AM Resident #18 was asked if she was okay with the staff member standing over her and feeding her breakfast. She said, Well, I don't think she was very comfortable with that. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 09/18/24 at 08:51 AM LVN C stated she took a course on how to feed residents million years ago when she became a nurse. She said it was not appropriate for her to stand when feeding Resident #18, Because I was not taking care of her. I was not face to face with her, cueing her appropriately. During an interview on 09/18/24 at 09:25 AM ADM stated a staff member standing over a resident feeding them was a dignity issue. She stated, They need to be seated. Resident might not eat as much for sure and might feel rushed. During an interview on 09/18/24 at 10:09 AM DON and VP of C stated a possible negative outcome of staff standing over a resident to feed them was it would negatively impact the resident's dignity. DON stated all staff had been trained to be seated on eye-level with any resident they are feeding. During an interview on 09/18/24 at 10:11 AM LVN C stated a possible negative outcome of standing to feed a resident was the resident might choke, she (LVN C) might poke the resident in the cheek with the fork, or the resident might not know she was there. Record review of facility policy titled Meal Supervision and Assistance and dated 2023 revealed in part: . The resident will be prepared for a well-balanced meal in a calm environment, location of his/her preference and with adequate supervision and assistance to prevent accidents, provide adequate nutrition, and assure an enjoyable event. 12 Be careful to provide portions of food easy for the resident to chew. 13. Feed slowly allowing plenty of time between bites. 14. Provide a relaxing, enjoyable environment during mealtimes. 17. Encourage the resident to participate with his or her meal as much as possible. Record review of facility policy titled Resident Rights and dated 2024 revealed in part: . The resident has the right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility. The resident has the right to be treated with respect and dignity . 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 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. 47159 Based on Record Review and Interview the facility failed to have a registered nurse for at least 8 consecutive hours a day, 7 days a week for 1 (September 2, 2024) day of 90 days reviewed for RN coverage. The facility failed to have a registered nurse for at least 8 consecutive hours a day on September 2, 2024. This failure could place residents at risk of not receiving the care and services needed to maintain their highest practicable level of physical, mental, and psychosocial well-being. Findings included: Record review of the facility RN coverage census for the 90-day period from 07/01/2024 through 09/17/2024 revealed on 09/02/2024, only 6-hours of RN coverage was provided to the residents. In an interview with the DON on 09/17/2024 at 2:50PM revealed on 09/02/2024 RN E was scheduled to work from 8AM-5PM. RN E had given her resignation. This day was to be her last day of scheduled employment. RN E had expressed to the DON she was unhappy and did not want to be at work, in the facility, that day. The DON expressed her desire for RN E to finish her shift. RN E clocked out from the facility at 2:34PM, abandoning her shift approximately 2.5 hours early. When asked the negative outcome of not having an RN for 8 consecutive hours, 7 days a week the DON stated staff who remained in the building did not have the clinical knowledge base, should an emergency arise with a resident. When asked why RN E was not referred to the Texas State Nursing Board for abandoning her shift the DON stated she had thought about referring RN E's license but had decided not to. Record Review of facility Policy and Procedures dated February 2023 revealed the following: Policy: It is the policy of the facility to provide sufficient staff with appropriate competencies and skill sets to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. The facility's census, acuity, and diagnoses of the resident population will be considered based on the facility assessment. Policy Explanation and Compliance Guidelines: 8. Except when waived, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47854 Based on observation, interview, and record review, it was determined the facility failed to ensure drugs and biologicals were stored in locked compartments and labeled in accordance with currently accepted professional principles and include the appropriate accessory and cautionary instructions, and the expiration date when applicable for 2 (medication cart #2 and Nurse's medication cart) of 3 medication carts reviewed for medication storage. -medication cart #2 revealed a bottle of Melatonin with an unreadable expiration date. -5 insulin medications were found in Nurse's medication cart that had a date of ,d+[DATE] written on them. -LVN E did not lock Nurse's medication cart while she went to go and get a resident for a treatment. The facility's failure placed residents receiving medication at risk for drug diversion, drug overdose, and accidental or intentional administration to the wrong resident. Findings included: Observation on [DATE] at 07:51 revealed medication cart #2 had a bottle of Melatonin 1mg with an expiration date that was not readable. MA C was asked what a negative outcome was for giving a medication that was out of date or expired. MA C stated that it could make the resident sick. Observation on [DATE] at 10:34 AM revealed the nurse's medication cart being left unattended and unlocked. LVN E left the med cart to go to the rotunda to get a resident to check her blood sugar. At 10:38 AM LVN E came back to her medication cart and continued on with the BG check in Resident #12's room. Observation and interview on [DATE] at 10:40 AM revealed the nurse's medication cart had 5 insulin bottles that were dated with an open date of ,d+[DATE]. LVN E was asked if the date on the medications represented ,d+[DATE] as in the month and day, or if it meant the month and the year? LVN E stated that she could not answer that because she didn't know which date it represented. During an interview on [DATE] at 10:52 AM, LVN E revealed that a negative outcome for leaving the medication cart unattended and unlocked could lead to a random resident getting into it. LVN E then stated that a negative outcome would be for having medications with unclear open dates on them. LVN E responded with you wouldn't know if the meds were good or not. During an interview on [DATE] at 11:10 AM, DON stated that a negative outcome of leaving a medication cart unattended and unlocked could lead to a resident getting into the cart and getting a hold of medication. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on [DATE] at 02:57 PM, DON stated that the negative outcome from not writing the correct open date would be that you won't know if the medication is still effective. Record review of the facility provided policy titled, Medication Storage, undated, revealed the following: Policy: It is the policy of this facility to ensure all medications housed on our premises will be stored in pharmacy and/or medication rooms according to the manufacturer's recommendations and sufficient to insure proper sanitation, temperature, light, ventilation, moisture control, segregation, and security. Policy Explanation and compliance Guidelines 1. General Guidelines: a. All drugs and biologicals will be stored in locked compartments (i.e , medication carts, cabinets, drawers, refrigerators, medication rooms) under proper temperature controls. b. Only authorized personnel will have access to the keys to locked compartments. c. During a medication pass, medications must be under the direct observation of the persons administering medications or locked in the medication storage area/cart. .8. Unused Medications: The pharmacy and all medication rooms are routinely inspected by the consultant pharmacist for discontinued, outdated, defective, or deteriorated medications with worn, illegible, or missing labels. These medications are destroyed in accordance with our Destruction of Unused Drugs Policy.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 47854 Based on observation, interview, and record review, the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment to help prevent the development and transmission of communicable diseases and infections for 1 of 12 (Resident #8) Residents reviewed for infection control, in that: -CNA B failed to use proper hand hygiene and glove change during incontinent care of Resident #8. These failures had the potential to affect residents in the facility by placing them at risk of contracting, spreading, and/or exposing them to bacterial or viral infections that could lead to the spread of communicable diseases. Findings included: Observation on 09/18/24 at 01:19 PM of incontinent care performed by CNA B and CNA A for Resident #8. CNA B and CNA A started incontinent care for resident. Both CNA's performed hand hygiene (HH) and put on gowns and gloves secondary to Resident #8 having a foley catheter in place. CNA B removed the residents brief and performed incontinent care with foley catheter care. Perineal care was performed with no concern, once CNA B had completed care, Resident #8 turned to her left away from CNA B and CNA A assisted resident into this position. CNA B cleaned the resident's buttocks and rectal area with no concerns. CNA B removed the soiled brief and threw it away in the trash. CNA B then reached for a clean brief and proceeded to place the clean brief under Resident #8. There was no glove change or HH was performed by CNA B. CNA B continued with securing the residents brief into place. CNA B removed all PPE and performed HH and discarded soiled brief and dirty PPE. During an interview on 09/18/24 at 01:33 PM, CNA B stated that she just panicked and I don't know why I didn't change my gloves or wash my hands. CNA B stated that a negative outcome for not performing hand hygiene and changing gloves in between dirty and clean areas of a resident was cross contamination. During an interview on 09/18/24 at 02:57 PM, DON stated that the negative outcome of not performing HH during incontinent care could lead to cross contamination for the resident. During an interview on 09/19/24 at 12:06 PM, ADON revealed that she was the responsible party for training CNAs on infection control protocols. ADON did state that a negative outcome for not performing hand hygiene during perineal care could lead an increased risk for infection. Record review of facility provided policy, titled Perineal Care, undated, revealed the following: Policy: It is the practice of this facility to provide perineal care to all incontinent residents during routine bath and as needed in order to promote cleanliness and comfort, prevent infection to the extent possible, and the prevent and assess for skin breakdown. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	.10. Re-position resident in supine position. Change gloves if soiled and continue with perineal care. .14. Apply skin protectants as needed and according to facility policy regarding skin care. 15. Reposition as desired and cover resident . Record review of facility provided policy, titled Hand Hygiene, undated, revealed the following: Policy: All staff will perform proper hand hygiene procedures to prevent the spread of infection to other personnel, residents, and visitors. This applies to all staff working in all locations within the facility. 2. Hand Hygiene is indicated and will be performed under the conditions listed in, but not limited to, the attached hand hygiene table. Record review of the Hand Hygiene Table, indicated that hand hygiene would need to be performed under certain conditions. The conditions are listed but not limited to the following: Before applying and after removing personal protective equipment (PPE), including gloves. . Before and after handling clean or soiled dressings, linens, etc. Before performing resident care procedures . .After handling items potentially contaminated with blood, body fluids, secretions, or excretions When, during resident care, moving from a contaminated body site to a clean body site After assistance with personal body functions (e.g., elimination, hair grooming, smoking)