STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675133	A. Building B. Wing	09/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Highland Pines Nursing Home	1100 N 4th St Longview, TX 75601

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 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** 45643 Based on observation, interview, and record review, the facility failed to develop and implement a comprehensive person-centered care plan to meet each resident's medical, nursing, mental and psychosocial needs for 1 of 5 residents reviewed for care plans. (Resident #1) The facility failed to develop and implement the comprehensive person-centered care plan for Resident #1 by not documenting foley catheter changes. This failure could place residents at risk of not having individual needs met, a decreased quality of life, and cause residents not to receive needed services. Findings include: Record review of a face sheet dated 11/7/22 revealed Resident #1 was [AGE] years old and was admitted on [DATE] with diagnoses including Obstructive and Reflux Uropathy (A blockage in the urinary tract that prevents urine from flowing normally. This can cause urine to back up into the kidneys, which can damage them.), COPD (Chronic obstructive pulmonary disease is a chronic lung disease that makes it difficult to breathe), Benign Prostatic Hyperplasia with lower Urinary Tract Symptoms (Benign prostatic hyperplasia (BPH) is a condition that occurs when the prostate grows and compresses the bladder and urethra, causing lower urinary tract symptoms). Record review of the Quarterly MDS dated [DATE] indicated Resident #1 was understood and understood others. The MDS indicated a BIMS of 12 indicating moderate cognitive impairment. The MDS indicated Resident #1 used a foley catheter. Record review of physician's orders for Resident #1 dated 08/6/24 indicated an order for Foley Catheter and Drainage Bag - change q month and PRN every night shift starting on the 14th and ending on the 15th every month related to OBSTRUCTIVE AND REFLUX UROPATHY, UNSPECIFIED (N13.9) AND as needed. Record review of a care plan dated 09/09/24 indicated Resident #1 had a problem with toilet use due to an ADL self-care deficit. TOILET USE: Resident #1 is incontinent of bowel. Has a supra-pubic foley (medical device that helps drain urine from your bladder) for bladder CNA elimination. Requires staff assist for clothing and cleansing. Toilet hygiene: dependent. Care plan did not indicate how often to change Resident #1's catheter. (continued on next page)

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

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #1's electronic health records, progress notes, revealed no indication that Resident #1's catheter had been changed from 1/1/2024 to 9/5/2024. During an interview and observation on 9/5/24 at 11:35 a.m ., LVN A said she would document on Resident #1's Catheter bag when it was last changed, but not everybody would do that . Resident #1 was observed to have a foley catheter, no documentation on catheter bag. Yellow urine with small amount of white sediment was in tubing and bag. LVN A said she could not say when the catheter was last changed that she would have to do some research. During an interview on 9/5/24 at 12:25 p.m., LVN A said catheter care would be documented if there was something abnormal with a catheter change. She said that if the change went smoothly with no issues, then the catheter change would not be documented in the residents progress notes. She said that the order for Resident #1's catheter change said that Resident #1's catheter should be changed on the 14th or PRN. She said that it had not been documented anywhere that resident #1 has had a catheter change. She said that his catheter tubing was not labeled either which would have indicated when it had last been changed . She said if she changed a resident's catheter she would write on his tubing or bag the date it was changed. She said at this time there was no way to determine the last time Resident #1 had a catheter change. During an interview on 9/9/24 at 1:12 p.m. with the DON she said care plans were developed by the facilities interdisciplinary team. She said it was the responsibility of any nurse to ensure that Resident #1's catheter was changed, and that change was documented. She said that if facility staff failed to document a catheter change then other staff would not know if a catheter change had been completed or not. She said this could place the resident at risk for UTIs for either late changes or too frequent catheter changes. During an interview on 9/9/24 at 1:16 p.m. with the ADM he said that it was the responsibility of his nursing staff to document and change Resident #1's catheter. He said that if his staff did not document resident's catheter changes then other staff would not know if the task had been completed or not. He said this could have placed residents at risk for urinary tract problems. Review of a facility policy titled, Catheter - Indwelling, Insertion of dated June 2020 indicated, To relieve bladder distention, to obtain a urine specimen for diagnosis testing and/or to maintain constant urinary drainage Document the following in the resident's medical record: Type and size of catheter inserted, Date and time of catheter insertion, Urine return and characteristics, color, and odor, if any, Amount of urine prior to residual catheterization and, Any difficulties or discomfort . Review of a facility policy titled, Care Planning dated December 2020 indicated, To ensure that a comprehensive person-centered Care Plan is developed for each resident based on their individual assessed needs The Facility will develop a person-centered Baseline Care Plan for each resident within 48 hours of admission. The Baseline Care Plan will include at least the following information: Initial goals based on admission orders, Physician orders.