STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675181	A. Building B. Wing	06/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Carriage House Manor	210 Pipeline Rd Sulphur Springs, TX 75482

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46062 Based on observation , interview, and record review the facility failed to ensure assessments accurately reflected the resident status for 4 of 22 residents (Resident #14, Resident 73, Resident #53, and Resident #186) reviewed for MDS assessment accuracy. 1. The facility failed to accurately document Resident #53's chair alarm use. 2.The facility failed to accurately reflect Resident #14 was PASRR positive (identified as having a serious mental illness) on her annual MDS assessment. 3. The facility failed to accurately reflect Resident #73 was receiving hospice services on her significant change MDS assessment. 4. The facility failed to accurately reflect Resident #186 had bed and chair alarms on his quarterly MDS assessment. These failures could place residents at risk for not receiving care and services to meet their needs. Findings included: 1. Record review of an undated face sheet revealed Resident #53 was an 86- year-old-female admitted to the facility on [DATE] with the diagnoses of Respiratory Failure with Hypoxia (happens when you don't have enough oxygen in your blood), Encephalopathy (a group of conditions that cause brain dysfunction), Acute Kidney Failure (Acute kidney failure occurs when your kidneys suddenly become unable) Record review of an Annual MDS dated [DATE] for Resident #53 revealed a BIMS of 05, which indicated severe cognitive impairment. The MDS also revealed Resident #53 was not marked for use of a chair alarm. Record review of resident #53's care plan revealed a problem initiated on 9/8/2023, I am at risk of falls and history of falls with multiple fractures and poor safety awareness. Fall alarm to wheelchair and bed. (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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #53's consolidated physician's orders dated 4/16/23 revealed Resident #53 had an order for, Alarm pad to chair and bed until further notice - make sure this is in place. During an observation on 06/24/24 at 10:40 a.m., Resident # 53 was observed with a chair alarm on her wheelchair. A chair alarm device that had a wire with a clip was attached to Resident #53's clothing. During an interview and observation on 06/25/24 at 08:49 a.m., revealed Resident #53 had a chair alarm attached to her clothing. Resident #53 said she did not know what it was. Resident #53 said it did not bother her. Resident #53 said she was not scared of the noise that was made by the wheelchair alarm. During an interview on 6/26/24 at 11:40 a.m., the DON said she expected accurate and timely MDSs as per facility policy. She said incorrect MDSs could affect the information transmitted to the state. She said it was the MDS nurse's responsibility to correctly code the MDS for residents. During an interview on 6/26/24 at 11:52 a.m. the ADM said it was the MDS nurse who was responsible for correctly coding the MDS. She said she expected accurate and timely MDSs. She said incorrect MDSs affected the information transmitted to State. 2. Record review of Resident #14's face sheet dated 6/25/24 revealed she was [AGE] years old and admitted to the facility on [DATE] and readmitted on [DATE]. Resident #14 had diagnoses of Primary Lateral Sclerosis (rare, slowly progressive neuromuscular (nerve and muscle) disease that leads to lose of muscle control and movement problems) and schizoaffective disorder, bipolar type (mental illness that combines symptoms of schizophrenia, such as hallucinations (seeing, hearing, smelling, tasting something that is not there), delusions (belief or altered reality that was persistently held despite evidence or agreement to the contrary), and psychosis (mental disorder characterized by a disconnection from reality), with a mood disorder such as mania (excessive enthusiasm or desire, or obsession) and depression (persistent sadness)). Record review of Resident #14's annual MDS assessment dated [DATE] indicated she marked as not currently considered by the state level II PASRR process to have serious mental illness and/or intellectual disability or a related condition. The MDS did not indicate Resident #14 had serious mental illness. The MDS indicated a BIMS score of 12 which indicated Resident #14 had moderate cognitive impairment. The MDS indicated Resident #14 had a diagnosis of Schizophrenia (for example schizoaffective and schizophreniform disorders). Record review of Resident #14's PASRR Comprehensive Service Form dated 4/10/24 indicated Resident #14 was PASRR positive for mental illness only. Record review of Resident #14's care plan printed 6/26/24 revealed she was PASRR positive for mental illness with a diagnosis of Schizoaffective disorder Bipolar Type. Resident #14 refused PASRR services but was receiving counseling services. 3. Record review of Resident #73's face sheet dated 6/25/24 revealed she was [AGE] years old and admitted to the facility on [DATE]. Resident #73 had diagnoses of dementia (progressive or persistent loss of intellectual functioning, memory, related to disease of the brain), Alzheimer's (progressive disease that destroys memory and other important mental functions), and anxiety disorder. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #73's significant change MDS dated [DATE] revealed she had a BIMS of 99, which indicated she had severe cognitive impairment and was unable to complete the interview. The MDS did not indicate she was receiving hospice services. Record review of Resident #73's Physician Orders dated June 2024 revealed an order to admit to hospice for diagnosis of dementia with a start date of 5/03/24. Record review of Resident #73's care plan printed 6/24/24 revealed she was receiving hospice care. 4. Record review of Resident #186's face sheet dated 6/25/24 revealed he was [AGE] years old and admitted to the facility initially on 8/09/19 and readmitted on [DATE]. Resident #186 had diagnoses of dementia, Parkinson's (disease of the brain that causes unintended or uncontrollable movements, such as shaking, stiffness, and difficulty with balance and coordination), and delusional disorder (belief or altered reality that was persistently held despite evidence or agreement to the contrary). Record review of Resident #186's quarterly MDS assessment dated [DATE] revealed he had a BIMS of 7, which indicated he had severe cognitive impairment. The MDS did not indicate he had bed or chair alarms. Record review of Resident #186's Physician Orders dated June 2024 revealed there was no orders for bed or chair alarms. Record review of Resident #186's care plan dated 6/26/24 revealed he was at risk for falls with history of multiple falls and had an intervention to place alarms as appropriate. During an interview and observation on 6/24/24 at 11:00 AM, Resident #186 was self-propelling himself in his wheelchair in the hallway with a chair alarm attached to the back of his wheelchair that attached to a pad under him. Resident #186 said he was doing just fine, and he did not know what the chair alarm was for. During an observation on 6/25/24 at 3:52 PM, Resident #186 was lying in bed asleep with a bed alarm attached to a pad under Resident #186. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 6/26/24 beginning at 2:24 PM with both MDS Coordinators, MDS B said she was responsible for the MDS assessments of residents with Medicare and MDS C said she was responsible for the MDS assessments of residents with Medicaid and private pay. MDS C said she completed Resident #73's significant change MDS assessment due to Resident #73 was admitted to hospice services. MDS C said she was responsible for ensuring the MDS assessments were accurate. MDS C said the MDS assessment calculated the RUG (Resource Utilization Group) score, and it reflected what the resident's care needs were. MDS C said if the MDS assessment was not accurate then the resident's care plan may not be accurate due to the care areas marked on the MDS assessment helped build the care plan for the resident. MDS C said hospice should have been checked on the Resident #73's significant change MDS assessment. MDS C reviewed Resident #73's 5/03/24 significant change assessment and said hospice was not checked. MDS C said she was responsible for Resident #186's MDS assessments. MDS C said Resident #186 had bed and chair alarms in place for a long time because he was a fall risk. MDS B reviewed Resident #186's MDS assessment and said Resident #186 did not have bed or chair alarms checked on his MDS assessment. MDS B said bed and chair alarms should have been included on Resident #186's MDS assessment. MDS C said she was responsible for Resident #14's MDS assessments. MDS C and MDS B said Resident #14 was PASRR positive and it should have been marked on her annual MDS assessment. MDS B reviewed Resident #14's annual MDS assessment and said PASRR was not marked on her MDS assessment. MDS B and MDS C said the PASRR section usually prepopulated, and they did not know why it did not prepopulate on Resident #14's MDS assessment, but it should have been marked. During an interview on 6/26/24 at 2:45 PM, the ADM said the MDS nurses were responsible for ensuring the MDS assessments were accurate. She said the MDS assessment should paint an accurate picture to the state on what level of care they were providing to the residents. The ADM said she would expect the MDS assessments to be accurate and paint a picture of the resident. Requested a policy on Accuracy of Assessments on 6/26/24 at 1:30 PM from the ADM and was provided policies on Electronic Transmission of MDS, MDS Completion and Submission Timeframes, and MDS Error Correction. These policies did not address accuracy of assessments. Record review of the Resident Assessment Instrument 3.0 User's Manual (RAI) last revised October 2023, revealed . the RAI process was the basis for the accurate assessment of each resident . Code yes if PASRR Level II screening determined that the resident had a serious mental illness . code serious mental illness, if resident had been diagnosed with a serious mental illness . code residents identified as being in a hospice program for terminally ill persons where an array of services is provided for the palliation and management of terminal illness and related conditions . identify all alarms that were used at any time during the 7-day look back period . bed alarm . chair alarm . code 2 if used daily . 45643

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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** 46062 Based on observation, interview, and record review the facility failed to develop, and implement a comprehensive care plan to meet the medical, nursing, mental and psychosocial needs for 1 of 22 residents (Resident #1) reviewed for care plans. The facility failed to implement a comprehensive person-centered care plan for Resident #1's diagnosis of Chronic combined systolic and diastolic congestive Heart Failure (heart does not pump blood adequately causing cough, shortness of breath, difficulty breathing, swelling, chest pain, weight gain, tiredness, and weakness). This failure could place residents in the facility at an increased risk of a decline in physical or functional well-being, of not receiving necessary care or services, and having personalized plans developed to address their needs. Findings included: 1. Record review of Resident #1's face sheet dated 6/25/24 revealed she was [AGE] years old and admitted to the facility initially on 4/25/16 and readmitted on [DATE]. Resident #1 had diagnoses of hypokalemia (low potassium), hypertension (high blood pressure), chronic combined systolic and diastolic heart failure. Record review of Resident #1's annual MDS assessment dated [DATE] revealed she had a BIMS of 10, which indicated she had moderate cognitive. The MDS indicated Resident #1 required total to maximum assistance for most ADLs. The MDS indicated Resident #1 had diagnoses of heart failure and hypertension. The MDS indicated Resident #1 had shortness of breath when lying flat. The MDS did not indicate Resident #1 was receiving a diuretic medication (used to pull extra fluid from body with increased urination). Record review of Resident #1's Physician Orders dated June 2024 revealed the following orders: * Torsemide 20 mg by mouth daily as needed, hold for blood pressure less than 100/60 or heart rate less than 60 for chronic combined systolic and diastolic heart failure with a start date of 3/1/24 *Torsemide 20 mg by mouth daily, hold for blood pressure less than 100/60 or heart rate less than 60 for chronic combined systolic and diastolic heart failure with a start date of 3/1/24. Record review of Resident #1's care plan dated 6/26/24 revealed she had hypertension and took a diuretic, but the care plan did not indicate Resident #1 had heart failure. Record review of Resident #1's Departmental Notes dated 6/11/24 indicated resident had a chest x-ray and new orders were to add torsemide 20 mg at 3:00 PM times five days in addition to the 20 mg every morning she was already taking. On 6/20/24, Resident #1 continued to have loose congestion and new orders received to increase Torsemide to twice daily for three days. (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 observation and interview on 6/24/24 at 11:07 AM, Resident #1 was lying in bed. Resident #1 said the staff took good care of her and she did not have any concerns with her care. Resident#1 had a wet sounding rattle while breathing. During an interview on 6/26/24 at 2:07 PM, the ADON said he was responsible for ensuring the care plans were accurate and included everything needed after the assessments were complete and updated the care plans as needed. The ADON said the purpose of the care plan was to guide the resident's care. The ADON said things such as wounds, risks dehydration, code status, hospice, weight loss, things that could affect disease processes, and congestive heart failure to monitor for edema (swelling) should be included in the resident's care plan. The ADON said if he caught that congestive heart failure was not on care plan during his review, he would add it. The ADON said congestive heart failure was not on Resident #1's care plan and it should have been included. The ADON said if the resident did not have a care plan for congestive heart failure, the resident could go into fluid overload, have respiratory issues, and could lead to death. The ADON said by not having a care plan for an active disease process, it could lead to an exacerbation of the disease process and be detrimental to the resident. During an interview on 6/26/24 at 2:16 PM, the DON she said the interdisciplinary team consisting of the Social Worker, DON, ADON, Activities Directory, Dietary Manager, and MDS Coordinators were all part of the care planning process. The DON said mostly the ADON was responsible for ensuring the care plans included all pertinent information. The DON said the purpose of the care plan was so staff would know how to take care of the resident and to individualize the resident's care. The DON said congestive heart failure was a diagnosis that should be included in the care plan if the resident was taking a medication for it. The DON said if the care plan did not have all pertinent information, then staff that did not know the resident, would not know how to take care of them. During an interview on 6/26/24 at 2:45 PM, the ADM said the purpose of the care plan was to give a clear picture of the resident and how the staff was to best care for the resident. The ADM said the staff may not know how to address the resident's care if there was not a care plan. The ADM said she would expect the care plans to include pertinent resident information such as CHF. Record review of the facility's policy dated revised March of 2022 and titled Care Plans, Comprehensive Person-Centered, revealed . a comprehensive, person-centered care plan that included measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs were developed and implemented for each resident . comprehensive, person-centered care plan would . describe the services that were to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being . reflected currently recognized standards of practice for problem area and conditions . care plan interventions were chosen only after careful data gathering, proper sequencing of events, careful consideration of the relationship between the resident's problem areas and their causes, and relevant clinical decision making . assessments of residents were ongoing and care plans were revised as information about the residents and the resident's conditions change .

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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** 48958 Based on observation, interview, and record review, the facility failed to ensure that a resident received appropriate treatment and services to prevent urinary tract infections (UTI) for 1 of 7 residents who were reviewed for quality of care. (Resident #77) 1. The facility failed to ensure Resident #77 had orders for the size and amount of fluid in the bulb of her indwelling urinary catheter (tube inserted into the bladder to drain urine). 2. The facility failed to ensure Resident# 77 had proper catheter care with an indwelling urinary catheter. The failures could place residents at risk for indwelling urinary catheter pain, urinary tract infections, and not receiving needed care. Findings included: 1. Record review of Resident #77's face sheet dated 6/24/24 indicated Resident #77 was a [AGE] year old female and admitted to the facility initially on 4/17/24 and readmitted on [DATE] with diagnoses including Unspecified dementia (progressive or persistent loss of intellectual functioning with impairment or memory and thinking and often with personality changes), UTI (urinary tract infection) site not specified, other acute kidney failure (a condition in which the kidneys suddenly can't filter waste from the blood), and urine retention. Record review of Resident #77's quarterly MDS assessment dated [DATE] indicated Resident #77 was usually understood and understood others. The MDS indicated Resident #77 had a BIMS score of 13 which indicated her cognition was intact. Resident #77 was maximal assistance on staff for toileting hygiene. The MDS indicated Resident #77 had an indwelling catheter (urinary catheter) and was always continent of bowel. Record review of Resident #77's care plan dated 4/18/2024 indicated she had a diagnosis of retention of urine and a failed removal of urinary catheter on 5/28/24. She had a current UTI. She was on enhanced barrier precautions with interventions of gloves and gown should be donned (put on) if any of the following activities occurred: linen change, resident hygiene, transfer, dressing, toileting/incontinent care, bathing, or other high contact activity. Record review of Resident #77's Order Summary Report dated 5/09/24 revealed an order to check the Foley catheter two times daily for correct placement, leaking and anchored to the skin. Staff should ensure her catheter bag is placed in a dignity bag when out of room. Resident #77's orders revealed there was no order noted related to Resident #77's urinary Foley catheter size and amount of fluid in the bulb. During an interview on 6/25/24 at 10:15 AM, the DON was notified Resident #77's urinary catheter size and bulb orders were not noted in her chart. The DON said she would find the orders. (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 6/25/24 at 2:30 PM the DON stated Resident #77's urinary catheter size and bulb orders were not in the resident's chart. During an observation and interview on 6/26/24 at 8:02 AM, revealed CNA D performed and CNA E assisted with incontinent/catheter care for Resident #77. CNA D washed her hands and applied gloves before she started incontinent care. CNA D cleaned Resident #77's crease between her right leg and groin area, then CNA D changed towels and proceed to clean her left leg and groin area. CNA D changed the towel and proceeded to clean the catheter tubing away from her but did not clean her meatus (a passage or opening leading to the interior of the body). CNA D did not clean Resident #77's mons pubis (the rounded mass of fatty tissue lying over the joint of the pubic bones). CNA D then provided perineal care to Resident #77's buttocks. CNA D was wearing the same gloves and removed a dirty incontinent pad and applied a clean incontinent pad. CNA D did not change her gloves and put the covers over Resident #77,then removed her gloves and washed her hands. During an interview on 6/26/24 at 8:32 AM, CNA E said she was 95% sure that CNA D missed a step while performing catheter care. CNA E said after washing the front peri area of the body CNA D was supposed to sanitize her hands then apply new gloves, then perform incontinent care to the backside of resident. CNA E said she would have cleaned the middle of the vagina and catheter first then clean the sides of the groin areas. CNA E said CNA D did not clean Resident #77's meatus. CNA E said the importance of catheter care was to keep the peri area clean and keep the catheter in place. CNA E said bad catheter care could cause infections. CNA E said when going from dirty to clean staff were supposed to change their gloves to prevent cross contamination. During an interview on 6/26/24 at 8:42 AM, CNA D said she felt like she did horrible with Resident #77's catheter care. CNA D said she felt like her clean hand got in the way. CNA D said she should have changed her gloves after peri care and catheter care. CNA D said the importance of catheter care was cleanliness and to keep the catheter intact. CNA D said bad catheter care could cause infections and not changing gloves during catheter care can cause cross contamination. During an interview on 6/26/24 at 10:23 AM, LVN F said CNAs should be going from the inside area to the outside areas with soap and water, unless the outer areas were soiled. LVN F said during catheter care cleaning they should be removing dirty gloves, sanitizing hands and changing gloves when they went from one part of the body to the other, to prevent cross contamination. LVN F said bad catheter care can cause a urinary tract infection with the elderly. During an interview and record on 6/26/24 at 11:11 AM, CNA G provided CNA D's skills check offs. CNA G said when she trained the CNAs she trained them on a dummy first. CNA G said CNAs should start catheter care with the top of the catheter and clean down. She said after she cleaned the tubing, removed dirty gloves, hands should be washed and clean gloves should be applied, then proceed to clean the peri area. She said after the peri area was cleaned, then clean across the top of the pubic area, then pat dry. She said after the front side was cleaned, then turn the resident over to proceed to clean the back area. She said to always have someone to help assist with catheter care . She said after she was done with catheter care she would roll her dirty pad, then change her gloves and sanitize my her hands, then apply clean gloves. She said she would have applied a clean incontinent pad under the resident, then the other person assisting with catheter care should remove the dirty pad. She said after the dirty pad was removed she would pull out the other side of the pad from underneath the resident. CNA G said improper catheter care could cause an UTI (urinary tract infection) or other infections. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of CNA D's skills check off dated 2/28/24 revealed CNA D passed and was very nervous, but she would be rechecked on her skills later. CNA D skills recheck off dated 4/1/24 revealed CNA D did very good, but she second guessed herself. During an interview on 6/26/24 at 2:12 PM, LVN F said before applying a catheter or replacing a catheter there should always be a physician or a nurse practitioner order reviewed. LVN F said the orders were typically on the MAR. LVN F said the charge nurses put in phone orders and the nurse that did the resident's admission usually put in their orders. LVN F said the way the nurses knew when orders were due was the orders came up on the MAR to inform them. LVN F said she typically read the orders of the resident and verified the orders before she changed a catheter. During an interview on 6/26/24 at 2:19 PM, the ADON said there should be orders for a catheter and catheter care on the resident's chart. The ADON said the orders should list the size and the amount of fluid should be placed in the bulb and the frequency the catheter should be changed. The ADON said the admitting nurses should put in the resident's orders, but any nurse can put in orders. The DON and ADON check the orders after the nurses. The ADON said he except the CNA to perform catheter care and go from clean to dirty. He said the CNAs should be washing their hands and changing their gloves in between steps. The ADON said the risk of not performing hand hygiene during catheter care could result in an infection. During an interview on 6/26/24 at 2:29 PM, the DON said there should be an order for an indwelling catheter. She said the order should had the size of the catheter, the amount of fluid in the bulb and when to change the catheter. The DON said the treatment nurse or the admitting nurse usually put the resident's orders in. The DON said the order fell through, because Resident #77's orders were discontinued when she was discharged to the hospital and the admitting nurse forgot to put the orders back in. The DON said during catheter care the CNAs were supposed to go from clean to dirty and change their gloves periodically. The DON said proper catheter care prevented infections. During an interview on 6/26/24 at 2:37 PM, the ADM said there should be an order for an indwelling catheter. The ADM said when applying a catheter, the nurse should be following the doctors' orders. The ADM said she expected the CNAs to use the correct PPE and follow the standard precautions guidelines, with incontinent care and catheter care. The ADM said staff members should be trying to prevent cross contamination and infections throughout the facility. Review of a Catheter Care, Urinary Policy dated revised August 2022 revealed .the purpose of this procedure is to prevent urinary catheter-associated complications, including urinary tract infections. Follow aseptic technique when inserting a urinary catheter. Use aseptic technique when handling or manipulating the drainage system. Routine perineal hygiene: With non-dominant hand separate the labia of the female resident. Maintain the position of this hand throughout the procedure. Assess the urethral meatus. For a female resident: Use a washcloth with warm water and soap (or clean bathing wipe) to cleanse the labia. Use one area of the washcloth (or wipe) for each downward, cleansing stroke. Change the position of the washcloth (or wipe) and cleanse around the urethral meatus. Do not allow the washcloth/wipe to drag on the resident's skin or linen. With a clean washcloth (or wipe), rinse using the above technique. Discard disposable items into designated containers. Remove gloves and discard into designated container. Wash and dry your hand thoroughly. Reposition the bed covers. Make the resident comfortable. (continued on next page)

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	675181	A. Building B. Wing	06/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Carriage House Manor	210 Pipeline Rd Sulphur Springs, TX 75482

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Physician Services Policy dated revised February 2021 revealed .The medical care of each resident is supervised by a licensed physician. Once a resident is admitted , orders for the resident's immediate care and needs can be provided by a physician, physician assistant (PA), nurse practitioner (NP), or clinical nurse specialist (CNS).

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46929 Based on interview and record review, the facility failed to ensure PRN orders for psychotropic drugs are limited to 14 days unless the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order for 2 of 7 residents (Resident #58 and Resident #73) reviewed for unnecessary medications. The facility failed to ensure Resident #58 and Resident #73 had a stop date or duration for PRN Lorazepam (a medication used to treat anxiety). These failures could put residents at risk of possible psychotropic medication side effects, adverse consequences, decreased quality of life, and dependence on unnecessary medications. Findings included: 1. Record review of Resident #58's face sheet, dated 06/26/24, indicated she was a [AGE] year-old female, admitted to the facility on [DATE]. Her diagnoses included Acute on chronic combined systolic and diastolic heart failure (a condition that develops when your heart doesn't pump enough blood for your body's needs), cardiomyopathy (an acquired or hereditary disease of heart muscle), peripheral vascular disease (a circulatory condition in which narrowed blood vessels reduce blood flow to the limbs), chronic viral hepatitis C (an infection caused by a virus that attacks the liver and leads to inflammation), depression (a mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life), and Parkinson's disease (a disorder of the central nervous system that affects movement). Record review of Resident #58's quarterly MDS assessment, dated 05/09/24, indicated she was usually able to make herself understood and she usually understood others. She had a BIMS score of 7, which indicated severe cognitive impairment. The assessment further indicated Resident #58 did not receive any antipsychotics during her 7-day assessment window. Record review of Resident #58's Physician's orders, printed on 06/26/24, indicated the following orders: *Lorazepam intensol 0.5mg by mouth every four hours as needed for anxiety. The start date was 02/09/24. There was no stop date. There was no duration given for the order. *Lorazepam 1ml by mouth every four hours as needed for anxiety. The start date was 02/09/24. There was no stop date. There was no duration given for the order. Record review of Resident #58's MAR for the month of February 2024 indicated she did not receive the PRN Lorazepam from 02/09/24 through 02/29/24. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #58's MAR for the month of March 2024 indicated she did not receive the PRN Lorazepam during the month of March. Record review of Resident #58's MAR for the month of April 2024 indicated she did not receive the PRN Lorazepam during the month of April. Record review of Resident #58's MAR for the month of May 2024 indicated she did not receive the PRN Lorazepam during the month of May. Record review of Resident #58's MAR for the month of June 2024 indicated she did not receive the PRN Lorazepam during the month of June as of 06/26/24. Record review of Resident #58's consultant pharmacist physician communication, dated 03/11/24, indicated the consultant pharmacist communicated to the physician that the PRN lorazepam required a 14 day stop date. The note further indicated the provider could document a rationale for the extended time period and indicate a specific duration. The physician/prescriber response reflected: She's on hospice. There was no indicated duration or stop date for the PRN lorazepam. Record review of Resident #58's consultant pharmacist physician communication, dated 04/04/24, indicated the consultant pharmacist communicated to the physician that the PRN lorazepam required a 14 day stop date. The note further indicated the provider could document a rationale for the extended time period and indicate a specific duration. The physician/prescriber response reflected: She is on hospice. Extend Rx. There was no indicated duration or stop date for the PRN lorazepam. Record review of Resident #58's consultant pharmacist physician communication, dated 05/05/24, indicated the consultant pharmacist communicated to the physician that the PRN lorazepam required a 14 day stop date. The note further indicated the provider could document a rationale for the extended time period and indicate a specific duration. The physician/prescriber response reflected: Hospice [patient]. There was no indicated duration or stop date for the PRN lorazepam. Record review of Resident #58's consultant pharmacist physician communication, dated 06/04/24, indicated the consultant pharmacist communicated to the physician that the PRN lorazepam required a 14 day stop date. The note further indicated the provider could document a rationale for the extended time period and indicate a specific duration. The physician/prescriber response reflected: [patient] on hospice. There was no indicated duration or stop date for the PRN lorazepam. During an interview on 06/26/24 at 10:10 AM, RN A said she was taking care of Resident #58 on that day. She said Resident #58 had 2 orders for PRN Lorazepam and neither have a stop date. She said the orders should have a stop date at 14 days so the provider could re-evaluate the medications. She said there was a potential for the resident to receive too much medication if it was not stopped after 14 days. 2. Record review of Resident #73's face sheet dated 6/25/24 revealed she was [AGE] years old and admitted to the facility on [DATE]. Resident #73 had diagnoses of dementia (progressive or persistent loss of intellectual functioning, memory, related to disease of the brain), Alzheimer's (progressive disease that destroys memory and other important mental functions), and anxiety disorder. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #73's significant change MDS dated [DATE] revealed she had a BIMS of 99, which indicated she had severe cognitive impairment and was unable to complete the interview. The MDS did not indicate Resident #73 had an anxiety disorder. The MDS indicated Resident #73 received an antianxiety medication (used to treat anxiety). Record review of Resident #73's care plan dated 6/24/24 revealed she had a potential for drug toxicity due to psychotropic medication regimen. Resident #73 took lorazepam, and the facility was to monitor her for side effects of lorazepam. Record review of Resident #73's Physician Orders dated June 2024 revealed an order for lorazepam 0.5 mg by mouth every four hours as needed for anxiety/agitation with a start date of 05/03/24. There was no end date. There was no documentation in the order for the duration of the order. Record review of Resident #73's care plan dated 6/24/24 revealed she had a potential for drug toxicity due to psychotropic medication regimen. Resident #73 took lorazepam, and the facility was to monitor her for side effects of lorazepam. Record review of Resident #73's MAR dated May 2024 revealed she had an order for lorazepam 0.5 mg by mouth every four hours PRN for anxiety/agitation with a start date of 5/03/24. There was no stop date. There was documentation of Resident #73 only receiving PRN lorazepam 0.5 mg once on 5/03/24 and twice on 5/04/24 . Record review of Resident #73's MAR dated June 2024 revealed she had an order for lorazepam 0.5 mg by mouth every four hours PRN for anxiety/agitation with a start date of 5/03/24. There was no stop date. There was no documentation of Resident #73 receiving PRN lorazepam 0.5 mg during the month of June. Record review of the facility's Consultant Pharmacist/Physician Communication note dated 6/03/24 for Resident #73 revealed the consulting pharmacist had sent a note to the physician indicating . the resident was receiving the following psychotropic medication on a PRN basis: lorazepam 0.5 mg every four hours PRN . Per regulatory guidelines, the duration of treatment with such medications or a PRN basis should be limited to 14 days, however, a new order may be written to extend the duration beyond 14 days if the prescriber believed it was appropriate . Please evaluate the continued need for this medication . If it was to be extended, please document the rationale for the extended time period in the medical record and indicate a specific duration . The physician's response was to continue the medication due to the resident was on hospice and there was no specific duration documented for the medication. During an interview on 06/26/24 at 11:38 AM, the ADON said there should be a 14 day stop date on PRN psychotropics. He said personally he thought hospice was an appropriate rationale for continuing the lorazepam. He said the ADON was responsible for ensuring that PRN psychotropics had an end date. He said the medication not having a stop date could become an unnecessary medication. The nurses should also ensure that psychotropics that are PRN have an end date. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 06/26/24 at 11:43 AM, the DON said she felt that the rationale of being on hospice was an appropriate rationale for continuing the PRN lorazepam orders indefinitely. She said the regulation said that all psychotropics that were PRN should have a 14 day stop date. She said she did not think there was a negative effect to the resident for not having a stop date. She said the bedside nurse was responsible for ensuring that all prn psychotropics had stop dates. She said the ADON, DON, and medical records personnel were also responsible for ensuring that PRN psychotropics have a stop date. During an interview on 06/26/24 at 11:55AM, the Administrator said she was unsure if there should have been a stop date for PRN psychotropics. She said she was unsure of any negative effect to the residents as a result of the medication continuing to be on the orders. She said she was not a medical provider, so she did not know. She said nursing and pharmacy were responsible for ensuring that the PRN psychotropics have a stop date. Record review of the facility's policy, Psychotropic Medication Use, dated July 2022, stated: .A psychotropic medication is any [medication] that affects brain activity associated with mental processes and behavior . .12. Psychotropic medications are not prescribed or given on a PRN basis unless that medication is necessary to treat a diagnoses specific condition that is documented in the clinical record. a. PRN orders for psychotropic medications are limited to 14 days. (1) For psychotropic medications that are NOT antipsychotics: If the prescriber or attending physician believes it is appropriate to extend the PRN order beyond 14 days, he or she will document the rationale for extending the use and include the duration for the PRN order . 46062

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45643 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 for 1 of 1 kitchen reviewed for kitchen sanitation in that: The facility did not label, or date food stored in the kitchen's refrigerator. These deficient practices could place residents who received meals from the kitchen at risk for food borne illness. The findings were: During an observation on [DATE] at 8:55 a.m., it was observed that a whole pie, a slice of pie, French fries, tater tots, 1 gallon of partially eaten ice cream, and 2 bags of hard-boiled eggs did not have a date or label. During an interview on [DATE] at 8:53 a.m., the Dietary Manager said he expected that his staff to follow the dietary policy by dating and labeling all foods stored in their kitchen. He stated that residents can be placed at risk of foodborne illness by eating contaminated food. During an interview on [DATE] at 11:40 a.m., the DON said she expects that all facility staff including the kitchen staff follow facility policy. She said that residents could be placed at risk of foodborne illness if they ate expired food. During an interview on [DATE] at 11:52 a.m., with the ADM she said she expected that all facility policies are followed. She said she expected that food is labeled, dated and stored properly. She said that residents could be placed at risk of foodborne illness if they ate contaminated food. Review of the facility document revised on [DATE], titled Storage of Frozen and Refrigerated foods provided by the Administrator revealed: Refrigerate foods in shallow containers to speed the cooling process. Label to date placed in the refrigerator, time, expiration or use by date. Once a product has been opened the date opened shall be written on the product and use by date is 7 days from date opened. Food prepared in the building and properly cooled will be dated as to the date prepared and use by date which will be 7 days from the date Prepared.