STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675270	A. Building B. Wing	07/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pecan Manor Nursing and Rehabilitation	413 E Mansfield Cardinal Kennedale, TX 76060

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 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. 41781 Based on interview and record review, the facility failed to use the service of a Registered Nurse (RN) for at least eight consecutive hours a day, seven days a week for 9 of 30 days (04/13/24, 05/11/24, 05/12/24, 05/19/24, 06/09/24, 06/15/24, 06/23/24, 07/06/24, and 07/07/24) reviewed during a look back period from 04/09/24 to 07/15/24 for weekend coverage. The facility failed to have RN coverage in the facility for eight consecutive hours on 04/13/24, 05/11/24, 05/12/24, 05/19/24, 06/09/24, 06/15/24, 06/23/24, 07/06/24, and 07/07/24. This failure could place residents at risk for not having their nursing and medical needs met and improper care. Findings included: Review of the facility's Employee Time Cards, dated 7/14/24, reflected the following: - RN Z worked from 8:00 AM to 12:00 PM (4 total hours), took a break for lunch, then resumed work at 12:30 PM to 5:00 PM (4.5 total hours) on 04/13/24. - RN Z worked from 7:12 AM to 11:12 AM (4 total hours), took a break for lunch, then resumed work at 11:42 AM to 2:58 PM (3.27 total hours) and the DON worked from 2:00 PM to 4:00 PM (2 total hours) on 05/11/24. - RN Z worked from 7:54 AM to 11:54 AM (4 total hours), took a break for lunch, then resumed work at 12:24 PM to 4:38 PM (4.23 total hours) on 05/12/24. - RN Z worked from 7:47 AM to 11:47 AM (4 total hours), took a break for lunch, then resumed work at 12:17 PM to 3:54 PM (3.62 total hours) and the DON worked from 3:00 PM to 5:00 PM (2 total hours) on 05/19/24. - RN Z worked from 7:55 AM to 11:55 AM (4 total hours), took a break for lunch, then resumed work at 12:25 PM to 4:13 PM (3.8 total hours) and the DON worked from 5:46 PM to 9:12 PM (3.43 total hours) on 06/09/24. (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 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- RN Z worked from 12:06 AM to 4:06 AM (4 total hours), took a break for lunch, then resumed work at 4:36 AM to 8:10 AM (3.57 total hours) and the DON worked from 7:04 AM to 10:28 AM (3.4 total hours) on 06/15/24. - RN Z worked from 8:03 AM to 12:03 PM (4 total hours), took a break for lunch, then resumed work at 12:33 PM to 4:27 PM (3.9 total hours) and the DON worked from 7:57 PM to 12:00 AM (4 total hours) on 06/23/24. - RN Z worked from 1:49 AM to 5:49 AM (4 total hours), took a break for lunch, then resumed work at 6:19 AM to 10:06 AM (3.78 total hours) and the DON worked 9:00 AM to 11:00 AM (2 total hours) on 07/06/24. - RN Z worked from 8:04 AM to 12:04 PM (4 total hours), took a break for lunch, then resumed work at 12:34 PM to 3:48 PM (3.23 total hours) and the DON worked from 3:00 PM to 5:00 PM (2 total hours) on 07/07/24. Interview on 07/16/24 at 12:06 PM with the DON revealed she recently took over staffing from the last few months after the previous ADON left. The DON said she was not aware the facility did not have consecutive RN coverage for the dates listed above. The DON said she was not sure why the RNs were not working for an 8 consecutive hour shift but assumed it was due to them clocking out for a break or a lunch break. Interview on 07/16/24 at 3:35 PM with the Administrator revealed the facility did not have a policy for RN coverage and instead followed the CMS guidelines.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 42859 Based on observation, interview, and record review, the facility failed to ensure, in accordance with State and Federal laws, all drugs and biologicals were stored in locked compartments and were labeled in accordance with currently accepted professional principles for 1 (Resident #134) of 9 residents reviewed for pharmacy services. LVN D failed to put her initials, date, and time on Resident #134's IV medication bag and tubing when she administered the IV antibiotic, Meropenem. These failures could place residents at risk for medication error and delay in medication administration. Findings included: Review of Resident #134's face sheet, dated 07/16/24, revealed the resident was a [AGE] year-old male admitted on [DATE]. Resident #134's diagnoses which included sepsis without septic shock (a life-threatening medical emergency caused by body's overwhelming response to an infection) and bacteremia (the presence of bacteria in blood). Review of Resident #134's physician's orders dated 07/13/24 reflected: (Meropenem Intravenous Solution Reconstituted 1-gram (1000) milligrams /100 milliliters intravenously every 8 hours). Observation on 07/15/24 at 8:53 AM revealed LVN D performing morning medication pass for Resident #134. LVN D sanitized and prepared Meropenem 1 g/100 ml, saline syringes and alcohol swabs. She knocked on the door and explained the procedure to Resident #134. She washed her hands, put on gloves and fixed the tubing to the bag. She removed her gloves, sanitized her hands, and put on new gloves. She cleansed the PICC line tip with alcohol, connected the tubing, and adjusted the flow meter. She did not label the bag or the tubing with the date, time, and her initials after administering the IV medication. She removed her gloves, washed her hands, left the resident comfortable, and left the room. Observation and interview on 07/16/24 at 9:33 AM revealed Resident #134 was in his room, on his bed. He was observed with the IV medication being administered. The IV bag and the tubing were observed not labeled with date, time, and staff initials. Observation and interview on 07/16/24 at 10:15 AM with LVN D revealed Resident #134's IV medication bag and the tubing were missing the time, date, and her initials. LVN D said the intravenous bag was supposed to have the correct resident's name, date, time and initial of the nurse administering the medications. She stated she was aware she was supposed to label the bag and the tubing, but she forgot. She stated failure to label the bag and the tubing could lead to overdose, omission of a dose, and infection control. She stated the bag was changed as scheduled and the tubing could be changed every 24 hours. LVN D stated she had done training on IV administration. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 05/16/24 at 01:44 PM with the DON revealed her expectation was that the staff should date and initial IV bags and tubing when administering intravenous medications. She stated putting the dates and initials would show when the bags were hanged and when the tubing was last changed. The DON could not state the risk but stated nothing had happened yet. She stated she had done training and no documentation was provided. Review of the facility's IV Administration of drugs policy, revised August 2021, reflected: .1 verify label on intravenous bag with prescriber's order. Attach label (with date ,time, and nurse's initials) to tubing and bag

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F 0851 Level of Harm - Potential for minimal harm Residents Affected - Many	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. 41781 Based on interview and record review, the facility failed to follow guidelines for mandatory submission of staffing information based on payroll data in a uniform format by electronically submitting to CMS complete and accurate direct care staffing information, including information for agency and contract staff, based on payroll and other verifiable and auditable data in a uniform format according to specifications established by CMS for 8 (11/16/24, 11/17/24, 11/21/24, 11/23/24, 11/27/24, 11/28/24, 11/30/24, and 12/31/24) of 8 days reviewed. The facility failed to submit accurate licensed nurse hours for 11/16/24, 11/17/24, 11/21/24, 11/23/24, 11/27/24, 11/28/24, 11/30/24, and 12/31/24. The facility's failure could place residents at risk for personal needs not being identified and met, decreased quality of care, decline in health status, and decreased feelings of well-being within their living environment. Findings included: Review of the CMS PBJ report for CMS for FY Quarter 1 2024 (October 1- December 21) indicated the facility had failed to have Licensed Nursing Coverage 24 hours/day triggered. Review of the CMS PBJ report for FY Quarter 1 2024 (October 1- December 31) indicated the facility did not have licensed nursing coverage 24 hours/day for the following dates: 11/16 (TH), 11/17 (FR), 11/21 (TU), 11/23 (TH), 11/27 (MO), 11/28 (TU), 11/30 (TH), and12/31 (SU). Review of staff timesheets for 11/16/24, 11/17/24, 11/21/24, 11/23/24, 11/27/24, 11/28/24, 11/30/24, and 12/31/24 indicated there was licensed nursing coverage for 24 hours on those days. Interview via phone on 07/16/24 at 2:01 PM with the Corporate Analyst revealed he and another person were responsible for submitting the PBJ staffing information to CMS for the facility. The Corporate Analyst said there was an issue submitting the information where their system was not pulling the LVN worked hours. The Corporate Analyst said this meant that the facility was going to be triggered for not having licensed nursing coverage due to this. The Corporate Analyst said they identified the issue last quarter and corrected it so that going forward it would not happen anymore. Interview on 07/16/24 at 2:10 PM with the Administrator revealed he did not know anything about the facility's PBJ Staffing report because corporate was responsible for the reporting. Interview on 07/16/24 at 3:35 PM with the Administrator revealed the facility did not have a policy for PBJ Staffing and instead followed the CMS guidelines.