STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675295	A. Building B. Wing	05/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lytle Nursing Home	15366 Oak St Lytle, TX 78052

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 0577 Level of Harm - Potential for minimal harm Residents Affected - Many	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. 27520 Based on observation, interview and record review the facility failed to post in a place readily accessible to residents, and family members and legal representatives of residents, the results of the most recent survey of the facility for 4 of 7 survey days. Facility staff failed to ensure the survey binder was available 4 of 7 survey days in the lobby per the sign posted at the facility entrance. This deficient practice could affect any resident and could result in the violation of residents' rights to read the survey results. Findings included: Interview on 5/22/24 at 3:00 PM with Resident's #35, #40, #29, #28 and #19 stated they did not know where staff kept the binder with the survey results. Observation and interview on 5/24/24 at 4:30 PM with the ADM revealed the survey binder was supposed to be in the lobby. He looked for it in the file sleeve mounted on the wall. He stated it was not available and asked the ADON about the survey binder. The ADON provided the ADM with the binder and stated it was in on her desk and did not know what she was supposed to do with it Review of the survey binder revealed the survey results in the binder were from 2022. Review of a facility policy, titled Survey Results, Examination of, revised September 2004, read: A copy of the most recent standard survey, including any subsequent extended surveys, follow up revisits, reports, etc. , along with state approved plans of correction of noted deficiencies, is maintained in a 3- ring binder located in an area frequented by most residents, such as the main lobby or resident activity room.

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 0580 Level of Harm - Actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45857 Based on observation, interview and record review the facility failed to immediately consult with the resident's physician, when there was a significant change in the resident's physical, mental, or psychosocial status (that was, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications) and a need to alter treatment significantly for 1 of 6 Residents (Resident #45) who was reviewed for a decline in status, in that: The facility failed to ensure the Physician/Medical Director for Resident #45 was notified when the resident was sent to the hospitalER on at least 15 occasions for complications of his nephrostomy tube. Resident #45 was first documented to have a kidney stone requiring a nephrostomy tube (an opening between the kidney and the skin. A nephrostomy tube is a thin plastic tube that is passed from the back, through the skin and then through the kidney, to the point where the urine collects) and needed to see a urologist on 09/2023. Resident #45 was scheduled for surgery on 04/09/24 but the surgery was canceled due to an insurance issue since the facility did not properly follow up on the insurance requirements. The facility failed to follow up with the Resident's Physician and rescheduling the surgery. This failure could place residents at risk for harm by denying the physician an opportunity to intervene. The findings were: Record review of Resident #45's face sheet, dated 11/06/23, revealed Resident #45 was admitted to the facility on [DATE] with diagnoses of hypertension secondary to other renal disorders, and hydronephrosis with ureteropelvic junction obstruction. Record review of Resident #45's discharge-return anticipated MDS, dated [DATE], revealed Resident #45's cognition for daily decision making was severely impaired-never/rarely made decisions. Record review of Resident #45's care plan last updated 2/5/24 revealed a problem showing Resident #45 was known to exhibit aggressive behaviors during ADL care with approach to address the resident with a calm voice, allow opportunity to make choices and participate in care, address by his name, explain in simple steps the care provided, monitor for contributing factors of irritation/aggression during care, and monitor for signs and symptoms of infection that could contribute to behaviors and follow up with MD as needed. The care plan last updated 2/5/24 also revealed a problem showing Resident #45 had a nephrostomy tube related to kidney stone obstruction. Nurse to monitor for infection, skin irritation, and dislodgement of nephrostomy tube, staff to empty nephrostomy tube q shift and document output. Nurse to do preventative care (skin prep) to site every other day and as needed. Records review of Resident #45's physician orders, dated 4/2024, showed orders for nephrostomy site: cleanse with normal saline or wound cleanser pat dry apply skin prep, then split gauze, cover with adhesive dressing every other day or as needed, with a start date of 2/29/24 and no end date. (continued on next page)

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F 0580 Level of Harm - Actual harm Residents Affected - Few	Review of Resident #45's hospital documents from 09/14/23 to 03/22/24 showed he been hospitalized 15 times for issues with his nephrostomy. Hospital records show he was diagnosed with hydronephrosis (swelling of one or both kidneys due to a blockage that stops urine form flowing out the body. A common cause is kidney stones). Hospital records advised the resident to follow up with a specialist for surgery to remove a kidney stone. The stone was documented as 1 cm on 9/14/23 and 2.6 cm on 1/25/24 with a note that stated Please note that this is the sixth time the nephrostomy tube has been required replacement since initial placement in August 2023. Long-term percutaneous drainage is not feasible for this patient. Recommend urology consult for removal of the obstructing stone from the proximal ureter as the patient would likely no longer need percutaneous drainage once the obstruction is relieved. During an observation on 5/23/24 at 10:51 a.m. LVN A provided wound care to Resident #45's nephrostomy site and was assisted by CNA B. Resident #45 was laying on his left side. LVN A removed the bandage which covered the nephrostomy site/tube insertion into his lower back, or cleaned/dried the area with gauze, Resident #45, moaned, shouted, and kicked over the tray of supplies on the bed. Resident #45 kept moaning and grabbed CNA B as LVN A placed a new bandage over the site. LVN A held the resident's arm as she placed the bandage over the nephrostomy site. After the care was complete Resident #45 laid on his bed calmly. All previous and subsequent observations of the resident were of him laying calmly in a Geri chair with his eyes closed. During an interview on 5/24/24 at 10:12 a.m. LVN A stated the resident would normally react the same way he did during care the previous day off and on throughout the day. LVN A stated his behavior was random and had nothing to do with being in pain during care. LVN A stated she could tell if Resident #45 was in pain because of facial grimacing or he could tell you where his pain was. During an interview on 5/23/24 at 6:11 p.m. the DON stated Resident #45 did have kidney stone and stated the hospital was supposed to perform the surgery to remove the stone. The DON stated there was an insurance issue with the primary care provider (PCP) selected on his primary insurance was not the medical director of the facility and the resident had not established care with the PCP selected on his primary insurance. The DON stated she sent the resident's friend to the listed PCP to obtain a signed referral for surgery, but the friend was told the PCP would not sign it because he had not seen the resident. The DON stated she needed to call the insurance but had not had time because she was busy with something else for over a month and could not have her floor nurses sitting on the phone. The DON stated the resident had standing orders for pain medication and no one had ever informed her that he seemed to be in pain during care. During an interview on 5/24/24 at 3:34 p.m. Resident #45's friend stated he had the nephrostomy tube since June 2023. She stated they have wanted to remove the stone since he got the tube placed, they just needed a specialist to say it needed to be removed first. She stated the DON told her she needs a reference number from [the insurance] company for her to get him seen by a specialist and possibly a notarized medical power of attorney so she can talk to the insurance company because the facility could not talk to the insurance company. The friend stated she had no plans to legally marry the resident due to personal reasons. The friend stated she hoped after the kidney stone was removed and the nephrostomy tube was removed the resident would be able to be taken off all the psychiatric medications that were making him heavily medicated. (continued on next page)

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F 0580 Level of Harm - Actual harm Residents Affected - Few	During an interview on 5/24/24 at 4:03 p.m. the BOM stated they had a copy of Resident 45's private insurance card. She stated the facility did not accept that insurance but they did have a copy of it. During a follow up interview on 5/25/24 at 12:15 p.m. the DON stated she received a call on 4/04/24, from the hospital about surgery to remove Resident #45's kidney stone. The DON stated the surgery was scheduled for April 9th and she was given a deadline of April 5th by the hospital to get a signed referral from the PCP listed on the insurance. The DON stated she asked Resident #45's friend, who was like his family member but not legally his family, needed to call the insurance and change his PCP. The DON stated they missed the deadline, and the surgery was canceled. The DON stated she personally had not spoken with the insurance company or done anything to follow up on the referral or if the friend changed the PCP because again, she was busy until a few days before with something else. The DON stated the previous day she had called the private insurance with the friend and heard an insurance representative tell the friend they could not release any information to her, only to the resident. The DON stated they tried to tell the insurance Resident #45 was not able to speak or make decisions and the friend was like his family, but the insurance would not release information to them and stated the friend could not make any changes to the insurance. During an interview on 5/27/24 at 3:02 p.m. the Medical Director (MD) stated he did not recall a resident under his care with a kidney stone. He stated he did recall the NP informing him of a resident who had been in and out of the hospital with complications from a nephrostomy tube, but he was sure he had seen a urologist when he went to the hospital. The MD stated he was not informed of the issues the facility was having with a referral from the insurance. The MD stated he would have been able to do a doctor-to-doctor referral or contact the insurance directly to ensure the resident still had the surgery. The MD stated it was a very broken system and he planned to contact the facility to ensure the resident received the care he needed. Record review of the facility's policy titled Physician Services, dated 04/2013, stated Policy Statement, the medical care of each resident is under the supervision of a licensed physician. Policy interpretation and implementation. 1. the resident's attending physician participates in the residence assessment and care planning, monitoring changes in the resident's medical status, providing consultation or treatment when called by the facility, and overseeing a relevant plan of care for the resident. 2. The attending physician will determine the relevance of any recommended interventions from any discipline. Record review of the facility's policy titled Nephrostomy Tube, Care of, dated 10/2010, stated Purpose of this procedure is to provide guidelines for the care of the resident with a percutaneous nephrostomy tube. Preparation 1. Verify that there is a physician's order for this procedure .Reporting, report any of the following signs or symptoms to the physician: 1. Redness, inflammation, reports of pain, or other signs of infection at the insertion site; 2. Reduce output or output below established parameters; 3. Inability to irrigate tube or signs of obstruction of the tube; 3. Inability to irrigate tube or signs of obstruction of the tube; 4. Signs of skin breakdown around the dressing site; 5. If the tube becomes dislodged.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 45857 Based on observation, interviews, and record review the facility failed to provide a safe, functional, sanitary, and comfortable environment for residents for 1 of 3 resident shower rooms (B Hallway) observed for resident environment. The facility failed to ensure the B hallway bathroom was clean. There was a black substance on the bathroom tile, a foul smell, and broken tiles on the floor. This failure could place residents at risk for an unsafe and unsanitary environment. The Findings included: During an observation and interview on 5/25/24 at 5:43 p.m. the B hallway shower had a strong odor of sulfur, the floor and shower wall had black stops all over it, approximately half foot hole in the shower floor with white cloudy water, and the trim plate was missing around the shower faucet. The DON stated she could not smell the bathroom. The DON stated she would not want her family to have to use that shower. The DON stated residents who were prone to infection and did not have their feet covered could get an infection from using the shower in that condition. During an interview on 05/27/24 at 1:48 p.m. the Administrator stated if residents used the shower in hall B and had a wound the wound could be contaminated. The Administrator stated he did rounds in the building but had never seen the shower because someone was always using it. Record review of the facility's policy titled Bathrooms, no date, stated Bathrooms, policy statement, Bathrooms shall be maintained in a clean and sanitary manner and shall be cleaned on a daily basis. Policy interpretation and implementation. 1. bathroom, including showers . will be clean daily in accordance with our established procedures. 2. Daily bathroom cleaning includes .f. clean walls .h. polishing fixtures .i. sweeping, mopping, and scrubbing floors.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27520 Based on observation, interview and record reviews, the facility failed to ensure that all alleged violations involving abuse including injuries of unknown source were reported immediately, but not later than 2 hours after the allegation was made, and to report the results of all investigations to the State Survey Agency, within 5 working days of the incident for 3 of 14 Residents (Resident #7, Resident #46 and Resident #200) whose records were reviewed for reportable allegations of abuse. *The facility failed to report the results of the investigation for 2 self-reported incidents involving Resident #7 and #46 by not completing Form 3613 A and sending it to the State Agency within 5 days. *Resident #200 had an unwitnessed fall on 5/4/24 and sustained a golf sized hematoma to her head. The ADM did not report it as an injury of unknown origin. These deficient practices could result in an incomplete investigation being conducted leaving residents vulnerable to further incidents causing injuries and or abuse. The findings were: 1. Review of Resident #7's face sheet, undated, revealed she was admitted to the facility on [DATE] with diagnoses including Congestive Heart Failure (long-term condition that happens when your heart can't pump blood well enough to give your body a normal supply), Hypertension (high blood pressure) and Arthritis (joint disorder). Interview of Resident #7's annual MDS assessment, dated 3/6/24, revealed Resident #7's BIMS was 5 out of 15 indicating severe cognitive impairment; was dependent on 1 staff for all ADL's and was receiving Hospice services. Review of an incident report dated 4/6/24 revealed at 10:00 AM Hospice CNA asked the charge nurse how long had Resident #7's arm been dislocated. The charge nurse assessed and noted a raised area to Resident #7's right shoulder. Review of X-Ray results, dated 4/7/24, revealed Findings: AP and oblique views of the right shoulder demonstrate a diffuse osteoporosis. There is a prior humeral fracture with hardware placement. However, the surgical screw in the humeral head is broken. There is no radiopaque foreign body. Mild to moderate AC joint degenerative disease is visualized. The glemo- humeral joint is moderately narrowed. The humeral head is superiorly migrated. The soft tissues are unremarkable. Interview on 05/22/24 at 4:15 PM with the ADM revealed he did not have a PIR for Resident #7. He stated he would check with the local support person from another facility who assisted him. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 05/27/24 at 01:17 PM with the ADM revealed he reported the incident on 4/8/24, interviewed other residents, talked to staff and the DON provided an in-service on abuse and neglect. He stated he had all of the information in a file but could not find it. The ADM was not familiar with the Provider Investigation Report, 3613 form. He stated he did not hear back from the local support person. 2. Record review of Resident #48's face sheet documented a [AGE] year-old female admitted to facility on 03/11/24. Resident #48's diagnoses included cerebral atherosclerosis (arteries in brain become thick, hard and narrow due to buildup of fatty deposits inside artery walls); vascular dementia (general term describing problems with reasoning, planning, judgment, memory caused by brain damage from impaired blood flow in the brain), severe, with agitation; Type 2 diabetes mellitus (body doesn't use insulin properly resulting in high blood sugar levels), and essential hypertension (a condition resulting in abnormally high blood pressure). Review of Resident #48's Admission MDS dated [DATE] recorded a BIMS score of 2, indicating severe cognitive impairment. Review of Resident #48's Care Plan dated 03/22/24 revealed problem that resident was at risk for falls. It also indicated a fall on 04/07/24 with acute fracture distal radius and ulna process. The approaches included low bed in place, staff to ensure R#48 has proper footwear, Staff to assist R #48 with all transfers in and out of bed or w/c as needed; nurse to monitor resident when up walking around for balance and coordination; and fall mat to be placed on side of bed when R#48 is in bed. During an observation and interview with Resident #48 on 05/26/24 at 1:48 pm, Resident was observed standing in her room and then she sat down on her bed to talk with surveyors. Resident #48 only spoke Spanish but was unable to speak coherently. A fall mat was observed on top of her bed. Resident #48 could not explain what the fall mat's purpose was or where it belonged. Resident #48 was observed throughout the survey to either be asleep in bed or wandering around facility. Record review of the facility's internal Incident/accident report dated 04/07/24 revealed resident had pulled on a tablecloth in the dining room and fell backward causing a fracture of her distal radius and ulna process (broken long bones in the forearm). Resident #48 was sent to the hospital where she received a splint. Review of the incident report dated 04/07/24 revealed a description of the incident, a copy of the TULIP report and copies of the x-ray reports. Further review of the report revealed the DON conducted an in-service on 04/10/24 which discussed fall prevention, frequent rounding and hoyer transfers. There were no staff interviews or resident interviews documented as part of the facility's investigation. Interview with the DON on 05/24/24 at 11:30 a.m. revealed she completed an in-service which covered two of the incidents the facility called in since they were only a day apart. Interview with ADM on 05/27/24 at 1:30 p.m. revealed he was not aware of the requirement for sending the Provider Investigation Report Form 3613 A within 5 days of reporting an incident. The ADM stated he did not have the form to complete. (continued on next page)

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	675295	A. Building B. Wing	05/27/2024

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. Review of Resident #200's face sheet, dated 5/23/24, revealed she was admitted into the facility on [DATE] with diagnoses including Fragile X Chromosome (genetic condition inherited from parents which results in various developmental problems like intellectual disabilities and cognitive impairment) and Severe Intellectual Disabilities. Review of Resident #200's admission nursing assessment, dated 4/23/24, revealed Resident #200 had severe cognitive impairment, she was never understood and did not understand others, required assistance with all ADLs by 1 staff, was incontinent of bowel and bladder, she wandered and was a high risk for falls. Review of incident/accident log revealed Resident #200 fell on [DATE] and sustained a golf sized hematoma to the head. Interview on 05/23/24 at 09:15 AM with the DON/ revealed Resident #200 fell on [DATE]. The DON stated they suspected Resident #200 had a fall because she was wrapped in her blankets but stated the nurse who found her did not witness the fall. Resident #200 was unable to speak and not able to tell the nurse what happened. The DON stated the nurse reported the fall to her right away and she informed the ADM about the fall. She stated they sent Resident #200 out to the hospital in the morning and returned the same date, in the evening. The DON questioned whether it was reportable and would not necessarily consider a golf sized hematoma a major injury. However, stated they would not know if there was a subdural hematoma until they received the hospital report. The DON stated an injury of unknown origin should be reported within 2 hours. Interview on 5/25/24 at 4:30 PM with the ADM revealed he knew about Resident #200's fall but did not report it. Upon reviewing the facility abuse policy, he stated he should have reported it within 2 hours. A review of the undated facility abuse policy under External Reporting stated: Report the results of all investigations to the administrator or his or her designated representative and to the State Survey Agency, law enforcement and the follow up report to the State Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27520 Based on observation, interview and record review the facility failed to conduct an initial comprehensive assessment of each resident's functional capacity including the resident's needs, strengths, goals, life history and preferences for 1 of 5 Residents (Resident 200) reviewed for assessments. The MDS Coordinator failed to complete Resident #200's comprehensive assessment within 14 days after admission, 4/23/24 This deficient practice could affect newly admitted residents and result in residents not receiving the care and services as needed. The findings were: Review of Resident #200's face sheet, dated 5/23/24, revealed she was admitted into the facility on [DATE] with diagnoses including Fragile X Chromosome (genetic condition inherited from parents which results in various developmental problems like intellectual disabilities and cognitive impairment) and Severe Intellectual Disabilities. Review of Resident #200's admission nursing assessment, dated 4/23/24, revealed Resident #200 had severe cognitive impairment, she was never understood and did not understand others, required assistance with all ADLs by 1 staff, was incontinent of bowel and bladder, she wandered and was a high risk for falls. Review of Resident #200's chart from 4/23/24 to 5/27/24 revealed there was no indication Resident #200's initial MDS was completed. Observation on 05/21/2024 at 10:25 AM revealed Resident #200 was sitting on her bed upon entering the Resident's room. Resident #200 moaned and groaned during an attempt to engage her in conversation. Resident #200 stood up and exited the room. Resident #200 was observed walking down the hall with a shirt and a brief on. Her gait was unsteady. Further observation revealed staff at the end of the hall redirecting Resident #200 back into her room. Interview on 05/23/24 at 05:15 PM with the MDS Coordinator revealed she had not completed Resident #200's initial comprehensive assessment which was due 14 days after admission; May 7, 2024. The MDS Coordinator stated the comprehensive assessment would include all of the Resident's care areas and then would be included in the comprehensive Care Plan. Staff had access to the comprehensive assessment and Care Plan which both included the care and services Resident #200 required. Interview on 05/23/24 at 05:20 PM with the DON revealed it was the MDS Coordinator's responsibility to ensure the assessments were completely timely which identified all of the residents' care needs. She stated a comprehensive assessment was due 14 days after a resident's admission. (continued on next page)

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a facility policy, Resident Assessment Instrument, revised September 2010, read: The Assessment Coordinator is responsible for ensuring that the Interdisciplinary Assessment Team conduct timely resident assessments and reviews according to the schedule: a. Within (14) fourteen days of the resident's admission to the facility.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27520 Based on observation, interview and record review the facility failed to ensure the assessment accurately reflect the resident's status for 1 of 5 Resident's (Resident #4) whose records were reviewed for assessments. The MDS Coordinator failed to code that Resident #4 had a limited range of motion on her upper extremity related to left hand contracture for two, 2 assessment periods, 6/2/23 and 2/15/24 This deficient practice could affect residents and contribute to the resident's not receiving the necessary care and services as needed. The findings were: Review of Resident #4's annual assessment, dated 6/2/23, revealed she was admitted to the facility on [DATE] with diagnoses including Hypertension (high blood pressure and Alzheimer's Disease (a brain disorder that causes memory loss, thinking problems and behavior changes). Further review revealed Resident #4's limited range of motion of her upper extremity related to left hand contracture was not coded. Review of Resident #4's quarterly MDS assessment, dated 2/15/24, revealed Resident #4's limited range of motion on her upper extremity related to left hand contracture was not coded or that she used a wheelchair for mobility. Observation and an attempted interview on 05/21/2024 at 12:30 PM revealed Resident #4 was sitting in a wheelchair by the nurse's station. Further observation revealed she engaged in limited conversation but it was difficult to understand her. Resident #4 was noted with left hand contracture. Interview on 05/23/2024 at 5:00 PM with the MDS Coordinator revealed Resident #4 had a left hand contracture and she used a wheelchair for mobility. The MDS Coordinator revealed Resident #4's contracture should have been coded under limited range of motion on her upper extremity on both assessments dated 6/2/23 and 2/15/24. She further stated the annual assessment, dated 6/2/23, should have also included she used a wheelchair for mobility. Interview on 05/25/24 at 04:05 PM with the MDS Coordinator revealed it was important to capture all health needs on the residents' MDS assessments to ensure staff provided the care and services the resident's needed. The MDS Coordinator was asked for a policy on accuracy of MDS assessments on 5/25/24. It was not provided by exit on 5/27/24.

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	675295	A. Building B. Wing	05/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lytle Nursing Home	15366 Oak St Lytle, TX 78052

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45857 Based on interview and record review the facility failed to refer all residents with possible serious mental disorder or a related condition for level II resident review upon a significant change in status assessment for 1 of 6 Residents (Resident #45) whose records were reviewed for mental disorders. The facility failed to refer Resident #45 for a PASARR evaluation based on mental disorder diagnoses including bipolar disorder and anxiety. The facility failed to refer Resident #45 for a PASARR evaluation based on mental disorder diagnoses including manic depression (bipolar disease), anxiety and depression. This deficient practice could affect residents with a mental illness and contribute to a delay in services needed. The findings were: Record review of Resident #45's face sheet, dated 11/06/23, revealed Resident #45 was admitted to the facility on [DATE] with diagnoses of Diffuse traumatic brain injury with LOC of unspecified duration, cerebral infarction, hypertension secondary to other renal disorders, anxiety disorder, depression, and hydronephrosis with ureteropelvic junction obstruction. Bipolar disorder was not documented on the face sheet. Review of Resident #45's medical record revealed a PASARR Level 1 screening completed 7/5/23. Further review revealed it did not reflect Resident #45 had diagnoses manic depression (bipolar disease), anxiety or depression or that he had a mental illness or indicator that Resident #45 had a mental illness. Record review of psychiatric service progress noted, dated 11/03/23, stated resident #45 was being seen for evaluation and management of anxiety and bipolar medications. It showed he took sertraline for anxiety and Depakote and Seroquel for bipolar disorder. Record review of Resident #45's discharge- return anticipated MDS, dated [DATE], revealed Resident #45's cognition for daily decision making was severely impaired-never/rarely made decisions. Section I showed he had diagnosis of anxiety and manic depression (bipolar disease) and section N showed he took antipsychotic, antianxiety, and antidepressant medication. Record review of Resident #45's care plan last updated 2/5/24 revealed he was at risk for anxiety and to administer medications as ordered by MD, was at risk for depression and received antidepressant medications, and was at risk for psychotic behaviors and received antipsychotic, antianxiety, and anticonvulsant medication. (continued on next page)

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	675295	A. Building B. Wing	05/27/2024

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 02/22/24 at 02:04 PM with MDS Coordinator revealed Resident #45's initial PASARR evaluation was answered as no for a mental illness so a follow up was never initiated. The MDS nurse stated she would submit a new PASARR level 1. Record review of the facility's policy titled Antipsychotic Medication Use, dated 12/26, stated Policy statement .Policy Interpretation and Implementation .5. Resident who are admitted from the community or transferred from a hospital and who are already receiving antipsychotic medications will be evaluated for the appropriateness and indications for use. The interdisciplinary team will: a. Complete a PASARR screening (preadmission screening for mentally ill and intellectually disabled individuals), if appropriate; or b. Reevaluate the use of antipsychotic medications at the time of admission and/ or within two weeks (at the initial MDS assessment) to consider whether or not the medication can be reduced, tapered, or discontinued .

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27520 Based on observation, interview, and record review the facility failed to ensure the comprehensive care plan was reviewed and revised by the interdisciplinary team after each assessment including both the comprehensive and quarterly review assessments person-centered care plan to reflect the current condition for 2 of 16 residents (Resident #4 and Resident #7) reviewed for care plan revisions. 1. The facility failed to ensure Resident #4's comprehensive care plan was updated to reflect she had a left hand contracture. 2. The facility failed to ensure Resident #7's comprehensive care plan was updated to reflect she was on Hospice services, was receiving oxygen and was receiving wound care. This deficient practice could place residents at risk of not receiving appropriate interventions to meet their current needs. The findings included: 1. Review of Resident #4's annual assessment, dated 6/2/23, revealed she was admitted to the facility on [DATE] with diagnoses including Hypertension (high blood pressure and Alzheimer's Disease (a brain disorder that causes memory loss, thinking problems and behavior changes). Review of Resident #4's comprehensive Care Plan, revised on 2/15/24, revealed it did not include she had a left hand contracture. Observation on 05/21/2024 at 12:30 PM revealed Resident #4 was sitting in a wheelchair by the nurse's station. Resident #4 was noted with left hand contracture. Interview on 05/25/24 at 04:05 PM with the MDS Coordinator revealed it was important to capture all health needs on the residents' comprehensive Care Plan. She stated Resident #4's left hand contracture was not reflected in her Care Plan. 2. Review of Resident #7's face sheet, undated, revealed she was admitted to the facility on [DATE] with diagnoses including Congestive Heart Failure (long-term condition that happens when your heart can ' t pump blood well enough to give your body a normal supply), Hypertension (high blood pressure) and Arthritis (joint disorder). Review of Resident #7's annual MDS assessment, dated 3/6/24, revealed Resident #7's BIMS was 5 out of 15 indicating severe cognitive impairment; was receiving Hospice services and oxygen therapy. Review of Resident #7's consolidated physician orders for May 2024 read: monitor 02 SATS Q shift. Call (name of provider) Hospice for any questions, falls or any needs. (continued on next page)

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	675295	A. Building B. Wing	05/27/2024

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Hospice nursing progress note, dated 5/21/24, revealed Resident #7 had a Stage 2 pressure ulcer on her left great toe. Further review revealed orders for wound care; cleanse with NS/wound cleanser, pat dry with gauze, apply skin prep. Review of Resident #7's Comprehensive Care Plan, updated 2/15/24, revealed it did not reflect she was receiving Hospice services, oxygen therapy or wound care. Interview on 5/22/24 at 11:00 AM with the DON revealed Resident #7's Care Plan was dated, onset date 3/1/22. The DON reviewed the Care Plan did not address Resident #7 was receiving oxygen therapy, wound care related to DTI (Deep Tissue Injury) on left great toe, foot/heel and was on Hospice services. She stated it was important to include all of Resident #7's care areas to include interventions to ensure she received the care and services she needed. Review of facility policy, titled Care Plans, Comprehensive Person-Centered, revised December 2016, read: 1. The inter-disciplinary team (IDT) in conjunction with the resident and his/her family or legal representative, develops and implements a comprehensive, person-center care plan for each resident. 2. The care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment. 14. The Interdisciplinary team must review and update the care plan: d. At least quarterly, in conjunction with the required quarterly MDS assessment.

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety 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** 45857 Based on observation, interview, and record review, the facility failed to ensure residents received treatment and care in accordance with professional standards of practice for 1 of 6 residents (Resident #45) reviewed for notification of changes in that: The facility failed to ensure Resident #45's nephrostomy tube was removed as soon as medically possible. Resident #45 was first documented to have a kidney stone requiring a nephrostomy tube (an opening between the kidney and the skin. A nephrostomy tube is a thin plastic tube that is passed from the back, through the skin and then through the kidney, to the point where the urine collects) and needed to see a urologist on 09/2023. Resident #45 was scheduled for surgery on 04/09/24 but the surgery was canceled due to an insurance issue the facility did not properly follow up on the insurance requirements. The facility failed to follow up with the Resident's Physician and rescheduling the surgery. These failures resulted in the identification of an Immediate Jeopardy (IJ) on 5/25/24 at 7:05 p.m. While the IJ was removed on 5/27/25 the facility remained out of compliance at a level of potential harm with a scope identified as isolated until interventions were put in place to ensure prompt notification of a resident's physician and follow up for resident appointments. This deficient practice could affect residents with a change in condition and place them at risk of a delay in medical intervention, pain, and decline in health. The findings were: Record review of Resident #45's face sheet, dated 11/06/23, revealed Resident #45 was admitted to the facility on [DATE] with diagnoses of diffuse traumatic brain injury with LOC of unspecified duration (a brain injury that affects multiple areas of the brain. It is caused by the shearing of the brain's long connecting nerve fibers (axons) when the brain rapidly shifts inside the skull due to a violent blow or jolt. It can lead to coma and impairment of various brain functions. Loss of consciousness occurred for an unknown amount of time), cerebral infarction (blood supply to part of the brain is blocked or reduced. This prevents brain tissue from getting oxygen and nutrients. Brain cells begin to die in minutes), hypertension secondary to other renal (kidney) disorders, anxiety disorder, depression, and hydronephrosis with ureteropelvic junction obstruction (part of the kidney that normally drains urine becomes blocked). Record review of Resident #45's discharge- return anticipated MDS, dated [DATE], revealed Resident #45's cognition for daily decision making was severely impaired-never/rarely made decisions. Record review of Resident #45's care plan last updated 2/5/24 revealed a problem showing Resident #45 was known to exhibit aggressive behaviors during ADL care with approach to address the resident with a calm voice, allow opportunity to make choices and participate in care, address by his name, explain in simple steps the care provided, monitor for contributing factors of irritation/aggression during care, and monitor for signs and symptoms of infection that could contribute to behaviors and follow up with MD as needed. (continued on next page)

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	675295	A. Building B. Wing	05/27/2024

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Records review of Resident #45's physician orders, dated 4/2024, showed orders for nephrostomy site: cleanse with normal saline or wound cleanser pat dry apply skin prep, then split gauze, cover with adhesive dressing every other day or as needed, with a start date of 2/29/24 and no end date. Review of Resident #45's hospital documents from 09/14/23 to 03/22/24 showed he been hospitalized 15 times for issues with his nephrostomy. Hospital records show he was diagnosed with hydronephrosis (swelling of one or both kidneys due to a blockage that stops urine form flowing out the body. A common cause is kidney stones). Hospital records advised the resident to follow up with a specialist for surgery to remove a kidney stone. The stone was documented as 1 cm on 9/14/23 and 2.6 cm on 1/25/24 with a note that stated Please note that this is the sixth time the nephrostomy tube has been required replacement since initial placement in August 2023. Long-term percutaneous drainage is not feasible for this patient. Recommend urology consult for removal of the obstructing stone from the proximal ureter as the patient would likely no longer need percutaneous drainage once the obstruction is relieved. During an observation on 5/23/24 at 10:51 a.m. LVN A provided wound care to Resident #45's nephrostomy site and was assisted by CNA B. Resident #45 was laying on his left side. LVN A removed the bandage which covered the nephrostomy site/tube insertion into his lower back, or cleaned/dried the area with gauze, Resident #45, moaned, shouted, and kicked over the tray of supplies on the bed. Resident #45 kept moaning and grabbed CNA B as LVN A placed a new bandage over the site. LVN A held the resident's arm as she placed the bandage over the nephrostomy site. After the care was complete Resident #45 laid on his bed calmly. All previous and subsequent observations of the resident were of him laying calmly in a Geri chair with his eyes closed. During an interview on 5/24/24 at 10:12 a.m. LVN A stated the resident would normally react the same way he did during care the previous day off and on throughout the day. LVN A stated his behavior was random and had nothing to do with being in pain during care. LVN A stated she could tell if Resident #45 was in pain because of facial grimacing or he could tell you where his pain was. During an interview on 5/23/24 at 6:11 p.m. the DON stated Resident #45 did have kidney stone and stated the hospital was supposed to perform the surgery to remove the stone. The DON stated there was an insurance issue with the selected primary care provider (PCP) on his primary insurance was not the medical director of the facility and the resident had not established care with the selected PCP listed on his primary insurance. The DON stated she sent the resident's friend to the listed PCP to obtain a signed referral for surgery, but the friend was told the PCP would not sign it because he had not seen the resident. The DON stated she needed to call the insurance but had not had time because she was busy with something else for over a month and could not have her floor nurses sitting on the phone. The DON stated the resident had standing orders for pain medication and no one had ever informed her that he seemed to be in pain during care. (continued on next page)

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	675295	A. Building B. Wing	05/27/2024

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 5/24/24 at 3:34 p.m. Resident #45's friend stated Resident #45 had the nephrostomy tube since June 2023. She stated they have wanted to remove the stone since he got the tube placed, they just needed a specialist to say it needed to be removed first. She stated the DON told her she needs a reference number from [the insurance] company for her to get him seen by a specialist and possibly a notarized medical power of attorney so she can talk to the insurance company because the facility could not talk to the insurance company. The friend stated she had no plans to legally marry the resident due to personal reasons. The friend stated she hoped after the kidney stone was removed and the nephrostomy tube was removed the resident would be able to be taken off all the psychiatric medications that were making him heavily medicated. During an interview on 5/24/24 at 4:03 p.m. the BOM stated they had a copy of Resident 45's private insurance card. She stated the facility did not accept that insurance but they did have a copy of it. During a follow up interview on 5/25/24 at 12:15 p.m. the DON stated she received a call on 4/04/24, from the hospital about surgery to remove Resident #45's kidney stone. The DON stated the surgery was scheduled for April 9th and she was given a deadline of April 5th by the hospital to get a signed referral from the PCP listed on the insurance. The DON stated she asked Resident #45's friend who was like his family member but not legally his family to call the insurance and change his PCP. The DON stated they missed the deadline, and the surgery was canceled. The DON stated she personally had not spoken with the insurance company or done anything to follow up on the referral or if the friend changed the PCP because again, she was busy until a few days before with something else. The DON stated the previous day she had called the private insurance with the friend and heard an insurance representative tell the friend they could not release any information to her, only to the resident. The DON stated they tried to tell the insurance Resident #45 was not able to speak or make decisions and the friend was like his family, but the insurance would not release information to them and stated the friend could not make any changes to the insurance. During an interview on 5/27/24 at 3:02 p.m. the Medical Director (MD) stated he did not recall a resident under his care with a kidney stone. He stated he did recall the NP informing him of a resident who had been in and out of the hospital with complications from a nephrostomy tube, but he was sure he had seen a urologist when he went to the hospital. The MD stated he was not informed of the issues the facility was having with a referral from the insurance. The MD stated he would have been able to do a doctor-to-doctor referral or contact the insurance directly to ensure the resident still had the surgery. The MD stated it was a very broken system and he planned to contact the facility to ensure the resident received the care he needed. Record review of psychiatric service progress noted, dated 11/03/23, stated resident #45 was being seen for evaluation and management of anxiety and bipolar medications. The chief compliant from the resident was list as huh. The notes stated the patient could not answer questions logically and information was obtained from staff and his chart. Staff reports- He sustained a traumatic brain injury during a fight, patient appears to be adjusting to being in the facility. He is non-compliant with care at times but mainly when being changed . (continued on next page)

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	675295	A. Building B. Wing	05/27/2024

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of the facility's policy titled Nephrostomy Tube, Care of, dated 10/2010, stated Purpose of this procedure is to provide guidelines for the care of the resident with a percutaneous nephrostomy tube. Preparation 1. Verify that there is a physician's order for this procedure. 2. Review the resident's care plan to assess for any special needs of the resident. 3. Assemble equipment and supplies as necessary .Reporting, report any of the following signs or symptoms to the physician: 1. Redness, inflammation, reports of pain, or other signs of infection at the insertion site; 2. Reduce output or output below established parameters; 3. Inability to irrigate tube or signs of obstruction of the tube; 3. Inability to irrigate tube or signs of obstruction of the tube; 4. Signs of skin breakdown around the dressing site; 5. If the tube becomes dislodged. The DON was notified of an IJ on 5/25/24 at 6:55 p.m. and was given a copy of the IJ Template and a Plan of Removal (POR) was requested. The Plan of Removal was accepted on 5/26/24 at 7:36 p.m. and included the following: When residents come back with discharge paperwork, MDS Nurse and ADON will review ALL paperwork, to ensure it is complete and not missing any pages. MDS Nurse and ADON will call the hospital that the resident came from if pages are missing from the packet. For example: If the paperwork reads page 1 of 50 and only pages 1 through 42 are in the patient discharge paperwork, MDS and ADON will call to get the missing paperwork from the hospital. MDS Nurse and ADON will review discharge orders for any follow up appointments/outpatient procedures If the referral/discharge paperwork is sent via fax to the business office, the BOM or the Dietary Manager will be in charge of handing that paperwork to the MDS Nurse or ADON, if a physician's office calls the facility and the charge nurse/CNA/BOM/Dietary manager/administrator answer the phone, they are to call the MDS or ADON to take the call. Weekend charge nurses and CNAs will take a message with the call back number and then call the MDS/ADON so they could follow up with the appointments needed on Monday. **** if telephone orders are written by the NP or Physician the charge nurse will be responsible for getting the referral signed and completed and will need to be given to the MDS/ADON, for the follow-up and scheduling appointments for residents. The BOM will be in charge of making sure insurance cards are accurate and up to date, and if a resident is not self-responsible, the BOM will help the resident get guardianship/POA/DPA. MDS Nurse and ADON will know the process for identifying residents that require appointments and/or outpatient medical procedures, by being educated and trained during an in-service, the in-service will specify the importance of follow-up appointments and the MDS Nurse and ADON will also be introduced to the new log form and the binder and color of binder (GREEN) that the log will be placed in. The binder will be located in the MDS Nurse's office. All Nursing staff (Nurses and CNAs) will be in-service with our new process to ensure residents can be scheduled for any appointments/outpatient procedures. BOM, Dietary Manager, and the Administrator have all been in-serviced in our new process and are aware of the role that they play in our new process. The DON will monitor this system Monday through Friday. The administrator will be responsible for the oversight of the log, weekly (every Friday) All aspects of this process will be implemented and completed by today, Sunday, May 26, 2024. The charts have all been reviewed and completed(assessed all resident and identified any additional residents that may have been at risk) as of today, Sunday, May 26th 2024. The MDS/ADON will be in charge of the log. The director of nursing provided the staff in-service and will in-service all new hires moving forward. The surveyor verification of the Plan of Removal on 5/27/24 was as follows: Interviews with the MDS Nurse and ADON were conducted on 5/27/24. (continued on next page)

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	675295	A. Building B. Wing	05/27/2024

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 05/27/24 02:26 PM the ADON, was given the in service by the DON and MDS nurse. She will be in charge of phone calls regarding appointment reminders and paperwork from admission and readmits needs to be directed to MDS Nurse, DON, and herself and they make sure it gets done so there was an extra set of eyes, from her understanding they were all working together, she was in charge of making appointments and referrals, and if she was not available, staff can let MDS Nurse and DON know. They could contact her and she would make note of it but generally she was there on weekends. She stated herself the MDS Nurse, and DON are responsible. The ADON stated she would go through all the hospital paperwork, and made sure everything was transcribed correctly and made sure it's done correctly. The DON would go over to verify and they make sure it was in the logbook. They would communicate all the time. She stated, the MDS Nurse, or DON would add appointments to the logbook to include scheduled appointments and pending referrals for appointments. Interview on 5/27/24 at 2:25 PM with the MDS Nurse, revealed she verbalized an understanding of the new process in place to ensure the Res' attended or were scheduled for appointments; obtain referrals as needed. She stated her responsibility would be to follow up with any requests for appointments over the weekend. During the week she would ensure charge nurses were following through with referrals they received during shift. Interview on 05/27/24 2:12 PM with LVN A stated whenever we admit or readmit, we go through entire document with a fine-tooth comb, make sure that we received all of the pages, look for appointments, give it to the DON and ADON, the three of them including MDS Nurse, She is also in charge of getting referrals signed by the doctor. Interview on 05/27/24 2:22 PM medication aide C if someone calls about a resident they would take the information down unless MDS Nurse or ADON are here, then we would forward the call to them or call and tell them if they are not here. Interview on 5/27/24 at 2:15 PM with CNA D revealed she had worked at the NF since 2006, M-F 6AM to 2PM. She stated she did not have any responsibilities for ensuring Residents were scheduled for apts. However, if she answered the phone and her charge nurse was not readily available, she would take down the caller's info, the resident's info, and details of call. She would then provide it to her charge nurse and or the MDS Nurse or the ADON. Interview on 5/27/24 at 2:17 p.m. with CNA E stated MDS called me yesterday. She said if we answer the phones and if someone wants to tell us about an appointment, we would call the nurse to the phone. If the nurse is busy, we will take a message with the name and number of the person calling so the nurse can call them back. If a resident tells us about an appointment, we would report that to a nurse so she can get all the information. Interview on 5/27/24 at 2:26 p.m. with CNA F stated MDS texted me and then she called me. She said if we get a phone call then to let either MDS or the ADON know. Take down the doctor's name and phone number and appointment information. Then we will give it to MDS Nurse or ADON or I will let the nurses know. Interview on 5/27/24 at 2:29 p.m. with CNA G stated I got a call from MDS yesterday. If we receive any information about doctor appointments, we have to notify MDS Nurse or the ADON. I don't ever answer phones - I will pass call to charge nurse. I would take a message if the nurse were busy. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675295	A. Building B. Wing	05/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lytle Nursing Home	15366 Oak St Lytle, TX 78052

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview on 5/27/24 at 4:00 PM with the BOM revealed she would transfer a call to MDS/ADON pertaining to a Resident/apt or referral if readily available. If not she would take a detailed written message and deliver it to the charge nurse, MDS nurse and or the ADON. She would confirm all pages for faxes were received. If not would call to let sender know did not receive the complete fax. Then would deliver any faxes having to do with resident care to the charge nurse, MDS nurse and ADON. Interview on 05/27/24 at 6:58 p.m. the dietary manger shares an office with the BOM where the fax machine is located. She will monitor for incoming faxes and provide them to nursing. Interview on 05/27/24 2:12 PM with LVN A, B hall charge nurse confirmed she will complete referrals by obtaining signatures and giving it to the ADON, DON, or MDS nurse. Interview on 05/27/2024 at 5:50 p.m the BOM stated she would make sure she kept insurance cards up to date she would update the book when they come in and add notes in their files with what insurance they are under. If a resident cannot speak for themselves or not handle medical decisions or find them a guardian or POA or who they designate to represent them and if they cannot afford an attorney, she would assist with getting social security so they can have funds or get a pro [NAME] attorney. She had a website address where they could apply for guardianship. She also did contact the ombudsman for resource and HHSC for guardianship resources. Interview On 05/27/24 at 1:17 PM The Administrator stated he had a calendar and would put appointments on the calendar. He stated they would check with the insurance and pending surgery. He stated he was going to get the Ombudsman involved to see if they can assist with getting information. Interview 05/27/24 11:03 AM with the DON, her POR, meant that when residents were coming from hospital the MDS Nurse and ADON would get the discharge paperwork together and will make sure it is the complete record like all pages, MDS Nurse and ADON would review the discharge paperwork for any appointments and referrals. The DON stated the reason it was both MDS Nurse and ADON was just in case one of them is out. Our BOM and dietary manager would monitor if anything comes in the fax or mail, they would bring it to nursing right away to MDS Nurse or ADON. Whoever answers the phone for outside providers calling for appointments, would transfer the call to the MDS Nurse or ADON, on weekends they would make sure they have a call back number and the give the ADON or the MDS nurse on call. The charge nurse was to make sure referrals had signatures for referrals, if NP was there, she would sign or fax to MD if needed right away and follow up and give to the ADON or the MDS Nurse, The BOM would document in medical charts if she was completing social worker task like following up with insurance or helping schedule appointments, or making arrangements for appointment of residents to be seen in the facility by dental or vision. Record review of Resident #45 revealed he was sent out to the hospital on 5/26/24 due to his nephrostomy tube being dislodged and he would be receiving surgery for removal of the kidney stone. Record review of a document, titled Hospital Surgery/MD/Specialist Follow up Appointments, no date, was verified on 05/27/24, and the log contained 6 appointments for residents. Record review of the untitled Inservice revealed 32 staff were in serviced on 05/26/24 in person if they were present at work or through text and responded to confirm they received the text. 20 staff were texted about the in service, some later came to work and were interviewed by surveyors. (continued on next page)

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	675295	A. Building B. Wing	05/27/2024

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 5/27/24 at 7:10 p.m., the Administrator was notified the IJ was removed. However, the facility remained out of compliance at a level of potential harm with a scope identified as isolated due to the facility's need to monitor the implementation and effectiveness of its POR.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27520 Based on observation, interview and record review the facility failed to ensure a resident with pressure ulcers received necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing for 1 of 5 Residents (Resident #7) reviewed for skin integrity. LVN H failed to use adequate hand hygiene during wound care; failed to clarify the order for wound care and failed to follow the order provided by Hospice services for Resident #7's wound on her left great toe. These deficient practices could affect residents who required pressure ulcer treatment and contribute to wounds becoming infected preventing the wounds from healing. The findings were: Review of Resident #7's face sheet, undated, revealed she was admitted to the facility on [DATE] with diagnoses including Congestive Heart Failure (long-term condition that happens when your heart cannot pump blood well enough to give your body a normal supply), Hypertension (high blood pressure) and Arthritis (joint disorder). Review of Resident #7's annual MDS assessment, dated 3/6/24, revealed Resident #7's BIMS was 5 out of 15 indicating severe cognitive impairment; was dependent on 1 staff for all ADL's; was receiving oxygen therapy and Hospice services. Further review revealed Resident #7 had a stage 1 or greater, over a scar over bony prominence, or a non-removable dressing/device. Review of weekly skin sheets dated 4/23/24, 4/30/24 and 5/7/24 revealed Resident #7 had a black scab to left great toe. Review of weekly skin sheets dated 5/14/24 and 5/21/24 revealed treatment to left great toe and heels. Further review revealed the affected areas on the left foot and heels were not measured and or described. Review of a Hospice nurse progress note dated, 5/21/24, reflected Resident #7 had a Stage 2 pressure ulcer on her left great toe. Further review revealed orders for wound care; cleanse with NS/wound cleanser, pat dry with gauze and apply skin prep. Review of Resident #7's chart revealed a telephone order, dated 5/16/24 which read: apply skin prep to left great toe. Start ABT to R great toe, Bactrim ds 1 tablet PO BID x 14 days. Review of Resident #7's consolidated physician orders for May 2024 revealed an order dated 4/10/24, which read: Left heel DTI,, cleanse left great toe with NS or wound cleanser, apply skin prep LOTA QD. Further review did not provide instructions to treat the reddened raised areas on the left foot and heel. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 05/22/24 at 10:26 AM revealed LVN H brought in a basket with 4-5 packages of skin prep in it. LVN H washed her hands, put clean gloves on both hands, touched the top of Resident #7's linens with her gloves on, and let the Resident know she was going to do wound care. LVN H unfastened the offloading boot on Resident #7's left foot, opened 1 package of skin prep, lifted the residents left foot, wiped the heal of her left foot with the skin prep, she did not cleanse the area prior with gauze and normal saline. LVN H then opened another package of skin prep and wiped the resident's lateral (outer) side of her left foot. The area had an approximately 0.5 cm raised red bump with a yellow center. LVN H did not cleanse the site with gauze and normal saline prior to applying the skin prep. LVN H opened another package of skin prep and wiped the medial (inner) side of the resident's foot. The area had an approximately 0.5 cm red bump with a yellow center. No gauze was used with normal saline was used to cleanse the site prior. LVN H then used another package of skin prep to wipe the resident's left great toe. LVN H H did not cleanse the area prior with gauze and normal saline. LVN H did not change her gloves during the wound care or perform hand hygiene when moving from one site to the next. Resident #7's left great toe was black with eschar (dark, crusty tissue that covers a wound, often seen with pressure ulcers) on the tip. The rest of the toe appeared swollen with reddened edges. Interview on 05/22/24 at 11 AM with LVN H revealed she followed the telephone order, dated 5/16/24, in Resident #7's medical record. She stated she did not change gloves, sanitize her hands or wash her hands in between opening the packages of skin prep and before applying skin prep to the heel on the left foot, the left side of the foot and to the left great toe, . She stated she did not believe she had to because she was only applying skin prep. She stated she did not think about the fact she touched Resident #7's linens or that she unfastened the prevalent boot on the Resident's left foot. LVN stated she should have changed her gloves and washed her hands before starting wound care. She stated Resident #7's great toe was infected and was receiving Bactrim (antibiotic) twice daily. She stated it was necessary to wash her hands prior to beginning wound care so she did not contaminate the wounds on her left foot. Interview on 5/23/24 at 9:35 AM with LVN H revealed Resident #7 was diagnosed with a DTI and not a pressure ulcer. She stated she started applying skin prep and administering Bactrim when Resident #7's left great toe became infected. She stated she signed off on the TAR when she provided treatment She stated she did not measure the wound on the left great toe and stated the areas on the left foot and heal were reddened areas. Interview on 5/25/245 at 11:47 AM with the DON revealed nursing staff follow standard practice when providing wound care. A wound should always be cleansed prior to treating the wound. The DON stated LVN H should know this fact and should have called Resident #7's physician for clarification on the order. In addition, she was responsible for talking to the Hospice nurse and reading the notes to ensure she obtained accurate orders for wound care. The DON stated LVN H should also be conducting weekly skin checks; measuring the wound and describing the types of wounds identified to track whether or not the wounds were healing. (continued on next page)

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	675295	A. Building B. Wing	05/27/2024

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 05/27/24 at 11:00 AM with the DON revealed LVN H should have changed her gloves after she touched the linens and before starting wound care on Resident #7's left foot. She stated LVN H should have opened up the skin prep beforehand and it would have made it easier. The DON stated because LVN H applied skin prep to different areas of Resident #7's foot, LVN H should have changed gloves and washed her hands after applying the skin prep to each affected area. She stated Resident #7's left great toe was infected and it was highly probable that LVN H would spread the infection because she did not wash or change her gloves in between treating the different sites. The facility provided a policy titled, Prevention of Pressure Ulcers and Injuries, revised September 2017 read: The purpose of this procedure is to provide information regarding identification of pressure ulcer/injury risk factors and interventions for specific risk factors. Further review revealed the policy did not address wound care and hand hygiene.

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	675295	A. Building B. Wing	05/27/2024

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27520 Based on observation, interview and record review the facility failed to ensure that a resident who needs respiratory care was provided such care, consistent with professional standards of practice for 1 of 1 Resident (Resident #7) whose record was reviewed for oxygen therapy. Nursing staff failed to clean Resident #7's filter on the oxygen concentrator; it had a layer of lint covering the entire outside of the filter. This deficient practice could affect residents receiving oxygen therapy and could contribute to an upper respiratory infection and a resident's decline in physical health. The findings were: Review of Resident #7's face sheet, undated, revealed she was admitted to the facility on [DATE] with diagnoses including Congestive Heart Failure (long-term condition that happens when your heart can ' t pump blood well enough to give your body a normal supply), Hypertension (high blood pressure) and Arthritis (joint disorder). Review of Resident #7's annual MDS assessment, dated 3/6/24, revealed Resident #7's BIMS was 5 out of 15 indicating severe cognitive impairment; was dependent on 1 staff for all ADL's; was receiving oxygen therapy and Hospice services. Review of Resident #7's Care Plan, dated 3/21/22, revealed it did not provide any interventions for the use of oxygen therapy. Review of Resident #7's consolidated physician orders, dated May 2024, read: monitor placement of 02 of NC to receive 02 @ 2L, monitor 02 SATS Q shift. Further review revealed there were no instructions for the care of the oxygen concentrator. Observation on 05/21/24 at 10:21 AM revealed Resident #7 lying in bed asleep with glasses on. Resident #7 was receiving O2 via nasal cannula infusing at 3 liters. The filter on the oxygen concentrator was completely white/covered with lint. Observation and interview on 05/22/24 at 09:50 AM revealed Resident #7 lying in bed receiving 02 via nasal cannula infusing at 3 liters. Interview with LVN H revealed, during rounds, she checked Resident #7 had the nasal cannula on because she had a tendency to remove it. She stated she would change the bottle when it ran out of liquid and thought the oxygen filters were cleaned on Sunday's but was not sure. She stated she had not cleaned a filter and did not know how to clean it. She stated she did not check the filter during her rounds. LVN H removed the filter from the oxygen concentrator and stated the outside was white; covered with lint. She stated it was not clean, full of lint and Resident #7 was inhaling it. LVN H stated It could cause an upper respiratory infection. (continued on next page)

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	675295	A. Building B. Wing	05/27/2024

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 05/23/24 at 9:15 AM with the DON revealed nursing staff should be checking the filter on the oxygen concentrator and clean it as needed. She stated nursing staff usually checked and cleaned the filters on Sunday night. The DON stated there were no physician orders for cleaning the filter but it was, common sense. The DON stated that LVN H showed her the filter on Resident #7's oxygen concentrator and commented there is no way it got that dirty if staff was cleaning it every Sunday. She stated the lint could settle into Resident #7's lungs and create problems breathing. Her condition could worsen or the lint could cause an infection. The DON stated she would provide a policy for oxygen therapy, but did not by the end of survey on 5/27/24.

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F 0710 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Obtain a doctor's order to admit a resident and ensure the resident is under a doctor's care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27520 41095 Based on interview and record review the facility failed to ensure that a physician was notified and provided orders for a resident's immediate care and needs for 2 of 14 residents (Resident #49 and Resident #200) reviewed for physician orders. The facility failed to ensure the Physician personally signed the initial admission orders for Resident #49 and Resident #200. This failure could affect the residents in the facility by placing them at risk for not receiving physician care for their immediate needs. Findings included: 1. Record review of Resident #49's face sheet dated [DATE] was an [AGE] year old female admitted to facility on [DATE]. Her diagnoses included fracture of unspecified part of neck of right femur (the bone that connects in the hip joint), Alzheimer's disease, and severe persistent asthma with status asthmaticus (severe asthma unresponsive to courses of therapy such as inhaled albuterol). Record review of Admission Orders dated [DATE] revealed they were signed by a Nurse Practitioner. The attending physician was listed as the Medical Director (Physician MD). Record review of Telephone Orders dated [DATE] stated Admit to [Nursing Facility] under care of Physician MD .Labs per facility protocol. The order was signed by the Nurse Practitioner. Record review of Nurses Notes revealed Resident #49 was readmitted from hospital on [DATE] under hospice care. Resident #49 then expired on [DATE]. 2. Review of Resident #200's face sheet, dated [DATE], revealed she was admitted into the facility on [DATE] with diagnoses including Fragile X Chromosome (genetic condition inherited from parents which results in various developmental problems like intellectual disabilities and cognitive impairment) and Severe Intellectual Disabilities. Review of Resident #200's admission nursing assessment, dated [DATE], revealed Resident #200 had severe cognitive impairment, she was never understood and did not understand others, required assistance with all ADL's by 1 staff, was incontinent of bowel and bladder, she wandered and was a high risk for falls. Review of Resident #200's admission physician orders dated [DATE] revealed the NP signed the admission order. During an interview on [DATE] at 4:47 p.m. the DON stated the MD had not signed any of the Resident's orders. They were all signed by the NP. (continued on next page)

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	675295	A. Building B. Wing	05/27/2024

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F 0710 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on [DATE] at 3:00 p.m. the MD stated he had not physically signed any Resident's orders at the facility. The MD stated they used standing orders and orders for labs when patients were admitted . The MD stated he could have done a better job providing documentation based on requirements. Record review of the facility's policy titled Physician Services, dated ,d+[DATE], stated Policy Statement, the medical care of each resident is under the supervision of a licensed physician. Policy interpretation and implementation. 1. the resident's attending physician participates in the residence assessment and care planning, monitoring changes in the resident's medical status, providing consultation or treatment when called by the facility, and overseeing a relevant plan of care for the resident. 2. The attending physician will determine the relevance of any recommended interventions from any discipline. The physician is not obligated to accept these recommendations if he or she has clinically valid reasons for not doing so. 3. The position will perform pertinent, timely medical assessment prescribing appropriate medical regimen; provide adequate, timely information about the residence condition and medical needs; visit the resident at appropriate intervals; and ensure adequate alternative coverage. 4. Position orders and progress notes shall be maintained in accordance with current OBRA regulations and facility policy. 5. Physician visits, frequency of visits, emergency care of residents, ETC., are provided in accordance with current cobra regulations and facility policy. Consultative services shall be made available from community based consultants or from a local hospital or Medical Center. 6. The medical director will identify attending physician qualifications and responsibilities, based on clinical and regulatory requirements and the recommendations of relevant professional associations. Based on interview and record review the facility failed to ensure that a physician was notified and provided orders for a resident's immediate care and needs for 1 (Resident #49) of 2 residents reviewed for physician orders.

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure the resident's doctor reviews the resident's care, writes, signs and dates progress notes and orders, at each required visit. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27520 Based on interview and record review, the facility failed to ensure the physician reviewed the resident's total program of care, including medication and treatments, at each visit and wrote, signed and dated progress notes at each visit for 7 of 14 Residents (Resident #4, Resident #7, Resident #15, Resident #17, Resident #40, Resident #45 and Resident 200) reviewed for physician visits. The facility failed to ensure resident orders were signed by a physician, physician progress notes were available for Residents, were signed and dated by the physician(s) for each visit via the physical charts, and residents were seen by a physician at least once every 30 days for the first 90 days after admission, then at least once every 60 days thereafter. These failures could place residents at risk for not receiving appropriate care per physician orders and required oversight by the physician and could place the residents at risk for harm and overall physical health decline. Findings included: 1. Review of Resident #4's annual assessment, dated 6/2/23, revealed she was admitted to the facility on [DATE] with diagnoses including Hypertension (high blood pressure and Alzheimer's Disease (a brain disorder that causes memory loss, thinking problems and behavior changes). Further review revealed Resident #4's limited range of motion of her upper extremity related to left hand contracture was not coded. Review of Resident #4's quarterly MDS assessment, dated 2/15/24, revealed Resident #4's limited range of motion on her upper extremity related to left hand contracture was not coded or that she used a wheelchair for mobility. Review of Resident #4's physician orders for May 2024 revealed the NP signed the consolidated physician orders and the last physician visit was conducted by the NP on 4/9/23. Review of Resident #4's medical records reflected there was no evidence of any visits or physician progress notes from the MD since her admission to the facility. The records were requested from the DON on 5/23/24 at 4:47 PM and none were ever provided. She only provided notes from the NP and they were not co-signed by the MD. 2. Review of Resident #7's face sheet, undated, revealed she was admitted to the facility on [DATE] with diagnoses including Congestive Heart Failure (long-term condition that happens when your heart can ' t pump blood well enough to give your body a normal supply), Hypertension (high blood pressure) and Arthritis (joint disorder). Interview of Resident #7's annual MDS assessment, dated 3/6/24, revealed Resident #7's BIMS was 5 out of 15 indicating severe cognitive impairment; was dependent on 1 staff for all ADL's and was receiving Hospice services. (continued on next page)

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #7's physician orders for May 2024 revealed the NP signed the consolidated physician orders and the last physician visit was conducted by the NP on 3/22/24. Review of Resident #7's medical records reflected there was no evidence of any visits or physician progress notes from the MD since her admission to the facility. The records were requested from the DON on 5/23/24 at 4:47 PM and none were ever provided. She only provided notes from the NP and they were not co-signed by the MD. 3. Record review of Resident #15's face sheet, undated, revealed Resident #15 was a [AGE] year-old male who was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included acute cardiovascular insufficiency, major depressive disorder, chronic disease of tonsils and adenoids, other disorders of teeth and supporting structures, and hemiplegia affecting left non-dominant side. Record review of Resident #15's Quarterly MDS, dated [DATE], indicated Resident #15's cognition was moderately impaired for daily decision-making skills. Record review of Resident #15's care plan was last updated on 3/26/24 and showed he was at risk of social isolation due to his cognitive impairment with interventions to accommodate his limited cognitive ability to enable participation in activities, staff to reinforce attendance at activities outside of room with verbal praise and he is at risk for weight fluctuations with a current diet of regular mechanical soft and thin liquid. Interventions included dietician to evaluate and follow up per facility policy and as needed. The care plan did not mention the resident refused to go to medical appointments outside the facility. Record review of Resident #15's physician orders for 3/2024, 04/2024, 05/2024 were all signed by the NP. The orders contained no physician signatures. Review of Resident #15's medical records reflected there was no evidence of any visits or physician progress notes from the MD since his admission to the facility. The records were requested from the DON on 5/23/24 at 4:47 PM and none were ever provided. She only provided notes from the NP and they were not co-signed by the MD. 4. Review of Resident #17's face sheet, undated, revealed he was admitted to the facility on [DATE] with diagnoses including Hyperlipidemia (abnormally high levels of fats (lipids) in the blood, which include cholesterol and triglycerides) and Mood disorder due to known physiological condition. Review of Resident #17's quarterly MDS assessment, dated 4/10/24 revealed his BIMS was 11 out of 15 indicative of moderate cognitive impairment, he was dependent for all ADL's and was receiving Hospice services. Review of Resident #17's physician orders for May 2024 revealed the NP signed the consolidated physician orders and the last physician visit was conducted by the NP on 5/10/24. Review of Resident #17's medical records reflected there was no evidence of any visits or physician progress notes from the MD since his admission to the facility. The records were requested from the DON on 5/23/24 at 4:47 PM and none were ever provided. She only provided notes from the NP and they were not co-signed by the MD. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675295	A. Building B. Wing	05/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lytle Nursing Home	15366 Oak St Lytle, TX 78052

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5. Review of Resident #40's face sheet, undated, revealed he was admitted to the facility on [DATE] with diagnoses including Hypertension (high blood pressure and Diabetes Mellitus (a group of diseases that affect how the body uses blood sugar). Review of Resident #40's quarterly MDS, dated [DATE], revealed his BIMS was 10 of 15 indicative of moderate cognitive impairment; he required set-up or clean up assistance with all ADL's and he had limited range of motion on 1 side, lower extremity related to above the knee amputation. Review of Resident #40's physician orders for May 2024 revealed the NP signed the consolidated physician orders and the last physician visit was conducted by the NP on 3/28/24. Review of Resident #40's medical records reflected there was no evidence of any visits or physician progress notes from the MD since his admission to the facility. The records were requested from the DON on 5/23/24 at 4:47 PM and none were ever provided. She only provided notes from the NP and they were not co-signed by the MD. Observation and interview on 05/23/24 at 11:24 AM with Resident #40 revealed he was sitting in bed. Resident #40 stated he never saw a doctor while at the facility. 6. Record review of Resident #45's face sheet, dated 11/06/23, revealed Resident #45 was admitted to the facility on [DATE] with diagnoses of Diffuse traumatic brain injury with LOC of unspecified duration, cerebral infarction, hypertension secondary to other renal disorders, anxiety disorder, depression, and hydronephrosis with ureteropelvic junction obstruction. Record review of Resident #45's discharge- return anticipated MDS, dated [DATE], revealed Resident #45's cognition for daily decision making was severely impaired-never/rarely made decisions. Record review of Resident #45's care plan last updated 2/5/24 revealed a problem showing Resident #45 had a nephrostomy tube related to kidney stone obstruction. Nurse to monitor for infection, skin irritation, and dislodgement of nephrostomy tube, staff to empty nephrostomy tube q shift and document output. Nurse to do preventative care (skin prep) to site every other day and as needed. Records review of Resident #45's physician orders, dated 4/2024, showed orders for nephrostomy site: cleanse with normal saline or wound cleanser pat dry apply skin prep, then split gauze, cover with adhesive dressing every other day or as needed, with a start date of 2/29/24 and no end date. Review of Resident #45's medical records reflected there was no evidence of any visits or physician progress notes from the MD since his admission to the facility. The records were requested from the DON on 5/23/24 at 4:47 PM and none were ever provided. She only provided notes from the NP and they were not co-signed by the MD. During an interview on 5/27/24 at 3:00 p.m. the MD stated he attended a meeting at the facility once a month, and it was documented on a paper. The MD stated he was not fully aware of the situation with resident #45's nephrostomy tube. The MD stated he knew he was in and out of the hospital but was never informed that there were insurance issues that prevented the resident from receiving the care he needed. The MD stated it was a rural facility that faced challenges and they should have notified him if there was an issue. (continued on next page)

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	675295	A. Building B. Wing	05/27/2024

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #45's medical records contained no evidence of any visits or physician progress notes from the MD since his admission on 7/5/23. 7. Review of Resident #200's face sheet, dated 5/23/24, revealed she was admitted into the facility on [DATE] with diagnoses including Fragile X Chromosome (genetic condition inherited from parents which results in various developmental problems like intellectual disabilities and cognitive impairment) and Severe Intellectual Disabilities. Review of Resident #200's admission nursing assessment, dated 4/23/24, revealed Resident #200 had severe cognitive impairment, she was never understood and did not understand others, required assistance with all ADLs by 1 staff, was incontinent of bowel and bladder, she wandered and was a high risk for falls. Review of Resident #200's physician orders for May 2024 revealed the NP signed the consolidated physician orders and Resident #200's initial physician visit was conducted by the NP on 5/2/24. During an interview on 5/23/24 at 4:47 p.m. the DON stated they only had notes from the nurse practitioner to provide but they were not signed. The DON stated the MD did come to the facility monthly and signed a sheet that he attended a meeting. The DON stated she knew the MD made rounds and believed he talked to the residents but never actually saw him meeting with residents. The DON stated she could not say for certain what he did because the MD did not provide her with progress notes. During an interview on 5/27/24 at 3:00 p.m. the MD stated he attended a meeting at the facility once a month, and it was documented on a paper. He stated he knew it was his responsibility to conduct the initial visit for new admissions within 30 days upon admission, every 30 days for the first 90 days and then once every 60 days. The MD stated generally the NP was the one who did everything. The MD stated the NP would document and he would co-sign the notes. The MD stated they stored the notes on a program, but did not currently have access to the notes. The MD stated he had not physically signed any orders at the facility and only signed the monthly meeting notes. The MD stated they used standing orders and orders for labs when patients were admitted . The MD stated he could have done a better job providing documentation based on requirements. The MD stated he was responsible for the residents, and he consulted with the NP when she called him. (continued on next page)

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	675295	A. Building B. Wing	05/27/2024

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the facility's policy titled Physician Services, dated 04/2013, stated Policy Statement, the medical care of each resident is under the supervision of a licensed physician. Policy interpretation and implementation. 1. the resident's attending physician participates in the residence assessment and care planning, monitoring changes in the resident's medical status, providing consultation or treatment when called by the facility, and overseeing a relevant plan of care for the resident. 2. The attending physician will determine the relevance of any recommended interventions from any discipline. The physician is not obligated to accept these recommendations if he or she has clinically valid reasons for not doing so. 3. The position will perform pertinent, timely medical assessment prescribing appropriate medical regimen; provide adequate, timely information about the residence condition and medical needs; visit the resident at appropriate intervals; and ensure adequate alternative coverage. 4. Position orders and progress notes shall be maintained in accordance with current OBRA regulations and facility policy. 5. Physician visits, frequency of visits, emergency care of residents, ETC., are provided in accordance with current cobra regulations and facility policy. Consultative services shall be made available from community based consultants or from a local hospital or Medical Center. 6. The medical director will identify attending physician qualifications and responsibilities, based on clinical and regulatory requirements and the recommendations of relevant professional associations. 41095 45857

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	675295	A. Building B. Wing	05/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45857 Based on observations, interviews, and record review, the facility failed to have sufficient nursing staff with the appropriate competencies and skill sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable, physical, mental, and psychosocial well-being for 2 of 2 (LVN A and LVN H) nurses reviewed for competent nursing care. 1. The facility failed to ensure LVN A followed facility policy while providing nephrostomy care to Resident #45 when she used contaminated equipment, did not use sterile gloves, and contaminated her hands. 2. The facility failed to ensure LVN H was aware of how to calibrate a glucometer and ensured the glucometer she used to check residents blood glucose daily was calibrated. These deficient practices affect residents who depend on nursing care and could place residents at risk for injury, infection, and harm. The findings included: 1. Record review of Resident #45's face sheet, dated 11/06/23, revealed Resident #45 was admitted to the facility on [DATE] with diagnoses of Diffuse traumatic brain injury with LOC of unspecified duration (a brain injury that affects multiple areas of the brain. It is caused by the shearing of the brain's long connecting nerve fibers (axons) when the brain rapidly shifts inside the skull due to a violent blow or jolt. It can lead to coma and impairment of various brain functions. Loss of consciousness occurred for an unknown amount of time), cerebral infarction (blood supply to part of the brain is blocked or reduced. This prevents brain tissue from getting oxygen and nutrients. Brain cells begin to die in minutes), hypertension secondary to other renal disorders, anxiety disorder, depression, and hydronephrosis with ureteropelvic junction obstruction (part of the kidney that normally drains urine becomes blocked). Record review of Resident #45's discharge- return anticipated MDS assessment, dated 3/23/24, revealed Resident #45's cognition for daily decision making was severely impaired-never/rarely made decisions. Record review of Resident #45's care plan last updated 2/5/24 revealed a problem showing Resident #45 had a nephrostomy tube related to kidney stone obstruction. Nurse to monitor for infection, skin irritation, and dislodgement of nephrostomy tube, staff to empty nephrostomy tube q shift and document output. Nurse to do preventative care (skin prep) to site every other day and as needed. Records review of Resident #45's physician orders, dated 4/2024, showed orders for nephrostomy (an opening between the kidney and the skin. A nephrostomy tube is a thin plastic tube that is passed from the back, through the skin and then through the kidney, to the point where the urine collects) site: cleanse with normal saline or wound cleanser pat dry apply skin prep, then split gauze, cover with adhesive dressing every other day or as needed, with a start date of 2/29/24 and no end date. (continued on next page)

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	675295	A. Building B. Wing	05/27/2024

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 5/23/24 at 10:51 a.m. LVN A provided wound care to Resident #45's nephrostomy site and was assisted by CNA B. Resident #45 was laying on his left side. When LVN A provided care, removed the bandage which covered the nephrostomy site/tube insertion into his lower back, the resident kicked over the supplies. LVN A stated she contaminated everything and needed to start over. LVN A returned to the treatment cart and opened the MAR. LVN A placed wax paper on the tray, grabbed gauze with her bare hands, grabbed 3 packages of skin prep, touched her scrubs, reached in her pockets, went through the drawer, and stated she needed another pair of scissors because she threw them in the trash. LVN A returned with scissors from another cart, put them on the tray, then sanitized her hands. LVN A opened the cart with her keys, opened the MAR, grabbed more gauze and put it on the tray, grabbed wound cleanser and with her bare hands, sprayed half the gauze, grabbed two packs of t drain sponge, sanitized her hands, cut 4 adhesive strips with the non-sanitized scissors, put the non-sanitized scissors back on tray, grabbed a marker out of her pocket and dated the adhesive, put the keys back in her pocket, closed the MAR, grabbed gloves from box and placed them on the tray. LVN A then sanitized her hands, put on a PPE gown, mask, and gloves. LVN A then opened the residents room door with her gloves on. LVN A then grabbed gauze with the wound cleanser, and wiped the nephrostomy site with the gauze, and contaminated gloves. During an interview on 5/23/24 at 11:29 a.m. LVN A stated she got the other pair of scissors from her other nursing cart but was unsure of when she cleaned them last and stated she should have sanitized them before she used them to prevent cross contamination. LVN A stated she did not notice she touched the door with gloved hands and should have washed her hands in the room prior to starting wound care to prevent infection. During an interview on 5/25/24 at 5:16 p.m. the DON stated LVN A should have sanitized equipment before use and she should have washed her hands in the room, then put on gloves prior to wound care. The DON stated the resident was at risk of infection especially because the tube went straight to his kidney. 2. During an observation on 5/24/24 at 11:38 a.m. medication cart C contained two glucometers used to check residents blood glucose levels. One meter had a serial number ending in 0571 and the 2nd one 0497. The log on the cart for the glucose record did not match the serial numbers on the glucometers in the C hall cart. During an interview and observation on 05/24/24 at 11:47 a.m. LVN H stated the night shift would calibrate the glucometers and document them on the log. LVN H stated she used both glucometers in the C hall cart that morning to check resident glucose levels and administer insulins. LVN H stated she never looked at the log and had not calibrated a glucometer in a long time. LVN H was asked to calibrate the meters. LVN H stated she needed to get wipes to clean the meters. LVN H sanitized to meters before calibrating them. LVN H then put a test strip in the meter and began pressing random buttons on the meter. LVN H then took the unused test strip out of the meter and threw it in the trash. LVN H then placed another test strip in the meter and grabbed the control solution bottle, squeezed the bottle and put the tip of the bottle up to the test strip to place solution on the strip. The meter read ERROR. LVN H stated the meter 0497 was not working. LVN H then placed a drop of the control solution on the bottle top and obtained a reading for the low and high solution for the 2nd meter-0497. LVN H stated if she was not aware of what meter was being calibrated and used one that was broken, she should get a glucose reading that was inaccurate and administer the incorrect amount of insulin to a resident and possibly cause hypoglycemia (low blood glucose). (continued on next page)

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	675295	A. Building B. Wing	05/27/2024

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/25/24 at 5:16 p.m. the DON stated night shift completed the logs for the glucometers and the log should match the meter that is on the cart. The DON stated the meters were calibrated to make sure they obtained an accurate readings of the residents' glucose and residents received the correct amount of insulin. Record review of a document titled Assure 4 blood glucose monitoring system: daily quality control record, dated 5/24, showed meter ending in 2436, c hall, was checked daily except on May 4th 2024 and was with in normal limits for continued use. No records for the two meters on the cart were found on the cart. Record review of the facility's policy titled Nephrostomy Tube, Care of, dated 10/2010, stated Purpose of this procedure is to provide guidelines for the care of the resident with a percutaneous nephrostomy tube. Preparation .3. Assemble equipment and supplies as necessary .General Guidelines .9. Use sterile technique during dressing changes. Equipment and Supplies, For Dressing Changes: 1. Sterile 4x4 drain dressings; .3. Sterile saline/4x4 gauze/sterile basin .4. Clean gloves; 5. Sterile gloves; 7. Disposable under pad; 8. Sterile drape; . steps in the procedure 1. wash and dry your hands. 2. Assemble all equipment on the resident's over bed table. A. Open the sterile drape and create a sterile field. B. Open several packages of gauze pads .d. Open the disposable waste bag and place it away from the sterile field . Dressing changes: 2. place the under pad beneath the resident. 3. Wash your hands and put on clean gloves. 4. Carefully remove the wet or soiled dressing. 5. Discard the dressing and the disposable waste bag. 6. Observe the dressing site for signs of skin breakdown, infection, or drainage. 7. Remove gloves and discard in the disposable waste bag. 8. Wash and dry your hands. 9. put on sterile gloves. 10 .4x4 Dipped in NSS(normal saline) if ordered, cleansing the nephrostomy tube site in an outward circle from the insertion site. Use a new swab for each circle. Cleanse outward to approximately 3 inches in diameter from the insertion site .12 . Allow saline solution to dry. 13. Place one to two sterile drain dressings on the nephrostomy tube site, as indicated. Secure with adhesive tape. Record review of the facility's policy titled Standard Precautions, dated 12/2007, stated policy statement, standard precautions will be used in the care of all residents regardless of their diagnosis, or suspected or confirmed infection status. Standard precautions presume that all blood, body fluids, secretions, and excretions (except sweat), non intact skin and mucous membranes may contain transmissible infectious agents . Standard precautions include the following practices .2 .g. Remove gloves promptly after use, before touching non contaminated items and environmental surfaces .5. Resident care equipment .b. ensure that reusable equipment is not used for the care of another resident until it has been appropriately cleaned and reprocessed and single use items are properly discarded . Record review of the facility's policy titled Obtaining a Fingerstick Glucose Level, dated 10/2011, stated purpose, the purpose of this procedure is to obtain a blood sample to determine the resident's blood glucose level. Preparation .4. ensure that the equipment and devices are working properly by performing any calibrations before checks as instructed by the manufacturer or facility .

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	675295	A. Building B. Wing	05/27/2024

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27520 Based on interview and record review the facility failed to ensure each resident's drug regimen must be free from unnecessary drugs without adequate indications for its use for 1 of 3 Residents (Resident #17) whose record were reviewed for drug regimen. Nursing staff did not obtain a consent from Resident #17's family representative for the use of Depakote (anticonvulsant) used for mood disorder and did not indicate the medication classification on the consent form. These deficient practices could affect residents who received medications for mood disorder and could contribute to the use of unnecessary medications. The findings were: Review of Resident #17's face sheet, undated, revealed he was admitted to the facility on [DATE] with diagnosis including Mood disorder due to known physiological condition. Further review revealed Resident #17 had a family representative who served as his responsible party. Review of Resident #17's quarterly MDS assessment, dated 4/10/24 revealed his BIMS was 11 out of 15 indicative of moderate cognitive impairment. He was dependent for all ADL's and was receiving Hospice services. Review of Resident #17's Psychoactive Medication Therapy Informed Consent Form revealed Resident #17 signed the consent form on 2/27/24 for Depakote used for Mood Disorder. Further review revealed it did not indicate the medication classification and the family member did not sign it. Review of Resident #17's physician orders for May 2024 revealed an order for Depakote DR, 125 mg 1 tablet by mouth every morning. Review of Resident #17's MAR for May 2024 revealed he was receiving Depakote per physician orders. Interview on 05/22/24 at 10:58 AM with the DON revealed Resident #17 was not able to make informed decisions because he was cognitively impaired. She stated the nurse should have obtained the responsible party's consent and signature. The DON stated she would provide a policy but did not through the end of the survey dated 5/27/24. Interview on 05/24/24 at 10:45 AM with Resident #17 revealed he engaged in limited conversation. He presented as being alert with confusion. Interview on 5/26/24 at 4:30 PM with Resident #17's family representative nursing staff did not talk with her about administration of Depakote and was not familiar with the medication. She stated she Resident #17 would not understand the indication for the use of the medication.

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	675295	A. Building B. Wing	05/27/2024

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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. 45857 Based on observation, interview and record review, the facility failed to ensure all drugs and biologicals were stored in locked compartments under proper temperature controls and permit only authorized personnel to have access to the keys for 1 of 2 medication carts and 1 of 2 supply storage rooms (C hall and nursing supply room) reviewed for storage of drugs. 1 The facility failed to ensure the nurse supply room patient nourishment refrigerator did not contain staff food, expired products, unlabeled food products, and unsealed food products. 2. The facility failed to ensure the crash cart did not contain expired products. 3. The facility failed to ensure C hall medication cart did not contain loose pills and expired medications in it This deficient practice could place residents at risk of medication misuse and diversion. The findings were: 1. During an observation and interview on 5/24/24 at 10:35 a.m. revealed a refrigerator in the nursing supply room that contained unlabeled food container with a tan color food, a half empty liter of soda, condiment bottles with no labels, a container of dip from the local grocery store, a container of lemonade from the local grocery store with a dark brown liquid, several expired, 2 unused cartons of patient oral nutritional supplement for resident with prescribed orders, and several cartons of milk shakes for residents. LVN H stated the fridge should be for residents only, but staff would use the fridge too. The freezer contained several frozen milk shake carts and a Styrofoam cup with a frozen red drink with no top. There was no thermometer in the freezer. 2. During observation on 5/24/24 at 10:51 a.m. a crash cart in the nursing supply room contained a bottle of saline that expired on 05/12/2023 and a box of alcohol prep pads that expired on 03/12/2022. During an interview on 5/24/24 at 10:55 a.m. LVN H stated night shift was responsible for checking the crash cart. LVN H stated they would remove the expired items from the cart because they should not be used. 3. During an observation on 5/24/24 at 11:38 a.m. medication C hall cart contained 4 loose pills in the drawer with the residents medication blister packs. The cart also contained a bottle of acetaminophen that expired on 04/2024. During an observation and interview on 5/24/24 at 11:40 a.m. LVN H stated she did not think the loose pills were an issues. LVN H stated she did not know what the pills were or where they came from. LVN H then took one pill and threw it in the trash and asked if that was ok. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/25/24 at 5:16 p.m. the DON stated the fridge in the nursing supply room should only be for resident supplement drinks, shakes, and condiments but items needed a label. The DON stated staff should not be placing their food in the fridge. The DON stated any loose pills are documented and then discarded in the sharps containers. The DON stated loose pills were a concern because certain residents are only allotted a certain amount of medication and could run out if their medication is dropped. The DON also agreed it was possible staff could have dropped them while dispensing them into a medication cup, did not notice, and the resident never received the medications. Record review of the facility's policy titled Food Storage, dated 2013, stated leftover food is stored in covered container or wrapped carefully and securely. 13 .Each item is clearly labeled and dated before being refrigerated. Leftover food is used within three days or discarded .14. Refrigerated food storage .d. each nursing unit with a refrigerator/ freezer unit will be supplied with thermometers and monitored for appropriate temperatures .15. Frozen foods .c. all foods should be covered, labeled, and dated. All foods will be checked to assure that foods will be consumed by their safe use by dates or discarded . Record review of the facility's policy titled Labeling of Medication Containers, dated 04/2007, stated policy statement, all medications maintained in the facility shall be properly labeled in accordance with current state and federal regulations .

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	675295	A. Building B. Wing	05/27/2024

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Lytle Nursing Home	15366 Oak St Lytle, TX 78052

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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 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure therapeutic diets are prescribed by the attending physician and may be delegated to a registered or licensed dietitian, to the extent allowed by State law. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45857 Based on observations, interviews and record reviews, the facility failed to provide a therapeutic diet, in the appropriate form as prescribed by a physician for 1 of 6 residents (Resident #15) observed for therapeutic diets. The facility failed to provide Resident #15 a mechanical soft diet, as ordered by the physician. This failure could affect residents with physician orders for therapeutic diets and could result in consumption of inappropriate textured food items which could cause choking or aspiration and a decline in health. The findings were: Record review of Resident #15's face sheet revealed a [AGE] year-old male was admitted on [DATE] and readmitted on [DATE] with diagnoses that included acute cerebrovascular insufficiency, major depressive disorder, chronic disease of tonsils and adenoids, other disorders of teeth and supporting structures, and hemiplegia affecting left nondominant side, Record review of Resident #15's Quarterly MDS assessment, dated 3/29/24, indicated Resident #15's cognition was moderately impaired for daily decision-making skills. The MDS also indicated he received a mechanically altered diet. Record review of Resident #15's care plan was last updated on 3/26/24 and showed at risk for weight fluctuations with a current diet of regular mechanical soft and thin liquid. Interventions included dietician to evaluate and follow up per facility policy and as needed. The care plan did not mention the resident refused to go to medical appointments outside the facility. Record review of Resident #15's physician orders, dated 05/2024, showed an order for regular diet and mechanical soft texture and regular liquids, with a start date of 10/02/2023. During an observation and interview on 5/21/24 at 12:20 p.m. Resident #15 was observed eating in his room. The Resident had a piece of beef brisket that he was holding and biting. The resident grunted has he bit the meat. Resident #15 stated he was not able to chew his meat because he was missing teeth. The Resident smiled to show his teeth and he had some missing top teeth. The resident stated he eats on his own. The residents diet card on his meal tray showed he was on a regular diet and mechanical soft texture. During an interview on 05/23/24 at 4:50 p.m. the DON stated Resident #15 should be on mechanical soft diet and was on it because he had a mass in his throat at one time. The DON stated he had it removed last year and was supposed to follow up with the ENT after. The DON stated she was told her refused to go to medical appointments by other staff and he never went to the follow up appointment. The DON stated it should be documented in the nursing notes if the resident refused to go to an appointment. (continued on next page)

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/23/24 at 4:04 p.m. the SLP stated she recently worked with the resident for speech services. She stated she did observe him eating regular texture food and he seemed to have no issues. The SLP stated she thought Resident #15 was prescribed a regular texture diet. The SLP showed a noted she wrote from 4/2/24 that stated the resident denied any issues with swallowing functions or oral intake. During an interview on 5/25/24 at 5:29 p.m. the DM stated there should have been two checks of residents' meal tickets with their diets done before the meal tray gets to the resident. The DM stated the check was not done properly and she had in serviced the kitchen staff on only setting out one tray at a time, verifying the meal ticket, and then serving the food to prevent any errors in the future. The DM stated if the resident was not given the correct texture ordered for their diet there was a risk of aspiration or chocking. Record review of the facility's policy titled Interdepartmental Notification of Diet (Including Changes and Reports), dated 10/2008, stated policy statement, nursing services shall notify the food services department of a resident's diet orders, including any changes in the resident's diet, meal service, and food preferences.

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F 0838 Level of Harm - Potential for minimal harm Residents Affected - Many	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations and emergencies. 41095 Based on record review and interviews, the facility failed to conduct and document a comprehensive facility-wide assessment for the past 3 years to determine what resources were necessary to care for its residents competently during day-to-day operations and review and update the assessment at least annually. The Facility Assessment had not been completed or updated since 2021. This failure could place residents at risk of their needs going unmet and result in a lack of services provided by the facility to competently care for all residents. The findings included: During an interview and record review with the Administrator on 05/26/24 at 1:47 PM, the Administrator acknowledged that a Facility Assessment had not been conducted since his arrival in September of 2023. The ADM found a notebook in the Administrator's office titled Facility Assessment. It contained a very basic facility assessment form which was completed in 2019, 2020 and 2021. The last facility assessment was completed in 2021.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27520 45857 Based on interviews and record reviews, the facility failed to maintain medical records on each resident that are-accurately documented for 3 of 12 residents (Resident #15, Resident #45, and Resident #200) reviewed for accurate medical records in that: 1. The facility failed to document Resident #15's refusal to attend medical appointments. 2. The facility failed to ensure nursing staff completed documentation for Resident #45's nephrostomy care in March and April of 2024. The facility failed to completed medication consent forms for Resident #45. 3. The facility failed to ensure nursing staff wrote a progress note reflecting when and what hospital Resident #200 was sent to after she fell on [DATE]. These deficient practices could affect residents who have medical records and could result in misinformation about professional care provided. The findings included: 1. a. Record review of Resident #15's face sheet revealed a [AGE] year-old male was admitted on [DATE] and readmitted on [DATE] with diagnoses that included acute cardiovascular insufficiency, major depressive disorder, chronic disease of tonsils and adenoids, other disorders of teeth and supporting structures, and hemiplegia affecting left non-dominant side, Record review of Resident #15's Quarterly MDS assessment, dated 3/29/24, indicated Resident #15's cognition was moderately impaired for daily decision-making skills. Record review of Resident #15's care plan was last updated on 3/26/24 and showed he was at risk of social isolation due to his cognitive impairment with interventions to accommodate his limited cognitive ability to enable participation in activities, staff to reinforce attendance at activities outside of room with verbal praise and he is at risk for weight fluctuations with a current diet of regular mechanical soft and thin liquid. Interventions included dietician to evaluate and follow up per facility policy and as needed. The care plan did not mention the resident refused to go to medical appointments outside the facility. Record review of Resident #15's nursing notes from September 2023 through May 2024 revealed there were no notes reflecting the resident refused to go to medical appointments. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 05/23/24 at 4:50 p.m. the DON stated the resident should be on mechanical soft diet and was on it because he had a mass in his throat at one time. The DON stated he had it removed last year and was supposed to follow up with the ENT after. The DON stated she was told he refused to go to medical appointments by other staff and he never went to the follow up appointment. The DON stated it should be documented in the nursing notes if the resident refused to go to an appointment. 2. Record review of Resident #45's face sheet, dated 11/06/23, revealed Resident #45 was admitted to the facility on [DATE] with diagnoses of Diffuse traumatic brain injury with LOC of unspecified duration, cerebral infarction, hypertension secondary to other renal disorders, anxiety disorder, depression, and hydronephrosis with ureteropelvic junction obstruction. Record review of Resident #45's discharge- return anticipated MDS assessment, dated 3/23/24, revealed Resident #45's cognition for daily decision making was severely impaired-never/rarely made decisions. Record review of Resident #45's care plan last updated 2/5/24 revealed a problem showing Resident #45 had a nephrostomy tube related to kidney stone obstruction. Nurse to monitor for infection, skin irritation, and dislodgement of nephrostomy tube, staff to empty nephrostomy tube q shift and document output. Nurse to do preventative care (skin prep) to site every other day and as needed. Records review of Resident #45's physician orders, dated 4/2024, showed orders for nephrostomy site: cleanse with normal saline or wound cleanser pat dry apply skin prep, then split gauze, cover with adhesive dressing every other day or as needed, with a start date of 2/29/24 and no end date. Record review of Resident #45's TAR, dated 3/2024 showed an order for nephrostomy care cleanse with normal saline or wound cleanser pat dry apply skin prep, then split gauze, cover with adhesive dressing every other day. The MAR was blank for the following dates: 3/8/24-Resident was the at hospital and was not noted in the TAR. Returned on 03/09/24 3/10/24 3/12/24 3/14/24 3/16/24 3/18/24- Was at Hospital on 03/18/24 was not noted on the TAR 3/20/24 3/22/24 3/24/24- Was at Hospital on 3/23/24 and was not noted on the TAR 3/26/24 (continued on next page)

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	675295	A. Building B. Wing	05/27/2024

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3/28/24 3/30/24 Record review of Resident #45's TAR, dated 4/2024 showed an order for nephrostomy care cleanse with normal saline or wound cleanser pat dry apply skin prep, then split gauze, cover with adhesive dressing every other day. The MAR was blank for the following dates: 4/5/24 4/9/24 4/13/24 4/21/24 During an interview on 5/25/24 at 5:10 p.m. the DON stated nursing staff was completing the nephrostomy care treatments for Resident #45 but were not documenting it. The DON stated she was aware of the documentation issues with nursing staff not filling out the residents MARs and TARs and she had in serviced staff on 1/17/24 regarding documentation. The DON stated she advised staff if they did not document treatments then they did not occur. b. Record review of Resident #45's document titled Psychoactive Medication Therapy Informed Consent Form, dated 4/1/24, contained information for Ativan. The document contained a signature of the resident representative. The document was blank on the line for the signature of person obtaining consent. Record review of Resident #45's document titled Psychoactive Medication Therapy Informed Consent Form, dated 4/1/24, contained information for sertraline. The document contained a signature of the resident representative. The document was blank on the line for the signature of person obtaining consent. Record review of Resident #45's document titled Psychoactive Medication Therapy Informed Consent Form, no date, contained information for Depakote. The document contained a signature of the resident representative. The document was blank on the line for the signature of person obtaining consent and for a date. Record review of a document titled Consent for Antipsychotic or Neuroleptic Medication Treatment, Form 3713, May 2022, was filled out with Resident #45's name, and the facility's name. The section of the document was blank for the psychiatric condition and or maladaptive behavior. The next section was filled in with the diagnosis is based on the following diagnostic criteria and assessment findings exhibited by this individual: bipolar, depression, anxiety, diffused TBI with loss of consciousness. The area for course of therapy with antipsychotic or neuroleptic medications are proposed with the following medications, dosage and frequency was blank. The area of the document stating need for, and benefits of, the proposed treatment with antipsychotic or neuroleptic medications indicated was blank. The NP printed her name and signed the document with no date. The area for the resident representative contained a printed name and signature with no date. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 5/23/24 at 10:20 a.m. the Resident Representative who signed Resident #45's consent forms stated that she did sign the forms for consent to medications. The RP stated she had total trust in the facility and signed the forms they asked her to without knowing what she was signing because she trusted them. She stated in the future she would ask more questions because she did not realize she signed a incomplete form that could later be filled in. During an interview on 5/25/24 at 6:40 p.m. the DON stated the consent forms were supposed to be filled out by staff to show they witnessed the consent for the medication. 3. Review of Resident #200's face sheet, dated 5/23/24, revealed she was admitted into the facility on [DATE] with diagnoses including Fragile X Chromosome (genetic condition inherited from parents which results in various developmental problems like intellectual disabilities and cognitive impairment) and Severe Intellectual Disabilities. Review of Resident #200's admission nursing assessment, dated 4/23/24, revealed Resident #200 had severe cognitive impairment, she was never understood and did not understand others, required assistance with all ADLs by 1 staff, was incontinent of bowel and bladder, she wandered and was a high risk for falls. Review of Resident #200's nurses noted from 5/1/24 to 5/31/24 revealed there were no progress notes reflecting Resident #200 had a fall or that she was sent out to the hospital on 5/4/24. Interview on 05/23/24 at 09:15 AM with the DON/ revealed Resident #200 fell on [DATE]. She stated nursing staff did not complete a transfer form. She stated nursing staff should write a progress note about Resident #200's fall, reason for being transferred to the hospital and what hospital she was sent to for evaluation and care as needed. The DON reviewed Resident #7's chart and stated she could did not find documentation providing detailed information on Resident #7's fall, that she was sent to the hospital or what hospital to was transferred to for evaluation and care as needed. Record review of the facility's policy titled Charting and Documentation, dated 07/2017, stated policy statement, all services provided to the resident, progress towards the care plan goals, or any changes in the residents medical, physical, functional, or psychosocial condition, shall be documented in the resident's medical record. The medical record should facilitate communications between the interdisciplinary team regarding the resident's condition and response to care. Policy Interpretation and Implementation 1. Documentation in the medical record may be electronic, manual or a combination. 2. The following information is to be documented in the resident medical record: a. Objective observation b. Medications administered; c. Treatments or services performed; d. Changes in the resident's condition; e. Events, incidents or accidents involving resident; and f. Progress toward or changes in the care plan goals and objectives .

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. 27520 Based on interview and record review the facility failed to establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The facility did not have a QAPI plan, policies or procedures in place for program systematic analysis and systemic action. This deficient practice could affect all residents' overall quality of life and quality of care they received as a result of not having systems in place to improve direct care nursing staff provided. The findings were: Interview on 05/24/24 at 02:24 PM with the DON revealed they had a Quality Assurance Committee but did not have a Quality Assurance and Performance Improvement Program because they did not utilize PIPS (Performance Improvement Projects. She stated they did not have a written plan, policies or procedures in place. The DON stated all department heads along with the MD met once a month to discuss effective systems in the facility. She stated direct care staff was not involved in the process. She stated they did not complete written comparative analysis to determine root cause analysis or to determine if and how any new systems implemented were effective. The DON stated they would discuss improvements or the need to continue to monitor systems during the meetings.

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	675295	A. Building B. Wing	05/27/2024

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45857 Based on observations, interviews, and record reviews, the facility failed to maintain an Infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable disease and infection for 1 of 7 residents (Resident #45) reviewed for infection control, in that: The facility failed to ensure LVN A used sanitized scissors, followed hand hygiene, and followed procedure for sterile technique while providing nephrostomy care to Resident #45. These deficient practices could place residents at-risk for infection due to improper care practices. The findings included: 1. Record review of Resident #45's face sheet, dated 11/06/23, revealed Resident #45 was admitted to the facility on [DATE] with diagnoses of Diffuse traumatic brain injury with LOC of unspecified duration (a brain injury that affects multiple areas of the brain. It is caused by the shearing of the brain's long connecting nerve fibers (axons) when the brain rapidly shifts inside the skull due to a violent blow or jolt. It can lead to coma and impairment of various brain functions. Loss of consciousness occurred for an unknown amount of time), cerebral infarction (blood supply to part of the brain is blocked or reduced. This prevents brain tissue from getting oxygen and nutrients. Brain cells begin to die in minutes), hypertension secondary to other renal disorders, anxiety disorder, depression, and hydronephrosis with ureteropelvic junction obstruction (part of the kidney that normally drains urine becomes blocked). Record review of Resident #45's discharge-return anticipated MDS assessment, dated 3/23/24, revealed Resident #45's cognition for daily decision making was severely impaired-never/rarely made decisions. Record review of Resident #45's care plan last updated 2/5/24 revealed a problem showing Resident #45 had a nephrostomy tube related to kidney stone obstruction. Nurse to monitor for infection, skin irritation, and dislodgement of nephrostomy tube, staff to empty nephrostomy tube q shift and document output. Nurse to do preventative care (skin prep) to site every other day and as needed. Records review of Resident #45's physician orders, dated 4/2024, showed orders for nephrostomy (an opening between the kidney and the skin. A nephrostomy tube is a thin plastic tube that is passed from the back, through the skin and then through the kidney, to the point where the urine collects) site: cleanse with normal saline or wound cleanser pat dry apply skin prep, then split gauze, cover with adhesive dressing every other day or as needed, with a start date of 2/29/24 and no end date. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 5/23/24 at 10:51 a.m. LVN A provided wound care to Resident #45's nephrostomy site and was assisted by CNA B. Resident #45 was laying on his left side. When LVN A provided care, removed the bandage which covered the nephrostomy site/tube insertion into his lower back, the resident kicked over the supplies. LVN A stated she contaminated everything and needed to start over. LVN A returned to the treatment cart and opened the MAR. LVN A placed wax paper on the tray, grabbed gauze with her bare hands, grabbed 3 packages of skin prep, touched her scrubs, reached in her pockets, went through the drawer, and stated she needed another pair of scissors because she threw them in the trash. LVN A returned with scissors from another cart, put them on the tray, then sanitized her hands. LVN A opened the cart with her keys, opened the MAR, grabbed more gauze and put it on the tray, grabbed wound cleanser and with her bare hands, sprayed half the gauze, grabbed two packs of t drain sponge, sanitized her hands, cut 4 adhesive strips with the non-sanitized scissors, put the non-sanitized scissors back on tray, grabbed a marker out of her pocket and dated the adhesive, put the keys back in her pocket, closed the MAR, grabbed gloves from box and placed them on the tray. LVN A then sanitized her hands, put on a PPE gown, mask, and gloves. LVN A then opened the resident's room door with her gloves on. LVN A then grabbed gauze with the wound cleanser, and wiped the nephrostomy site with the gauze, and contaminated gloves. During an interview on 5/23/24 at 11:29 a.m. LVN A stated she got the other pair of scissors from her other nursing cart but was unsure of when she cleaned them last and stated she should have sanitized them before she used them to prevent cross contamination. LVN A stated she did not notice she touched the door with gloved hands and should have washed her hands in the room prior to starting wound care to prevent infection. During an interview on 5/25/24 at 5:16 p.m. the DON stated LVN A should have sanitized equipment before use and she should have washed her hands in the room, then put on gloves prior to wound care. The DON stated the resident was at risk of infection especially because the tube went straight to his kidney. Record review of the facility's policy titled Nephrostomy Tube, Care of, dated 10/2010, stated Purpose of this procedure is to provide guidelines for the care of the resident with a percutaneous nephrostomy tube. Preparation .3. Assemble equipment and supplies as necessary .General Guidelines .9. Use sterile technique during dressing changes. Equipment and Supplies, For Dressing Changes: 1. Sterile 4x4 drain dressings; .3. Sterile saline/4x4 gauze/sterile basin .4. Clean gloves; 5. Sterile gloves; 7. Disposable under pad; 8. Sterile drape; . steps in the procedure 1. wash and dry your hands. 2. Assemble all equipment on the resident's over bed table. A. Open the sterile drape and create a sterile field. B. Open several packages of gauze pads .d. Open the disposable waste bag and place it away from the sterile field . Dressing changes: 2. place the under pad beneath the resident. 3. Wash your hands and put on clean gloves. 4. Carefully remove the wet or soiled dressing. 5. Discard the dressing and the disposable waste bag. 6. Observe the dressing site for signs of skin breakdown, infection, or drainage. 7. Remove gloves and discard in the disposable waste bag. 8. Wash and dry your hands. 9. put on sterile gloves. 10 .4x4 Dipped in NSS(normal saline) if ordered, cleansing the nephrostomy tube site in an outward circle from the insertion site. Use a new swab for each circle. Cleanse outward to approximately 3 inches in diameter from the insertion site .12 . Allow saline solution to dry. 13. Place one to two sterile drain dressings on the nephrostomy tube site, as indicated. Secure with adhesive tape. (continued on next page)

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	675295	A. Building B. Wing	05/27/2024

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the facility's policy titled Standard Precautions, dated 12/2007, stated policy statement, standard precautions will be used in the care of all residents regardless of their diagnosis, or suspected or confirmed infection status. Standard precautions presume that all blood, body fluids, secretions, and excretions (except sweat), non intact skin and mucous membranes may contain transmissible infectious agents . Standard precautions include the following practices .2 .g. Remove gloves promptly after use, before touching non contaminated items and environmental surfaces .5. Resident care equipment .b. ensure that reusable equipment is not used for the care of another resident until it has been appropriately cleaned and reprocessed and single use items are properly discarded .

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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 0912 Level of Harm - Potential for minimal harm Residents Affected - Many	Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41095 Based on record review, observation and interview, the facility failed to provide 4 of 35 double occupancy resident rooms (Rooms 27, 28, 34 and 35) with at least 80 square feet per resident in that: Rooms 27, 28,34 and 35 did not have the required minimum of 80 square feet per resident. This failure could affect residents placed in these multiple occupancy rooms by reducing their living space. The findings included: Observation on 05/21/24 by life safety code revealed the following measurements of resident room dimensions for the room size waiver: 1. room [ROOM NUMBER] (two-person room) had a total of 157.34 square feet and 78.67 square feet per resident. 2. room [ROOM NUMBER] (two-person room) had a total of 156.79 square feet and 78.40 square feet per resident. 3. room [ROOM NUMBER] (two-person room) had a total of 141.94 square feet and 70.97 square feet per resident. 4, room [ROOM NUMBER] (two person room) had a total of 159.25 square feet and 79.62 square feet per resident. Review of the Bed Classifications form 3740, dated 03/20/2023 revealed each room had two beds. Review of the Room Census List dated 05/21/24 indicated room [ROOM NUMBER]a was occupied, room [ROOM NUMBER]b was occupied, room [ROOM NUMBER]a was unoccupied, 28b was occupied, room [ROOM NUMBER]a was unoccupied, room [ROOM NUMBER]b was occupied and room [ROOM NUMBER]a was occupied and 35b was unoccupied. During an interview with the Administrator on 05/27/2024 at 10:00 a.m., he stated the dimensions for rooms 27, 28, 34 and 35 had less than the 80 square feet per resident in the rooms and stated he would like to continue with the room size waiver for the resident rooms. Administrator was informed that 1 bed in room [ROOM NUMBER] needed to be de-licensed/de-certified since it did not meet the minimum of at least 72 square feet to qualify for a waiver.