STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675387	A. Building B. Wing	06/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Panola County Nursing & Rehabilitation	501 Cottage Rd Carthage, TX 75633

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48958 Based on observation, interview, and record review, the facility failed to provide a safe, clean, comfortable, and homelike environment for 5 of 17 residents reviewed for environment. (Residents #9, #35, #36, #16, and #7) The facility failed to ensure Resident #35 and Resident #36 had a clean room free from dust and dead roaches. The facility failed to repair Resident #9 ceiling tiles in room with water spots, due to water damage. The facility failed to ensure Resident #16's room was free of roaches. The facility failed to ensure Resident #7's room was free of water bugs. The facility failed to repair the ceiling in hall by the dining area. The facility had a trash can catching rainwater. These failures could place residents at risk of an unsafe or uncomfortable environment and a decrease in quality of life and self-worth. Findings included: Record review of Resident #35's face sheet indicated she was an [AGE] year-old female initially admitted to the facility on [DATE] with a diagnosis included: unspecified dementia (dementia without a specific diagnosis), restlessness and agitation (agitation is a normal emotion) and Alzheimer's disease (a progressive disease that destroys memory and other important mental functions). Record review of the quarterly MDS assessment dated [DATE] indicated Resident #35 rarely understood others and was rarely understood by others. The MDS BIMS assessment was not completed for Resident #35. The MDS indicated Resident #35 was dependent with ADL's. Record review of an undated care plan indicated Resident #35 had impaired cognitive function dementia or impaired thought processes related to diagnoses of dementia severe and Alzheimer's disease. (continued on next page)

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

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

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #36's face sheet indicated she was a [AGE] year-old female initially admitted to the facility on [DATE] with a diagnoses included: unspecified dementia (dementia without a specific diagnosis), chronic obstructive pulmonary disease (a group of lung diseases that block airflow and make it difficult to breathe) and Parkinson's disease (a disorder of the central nervous system that effects movement). Record review of the quarterly MDS assessment dated [DATE] indicated Resident #36 was usually understood and usually understood others. Resident #36 was not able to complete the BIMS assessment. The MDS indicated Resident #35 was dependent with ADL's. Record review of undated care plan indicated Resident #36 was monitored for signs and symptoms of acute respiratory insufficiency: anxiety, confusion, restlessness, shortness of breath at rest, cyanosis (is a condition that causes the skin, lips or nails to turn blue or purple due to low oxygen levels in the blood)and somnolence (drowsiness). Make sure call light was within reach and encourage the resident to use for assistance as needed. During observations on 06/04/24 at 8:47 AM in Resident #35's room, the resident was lying in bed looking around. Two dead roaches were next to Resident #35's fall mat that was beside the bed. When exiting the resident's room observed Resident #36's bed faced toward the opened closet. On the closet floor were two dead roaches on their backs surrounded by hair and dust. Record review of Resident #9's face sheet indicated she was an [AGE] year-old female initially admitted to the facility on [DATE] with a diagnoses included: multiple sclerosis (a disease in which the immune system eats away at the protective covering of nerves), paranoid schizophrenia (a pattern of behavior where a person feels distrustful and suspicious of other people and acts accordingly) and unspecified disorder of nose and nasal sinuses (diseases of the respiratory system). Record review of the quarterly MDS assessment dated [DATE] indicated Resident #9 was understood by others and understood others. The MDS assessment indicated Resident #9 had a BIMS score of 15 which indicated her cognition was intact. The MDS indicated Resident #9 was independent with ADL's. Record review of undated care plan indicated Resident #9 found these measures to be calming and to relieve risk of re-trauma: speak in a calm, non-threatening manner while working with resident. Establish and maintain a trusting relationship by listening to the client. She likes to be in her room alone at times where it is quiet. She voices that she does not have any lingering trauma from previous traumas. During observation and interview on 06/03/24 at 10:53 AM revealed in Resident #9 room there were dark and light brown water spots on the resident's ceiling tiles. The spots were noted in Resident #9's room and in bathroom. Resident #9 said the spots had been there for a while and when she complained about them the facility would paint over them with some white paint, but when it rained the spots showed up in different areas. Resident #9 said she did not like the spots on the ceiling and with tiles getting wet by rain that could cause mold and respiratory issues. During an interview on 6/05/2024 at 11:20 AM CNA I said the water spots on the facility's ceiling was a concern, because with the ceiling getting wet could cause the pieces to fall and hit someone. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During observation and interview on 6/05/2024 at 11:48 AM with Resident #9 she said she told management of the facility that fungus grew in wet areas and it could cause health issues, due to the ceiling tiles getting wet when it rained. During an interview on 6/05/2024 at 11:55 AM with the Maintenance man he said pest control came and sprayed last 5/30/24. He said the chemical pest control spray brought the bugs out, that was why the roaches were observed dead on the floors. He said pest control came once a month to spray the facility. He said he expected for housekeeping to disinfect the front lobby, the dining area, then they should clean the resident's room. He said housekeeping should ask permission to enter a resident's room and notify the resident what they were in the room for. He said he did feel like the roof leak was a hazardous issue. He said the facility was in the process of getting a new roof. He said the facility had already gotten the roof approved. He said when it rained the roof leaked and got the tile pieces in the ceiling wet. He said since the ceiling pieces got wet they could get heavy, and fall and hit someone. Review of an invoice from the local pest control company dated 5/30/2024 revealed services were rendered. During an interview on 6/05/2024 at 11:30 AM Resident #16 said he saw roaches all the time in his room and all over the bathroom. Resident #16 said the roaches would be on the walls and carried germs. Resident #16 said those roaches can bite and they are very nasty. Resident #16 said the raining in the facility was dangerous, because the sheet rock crumbling and falling was dangerous. He said the tile pieces in the ceiling could fall and hurt someone also. During an interview on 6/05/2024 at 12:22 PM with Resident #7 he said he had water bugs in his room all the time. He said the water bugs came out at night. He said water bugs were all in the hallways. He said he thought the water bugs were very nasty. He said he did not like seeing the bugs and he tried to kill them. During an interview on 6/05/2024 at 12:24 PM with Resident #27, she said she saw roaches running around the facility all the time. She said she tried to kill them. She said roaches were not very sanitary. She said she did not like the roaches running around the facility. Resident #27 said she had a lot of water spots in her room and they moved her into another room while they fixed the roof. She said a piece of the ceiling fell and hit her while she was lying in bed. She said she did not get hurt and it just felt like a wet sponge hit her. She said it happened a while back. During an interview on 6/05/2024 at 1:33 PM with Housekeeper K, she said yes, she had seen a lot of cockroaches when cleaning that hall . She said she did not hear the residents complain about the roaches. She said she would not want the roaches running around in her house. She said she did not think it was sanitary for the roaches to be running around the facility. She said the tiles in the top of the ceiling have fallen down when it rained. She said she felt like wet tiles in the ceiling were a hazard, because anyone could get hit on the head from the pieces if they fell . She said a resident had been hit by wet tiles from the ceiling before. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 6/05/2024 at 1:50 PM with LVN G, she said she seen a lot of water bugs in the resident's room. She said she had seen the exterminator at the facility, but she did not think the chemical they used worked well. She said it would not make her feel good if she had lived in the facility with bugs and it needed to be taken care of. She said the ceiling leaked all the time. She said a roof guy came a couple months ago and did some repairs to the roof. She said the roof leaks could cause all kind of health conditions; such as respiratory issues and someone can get hurt with the roof leaks. During an interview on 6/05/2024 at 2:58 PM with the DON, she said she had witnessed the roaches, but thought they came out when it rained. She said pest control came and sprayed monthly, but if staff or residents saw an increase in bugs they would notify Maintenance and he would notify pest control and had them come out and spray. She said the facility had had roof leaks and they came and did roof repairs throughout the building. She said the roof leaking was hazardous because the tiles could potentially fall and injure someone. During an interview on 6/05/2024 at 3:18 PM with the ADM, she said the exterminators just came last 5/30/2024 or 5/31/2024 and sprayed the facility. The bugs have come out. She said she was sure that it made the residents uncomfortable to see the roaches, but the facility was doing what they could to eliminate the bugs. She said she expected the housekeepers to keep this facility clean like it was the President's house. She said not cleaning thoroughly was not acceptable. She said the facility was working on the leaks and would get the rest of the ceiling tiles changed out that has water damage. She said the roof leaks could be a potential hazard due to mold and the tiles in the ceilings could fall and hit a resident. Record review of the facility Homelike Environment Policy, dated February 2021 revealed . Residents are provided with a safe, clean, comfortable and homelike environment and encouraged to use their personal belongings to the extent possible. Staff provides person-centered care that emphasizes the residents' comfort, independence and personal needs and preferences. Record review of the facility Resident Rights Under Federal Law Policy undated, revealed . the resident has the right to reasonable accommodation of individual needs and preferences except where the health and safety of the resident or other residents would be endangered.

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44933 Based on observation, interview, and record review, the facility failed to ensure the right to be free from any physical restraints imposed for purposes of convenience and not required to treat medical symptoms for 1 of 16 residents reviewed for restraint use (Resident #30). The facility failed to ensure Resident #30 was free from physical restraints in the form of CNA A locking her wheelchair which did not allow her to move freely around the secured unit. This failure could place residents at risk for a decreased quality of life, a decline in physical functioning and injury. Findings included: Record review of a face sheet printed on 06/05/24 indicated Resident #30 was a [AGE] year-old, female and was admitted on [DATE] with diagnoses including Alzheimer's disease (is a progressive disease beginning with mild memory loss and possibly leading to loss of the ability to carry on a conversation and respond to the environment), dementia (is a general term for loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life), and cerebral infarction (stroke). Record review of a quarterly MDS assessment dated [DATE] indicated Resident #30 was understood and usually understood others. The MDS indicated Resident #30 had a BIMS score of 03 which indicated severe cognitive impairment. The MDS indicated Resident #30 wandered. The MDS indicated Resident #30 normally used a wheelchair in last 7 days of the assessment period for a mobility device. The MDS indicated Resident #30 required setup for oral hygiene and eating, substantial assistance for lower body dressing and putting on/taking off footwear, partial assistance for upper body dressing, and dependent for toileting and personal hygiene, and shower/bathe self. The MDS indicated physical restraints were not used for Resident #30. Record review of a care plan dated 05/03/23, revised 02/08/24 indicated Resident #30 was at risk for falls related to Alzheimer's disease and no safety awareness. Intervention included Resident #30 needed prompt response to all request for assistance. Record review of a care plan dated 08/01/23 indicated Resident #30 was an elopement risk/wanderer as evidence by disoriented to place, history of attempts to leave facility unattended, impaired safety awareness, and wanders aimlessly-placement on secured unit. Intervention included distract from wandering by offering pleasant diversions, structured activities, food, conversation, television, and book. During an observation on 06/04/24 at 1:32 p.m., revealed CNA A pushed, in her wheelchair, Resident #30 out of the dining area on the secured unit towards the nursing station. CNA A locked Resident #30's wheelchair brakes then walked away from Resident #30. Resident #30 started trying to self-propel herself in the wheelchair, but it only moved a little. The MDS Coordinator noticed Resident #30 trying to self-propel herself and unlocked the wheelchair brakes. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 06/04/24 at 1:36 p.m., Resident #30 was wandering in front of the nursing station in her wheelchair. CNA A pushed Resident #30 towards the front side of the nursing station then locked her wheelchair brakes. During an observation on 06/04/24 at 1:49 p.m., revealed Resident #30's wheelchair brakes were still locked. During an interview on 06/05/24 at 11:05 a.m., the MDS Coordinator said locking the brakes on a resident's wheelchair when not transferring them, could be considered a restraint. She said she did recall Resident #30 trying to move in her wheelchair and the brakes being locked. She said she had to release the brake on Resident #30's wheelchair, but she thought it was only one brake. She said she did not see CNA A lock the brakes on Resident #30's wheelchair the second time. She said the facility did not use restraints. She said inappropriate use of restraints could cause injury to the resident. During an interview on 06/05/24 at 11:45 a.m., CNA H said locking a resident's wheelchair who could not unlock it, could be considered a restraint. She said the facility did not use restraints. She said Resident #30 could sometimes unlock her brakes but Resident #30 would not understand if they were locked and she wanted to move, she would need to unlock the brakes. She said Resident #30 wandered the unit in her wheelchair. She said using a restraint could cause the resident to tip over and did not let the resident do want they wanted to do. On 06/05/24 at 12:00 p.m., called CNA A for a phone interview. A voice message was left regarding the reason for the call and a call back phone number. No call back received before or after exit. During an interview on 06/05/24 at 1:35 p.m., LVN G said locking a resident's wheelchair brakes, who could self-propel themselves, could be considered a physical restraint. She said a resident's movement could not be restricted. She said the facility did not use physical restraints. She said inappropriate use of restraints could cause injury, harm, or falls to the resident. During an interview on 06/05/24 at 1:54 p.m., the DON said putting the brakes on a resident's wheelchair when not transferring them, could be considered a restraint. She said the facility was a restraint free facility. She said inappropriate use of restraints had the potential for injury to the resident. She said staff knew not to use restraints on residents. During an interview on 06/05/24 at 2:45 p.m., the ADM said locking a resident's wheelchair who could not unlock it, could be considered a restraint. She said the facility did not use restraints. She said restraints were not appropriate to use because the resident could not be mobile as they wished. Record review of a facility's Use of Restraints policy revised 04/2017 indicated .restraints shall only be used for the safety and well-being of the resident(s) and only after other alternatives have been tried unsuccessfully .restraints shall only be used to treat the resident's medical symptom(s) and never for discipline or staff convenience, or for the preventions of falls .physical restraints are defined as any manual method or physical or mechanical device .which restricts freedom of movement .the definition of a restraint is based on the functional status of the resident .practices that inappropriately utilize equipment to prevent resident mobility are considered restraints and are not permitted .