STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675418	A. Building B. Wing	04/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Manor at Seagoville	2416 Elizabeth LN Seagoville, TX 75159

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45268 Based on interview and record review the facility failed to ensure each resident was treated with respect and dignity and care for each resident in a manner and in an environment that promoted maintenance or enhancement of his or her quality of life, recognizing each resident's individuality and protect and promote the rights of the resident for one of three (Resident #1) residents reviewed for resident rights. The facility failed to ensure Caregiver A removed Icy Hot (a topical, over-the-counter pain reliever with active ingredients like menthol and wintergreen oil [methy salicyclate]) after it was applied to Resident #1's bottom, and the resident complained that it burned. This failure could place residents at risk of discomfort and a decreased quality of life. Findings included: Record review of Resident #1's electronic face sheet, printed 04/02/2024, reflected the resident was a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #1 had diagnoses which included but not limited to hypertension (high blood pressure) and end stage renal disease (permanent loss of kidney function). Record review of the care plan, initiated 9/22/22, reflected Resident #1 asked for his medications early and chose to take how much of each medication regardless of what was prescribed. Interventions included Resident #1 was assessed for adverse effects. Pain assessment was updated to assess for breakthrough pain due to the resident requesting medication early. The pain management nurse practitioner to evaluate to ensure pain is managed. Record review of Resident #1's quarterly MDS Assessment 01/29/2024 reflected a BIMS score of 14, which indicated the resident was cognitively intact. Record review of Resident #1s' physician orders reflected an order for Icy Hot no mess 16% topical liquid PRN every 6 hours was effective 03/30/2024. There was no order for Icy Hot prior to 03/30/2024. (continued on next page)

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

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the witness statement made by LVN B reflected: On 3/22/24 towards the end of the shift resident reported to this nurse that the night shift CNA put Icy Hot on his buttocks. Resident did not complain of discomfort or pain. Completed a head-to-toe assessment on resident with no new skin issues noted. ADL care was performed along with another nurse. Changed residents brief and skin smelled like menthol at the time. Interview on 04/02/2024 at 2:15 PM with Resident #1 revealed during incontinence care Icy Hot cream was put on his bottom instead of barrier cream. Resident #1 stated he kept the Icy Hot in his drawer, and his wife would put it on his shoulder for pain. Resident #1 stated after Caregiver A put the cream on his bottom, it began to burn. He stated he asked her what she put on him, and she said it was Vaseline. He stated he informed her it was not Vaseline, and it was burning, but she did not remove the cream. Resident #1 stated he was later cleaned up by another nurse and the ADON and the Icy Hot was taken from his room. Resident #1 stated he went to dialysis at 4:07 AM and was not changed until around 1:15 PM. Resident #1 stated his bottom was burning for a short while; however, the burning did stop. Interview on 04/02/2024 at 3:30 PM with the DON revealed Resident #1 informed her Caregiver A put Icy Hot on his bottom on 03/22/2024. She stated the ADON went in and removed the Icy Hot from Resident #1's bottom drawer as soon as they were made aware that he had it. The DON stated Resident #1 stated he told Caregiver A to grease him up, and Caregiver A put Icy Hot on his back according to Caregiver A. The DON stated Resident #1 did not have an order for Icy Hot at the time; however, after the incident, an order was called in. The DON stated Caregiver A stated she was not aware she put Icy Hot on Resident #1 and did not verify what she was putting on him. The DON stated Caregiver A should not put Icy Hot on Resident #1 due to not being qualified to do so and a nurse would be required to apply Icy Hot should there have been an order. The DON stated the risk of Caregiver A applying the Icy Hot to Resident #1 would be there could have been and adverse reaction. The DON stated the resident was assessed and cleaned by LVN B who stated Resident #1 did smell like menthol and there was a greasy film on his bottom. The DON stated Resident #1 did not complain to her or the ADON about any pain or discomfort. The DON did not acknowledge a risk to the resident due to the greasy film not being cleaned off of him when he stated it was burning. Attempts to interview Caregiver A via phone were made on 04/02/2024 at 2:52 PM and 3:15 PM; however, the attempts were unsuccessful. Another attempt to contact Caregiver A after exit was made on 04/04/2024 at 11:00 AM; however, the attempt was unsuccessful. Interview 04/05/2024 at 3:00 PM with Caregiver a A via phone revealed Resident #1 asked her to grease him up and she picked up the Icy Hot and showed it to him to confirm and he agreed. Caregiver A stated typically all medication and creams would be left on the medication cart. Caregiver A stated she would not normally put Icy Hot on a resident however since it was in room she went a head and put it on for him. Caregiver A stated she had never put Icy Hot on Resident #1 in the past. Caregiver A stated Resident #1 did not complain to her of any pain or ask her to take the Icy Hot off.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45268 Based on interview and record review, the facility failed to provide pharmaceutical services (including procedures that assured the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. for one of five residents (Resident # 9) reviewed for pharmacy services. 1. The facility failed to ensure Resident #1 had an order for Icy Hot (a topical, over-the-counter pain reliever with active ingredients like menthol and wintergreen oil [methy salicyclate]) before Caregiver A administered it to Resident #1. 2. The facility failed to ensure Caregiver A was qualified to apply Icy Hot to Resident #1. These failures could place residents at risk for not receiving the appropriate care and services to maintain their health and safety. Findings included: Record review of Resident #1's electronic face sheet, printed 04/02/2024, reflected the resident was a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #1 had diagnoses which included but not limited to hypertension (high blood pressure) and end stage renal disease (permanent loss of kidney function). Record review of the care plan, initiated 09/22/2022, reflected Resident #1 asked for his medications early and chose to take how much of each medication regardless of what was prescribed. Intervention included Resident #1 assessed for adverse effects. Pain assessment updated to assess for breakthrough pain due to resident requesting medication early. Pain management nurse practitioner to evaluate to ensure pain is managed. Resident #1's care plan indicated Resident #1 was at risk for pressure ulcers and intervention included but not limited to barrrier cream use. Record review of Resident #1's quarterly MDS assessment dated [DATE] reflected a BIMS score of 14, which indicated the resident was cognitively intact. Record review of Resident #1s' physician orders reflected an order for Icy Hot no mess 16% topical liquid PRN every 6 hours was effective 03/30/2024. There was no order for Icy Hot prior to 03/30/2024. Interview on 04/02/2024 at 2:15 PM with Resident #1 revealed during incontinence care Icy Hot cream was put on his bottom instead of barrier cream. Resident #1 stated he kept the Icy Hot in his drawer and his wife would put it on his shoulder for pain. Resident #1 stated after Caregiver A put the cream on his bottom it began to burn and he asked her what she put on him and she said it was Vaseline; however, he informed her it was not Vaseline and it was burning, but she did not remove the cream. Resident #1 stated he was later cleaned up by another nurse and the ADON, and the Icy Hot was taken from his room. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 04/02/2024 at 3:30 PM with the DON revealed Resident #1 informed her Caregiver A put Icy Hot on his bottom on 3/22/2024. She stated the ADON went in and removed the Icy Hot from Resident #1's bottom drawer as soon as they were made aware he had it. The DON stated Resident #1 stated he told Caregiver A to grease him up, and Caregiver A put Icy Hot on his back according to Caregiver A. The DON stated Resident #1 did not have an order for Icy Hot at the time; however, after the incident, an order was called in. The DON stated Caregiver A stated she was not aware she put Icy Hot on Resident #1 and did not verify what she was putting on him. The DON stated Caregiver A should not put Icy Hot on Resident #1 due to not being qualified to do so, and a nurse would be required to apply Icy Hot should there have been an order. The DON stated the risk of Caregiver A applying the Icy Hot to Resident #1 would be there could have been an adverse reaction. The DON stated the resident was assessed and cleaned up by the ADON and LVN B who stated Resident #1 did smell like menthol and there was a greasy film on his bottom. The DON stated Resident #1 did not complain to her or the ADON about any pain or discomfort. Attempts to interview Caregiver A via phone were made on 04/02/2024 at 2:52 PM and 3:15 PM, however, the attempts were unsuccessful. Another attempt to contact Caregiver A after exit was made on 04/04/2024 at 11:00 AM, however, the attempt was unsuccessful. Interview 04/05/2024 at 3:00 PM with Caregiver a A via phone revealed Resident #1 asked her to grease him up, and she picked up the Icy Hot and showed it to him to confirm and he agreed. Caregiver A stated typically all medication and creams would be left on the medication cart. Caregiver A stated she would not normally put Icy Hot on a resident however since it was in room she went a head and put it on for him. Caregiver A stated she had never put Icy Hot on Resident #1 in the past. Caregiver A stated Resident #1 did not complain to her of any pain or ask her to take the Icy Hot off. Record review of the facility's policy Administering medication, revised April 2019, reflected Only a person licensed or permitted in this state to prepare, administer and document the administration of medication may do so.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45268 Based on interview and record review the facility failed to ensure, in accordance with State and Federal laws, all drugs and biologicals were stored in locked compartments under proper temperature controls, and permitted only authorized personnel to have access to the keys for one of four resident rooms (Resident #1) reviewed for storage of medications. The facility failed to ensure over-the-counter topical cream Icy Hot (a topical, over-the-counter pain reliever with active ingredients like menthol and wintergreen oil [methy salicyclate]) was properly stored in Resident#1's room. This failure could place residents at risk of medication misuse and diversion. Findings included: Record review of Resident #1's electronic face sheet, printed 04/02/2024, reflected a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #1 had diagnoses diagnosis which included but not limited to hypertension (high blood pressure) and end stage renal disease(permanent loss of kidney function) Record review of Resident #1's care plan dated 09/22/2022 did not reflect any information related to self-administering medications or supplements. Record review of Resident #1's quarterly MDS Assessment reflected a BIMS score of 14, which indicated the resident was cognitively intact. Interview on 04/02/2024 at 2:15 PM with Resident #1 revealed during incontinence care Icy Hot cream was put on his bottom by Caregiver A instead of barrier cream. Resident #1 stated he kept the Icy Hot in his drawer, and his wife would put it on his shoulder for pain. Resident #1 stated after Caregiver A put the cream on his bottom. it began to burn. He asked her what she put on him, and she said it was Vaseline. He stated he informed her it was not Vaseline, and it was burning; however, she did not remove the cream. Resident #1 stated the ADON removed the Icy Hot from his room following the incident. Resident #1 stated his wife had bought him the Icy Hot and would put it on his shoulder occasionally. Resident #1 stated the Icy Hot had been in his drawer for while; however, staff never used it. (continued on next page)

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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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 04/02/2024 at 3:30 PM with the DON revealed Resident #1 informed her Caregiver A put Icy hot on his bottom on 03/22/2024. She stated the ADON went in and removed the Icy Hot from Resident #1's bottom drawer as soon as they were made aware that he had it. The DON stated Resident #1 stated he told Caregiver A to grease him up and Caregiver A put Icy hot on his back according to Caregiver A. The DON stated Resident #1 did not have an order for Icy hot at the time; however, after the incident, an order was called in. The DON stated Caregiver A stated she was not aware she had put Icy Hot on Resident #1 and did not verify what she was putting on him. The DON stated Caregiver A should not put Icy Hot on the resident and a nurse would be required to apply Icy Hot should there have been an order. The DON stated if there was an order for the Icy Hot it would have been kept on the medication cart. The DON stated there was a risk that the medication was not properly stored; however, Resident #1 was not able to access the medication by himself. Therefore, the DON stated she did not feel there was a risk. Attempts to interview Caregiver A via phone were made on 04/20/2024 at 2:52 PM and 3:15 PM; however, the attempts were unsuccessful. Another attempt to contact Caregiver A after exit was made on 04/04/2024 at 11:00 AM; however, the attempt was unsuccessful. Interview on 04/05/2024 at 3:00 PM with Caregiver A via phone revealed Resident #1 asked her to grease him up, so she picked up the Icy Hot. She showed it to him to confirm, and he agreed. Caregiver A stated typically all medication and creams would be left on the medication cart. Caregiver A stated she would not normally put Icy Hot on a resident; however, since it was in room, she went ahead and put it on for him. Caregiver A stated she had never put Icy Hot on Resident #1 in the past. Caregiver A stated Resident #1 did not complain to her of any pain or ask her to take the Icy Hot off. Record review of the facility's policy Administering Medication, revised April 2019, reflected: During administration of medications, the medication cart is kept closed and locked when out of sight of the medication nurse or aide. It may be kept in the doorway of the resident's room, with open drawers facing inward and all other sides closed. No medications are kept on top of the cart. The cart must be clearly visible to the personnel administering medications, and all outward sides must be inaccessible to residents or others passing by.