

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675418	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/29/2025
NAME OF PROVIDER OR SUPPLIER The Manor at Seagoville		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45268</p> <p>Based on interview and record review the facility failed to immediately inform the resident, consult with the resident's physician, and notify, consistent with his or her authority, the resident representative when there was significant change in the resident's physical, mental, or psychosocial status for one of four residents (Resident #2) reviewed for notification of changes.</p> <p>LVN C failed to notify the responsible party/resident representative when Resident #2 was transferred to the hospital due to change in condition.</p> <p>This failure could place residents at risk of not having their responsible parties notified of changes in their condition and deny them the right to participate in the care and treatment of the resident.</p> <p>The noncompliance was identified as past none compliance (PNC). The noncompliance began on 12/10/2024 and ended on 12/11/2024. The facility had corrected the noncompliance before the investigation began.</p> <p>Findings included:</p> <p>Review of facility electronic face sheet printed 01/29/2025, for Resident #2 revealed he was a [AGE] year-old male admitted to the facility on [DATE] with diagnosis that include but not limited to cerebral infarction (stroke), depression and anxiety disorder. Review of the of the responsible party's section had Resident#2's family listed and relationship type as all responsibilities.</p> <p>Review of Resident #2's admission MDS, dated [DATE], reflected a BIMS score of 02 indicating severe cognitive impairment. Review of section I titled active diagnosis indicated anxiety and depression.</p> <p>Review of Resident #2's care plan effective 11/26/2024 revealed Resident #2 was receiving antianxiety drugs on a regular basis. Ativan with interventions that included monitor for side effects of medication (drowsiness, loss of coordination, fatigue, mental slowness, confusion, constipation). Notify physician if side effects noted. Resident #2 was receiving antipsychotic drugs on a regular basis. Seroquel with intervention that included provide medication as ordered.</p> <p>(continued on next page)</p>

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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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident #2's nurses note dated 12/10/2024 written by LVN C revealed LVN C assessed Resident #2 and found thick secretion, oxygen was 74% on 4 liters, breathing labors, resident unable to be aroused . Resident sent to emergency room .Resident own responsible party; no other family listed in chart.</p> <p>Review of the facility grievance log dated 12/01/2024-12/29/2025 revealed a grievance filed by Resident #2's family member on 12/10/2024 stated the family member was upset that she was not notified of the resident transfer to the hospital. The facility follow up by the Clinical Director revealed [Clinical director talked with [Family Member] was upset and stated the facility usually calls her for everything but not this. [Clinical Director] apologized and let her know that we would educate the nurse that did not call her .</p> <p>Attempted call to LVN C on 1/29/2025 at 1:41PM was unsuccessful.</p> <p>Interview on 01/29/2025 at 1:45 PM with the Clinical Director revealed she spoke with Resident #2's family member who was upset about not being notified that Resident #2 was sent to the hospital. The Clinical Director stated Resident #2's family member is the responsible party for Resident #2 and should have been notified. The Clinical Director stated LVN C informed her that she forgot to inform the family member about the transfer because she got busy. The Clinical Director stated the facility in-serviced staff on notify responsible parties. The Clinical Director stated there would not be a risk to the resident however the responsible party should have been notified.</p> <p>Interview on 1/29/2025 at 4:05PM with the Administrator revealed she was not working in the facility at the time of the nurse not notifying the family member however the staff member went PRN following the incident and never picked up any shifts. The administrator stated resident responsible parties should be notified if the resident was sent out or had a change in condition. The Administrator stated the risk of not notifying responsible parties would be they would not know what was going on with the resident or where they were located.</p> <p>Review of the facility policy Change in a Resident's condition or change in status revised February 2021, Unless otherwise instructed by the resident, a nurse will notify the resident's representative when:</p> <ol style="list-style-type: none"> a. the resident is involved in any accident or incident that results in an injury including injuries of an unknown source; b. there is a significant change in the resident's physical, mental, or psychosocial status; c. there is a need to change the resident's room assignment; d. a decision has been made to discharge the resident from the facility; and/or e. it is necessary to transfer the resident to a hospital/treatment center <p>(continued on next page)</p>		

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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The noncompliance was identified as past none compliance (PNC). The noncompliance began on 12/10/2024 and ended on 12/11/2024. The facility had corrected the noncompliance before the investigation began.</p> <p>The facility too the following actions to correct the noncompliance prior to investigation:</p> <p>Review of in-service completed with all staff 12/12/2024 on abuse and neglect.</p> <p>Review of in-service completed with all staff 12/03/2024 on notification of resident arrival to facility, death, change in condition.</p> <p>Review of verbal in- services with LVN C on 12/11/2024 regarding notification of resident arrival to facility, death and change in condition.</p> <p>Review of employee abuse of investigation questionnaire completed 12/12/2024</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45268</p> <p>Based on observation, interview, and record review the facility failed to ensure each resident will have a person-centered comprehensive care plan developed and implemented to meet his or her preferences and goals, and address the resident's medical, physical, mental and psychosocial needs for</p> <p>one of five residents (Resident #1) reviewed for care plans.</p> <p>The facility failed to include the intervention/implementation of lowering the bed related to resident falls--develop/implement an intervention.</p> <p>This failure could place residents at risk for receiving delayed treatment and not obtaining/maintaining their highest practicable wellbeing.</p> <p>Findings include:</p> <p>Record review of Resident #1's face sheet, printed 01/29/2025, reflected a [AGE] year-old female admitted to the facility on [DATE] with diagnosis that include but not limited to acute cystitis without hematuria (infection of the bladder that arises suddenly), dysphagia (swallowing disorder), high blood pressure.</p> <p>Record review of Resident #1's quarterly MDS assessment dated [DATE] reflected a BIMS score of 03 out of 14 which indicated severely impaired cognition. Review of section GG function abilities revealed chair to bed transfer which was the ability to transfer from a bed to a chair or wheelchair required the helper to do all the effort, resident did none of the effort to complete the activity or assistance of 2 or more helpers was needed. Further review revealed sit to stand which as the ability to come to a standing position from lying back to sitting on the side of the bed with no back support required moderate to partial assistance in which the helper did less than half the effort and held the truck or limbs but provided less than half the effort.</p> <p>Review of Resident #1's care plan dated effective 08/29/2024 revealed Resident #1 has potential risk for injury due to unsafe independent transfers as identified by the nursing / rehab assessment. Encourage [Resident #1] to do all self-care activities as able with regard to bed mobility, encourage [Resident #1] to perform bowel and bladder activities with respect to bed mobility impairments. Based needs and physician orders, raise HOB to ___ degrees. Assist [Resident#1to set as upright in bed as possible during medication administration and meals.</p> <p>STATUS: Active (Current)</p> <p>Assist to set as uprights in bed as possible and then dangle knees on side of bed, STATUS: Active (Current)Floor mats as indicated</p> <p>STATUS: Active (Current) Bed in lowest positions as indicated. STATUS: Active (Current)</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Observation on 01/29/2025 at 3:09PM of Resident #1 in bed sleeping. The bed was not in the lowest position a fall mat was on the floor.</p> <p>Interview on 01/29//2025 at 4:05 PM with the Director of Nursing revealed Resident #1 was able to transfer herself in and out of bed. Resident #1's bed should be in the lowest position when she is in bed for the night. The Director of Nursing stated Resident #1 liked to get in and out of bed during the day and was good about using the call light however she did have a fall recently (1/22/2025). The Director of nursing stated the care plan should have been modified to indicate Resident#1 individual need to have the bed lowered during night only by the interdisciplinary team. The Director of Nursing stated staff were aware of resident needs by looking at the care plan which should accurately reflect resident care.</p> <p>Interview on 1/29/2025 at 4:10PM with CNA A wo was assigned to Resident #1 revealed for Resident#1 the bed was lowered in the past however recently staff have been keeping the bed raised to allow Resident#1 to transfer herself. CNA A stated she reviewed the care plan when beds were needed to be lowered or not.</p> <p>Interview on 1/29/2025 at 4:30PM with the MDS Coordinator revealed the IDT team was responsible for discussing and updating care plans. The MDS Coordinator stated she was not sure how long Resident #1 had been able to transfer herself. The MDS Coordinator stated she would have therapy to evaluate the resident and update the care plan today. The MDS Coordinator stated the risk of not ensuring care plan were updated would be the resident not getting care specialized to their needs.</p> <p>Review of the facility policy Care plan- Comprehensive revised September 2010 revealed .Assessments of residents are ongoing and care plans are revised as information about the resident and the resident's condition change. The Care Planning/Interdisciplinary Team is responsible for the review and updating of care plans :When there has been a significant change in the resident's condition; When the desired outcome is not met ;When the resident has been readmitted to the facility from a hospital stay; and At least quarterly.</p> <p>continues on next page The resident has the right to refuse to participate in the development of his/her care plan and medical and nursing treatments. When such refusals are made, appropriate documentation will be entered into the resident's clinical records in accordance with established policies</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45268</p> <p>Based on observation, interview and record review, the facility failed to store all drugs and biologicals in locked compartments for one (treatment cart #1) of 2 carts reviewed for storage of drugs and biologicals.</p> <p>The facility failed to lock treatment cart# 1 while in a resident room.</p> <p>These failures could affect residents at risk of drug diversion or misuse of medications.</p> <p>Findings included:</p> <p>Observation on 01/29/2025 at 2:39 PM revealed treatment cart# 1 was unlocked and unattended while LVN B was in a resident room for an undetermined amount of time. The drawers on the treatment cart #1 was able to be pulled open and contained prescribed tropical ointments and sterile supplies.</p> <p>Interview on 1/29/2025 at 2:40PM revealed LVN B stated she had worked in the facility for [AGE] years. LVN B stated she was aware that the treatment cart should have been locked however she stated she forgot. LVN B stated the risk of leaving the cart unlocked would be residents could have access to ointments and ingest them.</p> <p>Interview on 1/29/2025 at 4:05PM with Administrator revealed treatment carts should have been locked when not in sight of staff. The Administrator stated the risk of not locking the treatment cart would that that residents would have access to treatment creams and supplies.</p> <p>Review of the facility policy Administering Medication revised April 2019 revealed 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</p>