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	04/30/2025

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 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** 32581 Based on interviews and record reviews the facility failed to in accordance with the accepted professional standards and practices, the facility must maintain medical records for each resident for one resident (Resident #1) of 6 residents reviewed for Medical Records. The facility failed to ensure RN A documented giving Resident #1 all of his Physician ordered medications and treatments during her assigned double shift on Sunday 04/27/25; subsequently there was no documentation for most of the care provided to Resident #1 on 04/27/25 between 6:00 am and 10:00 pm. This failure could affect residents by placing them at risk of experiencing a change in their medical condition which could cause a decline in their health and psycho-social well-being. Findings included: Record review of Resident #1's Quarterly MDS assessment dated [DATE] revealed a [AGE] year-old male who admitted [DATE] with a Staff assessment for mental status score of 03 (Severely Impaired). He was dependent (Helper did all of the effort) for all ADL's including rolling from right to left. He was always incontinent to bowel and bladder. His diagnoses were hypertension, neurogenic bladder, diabetes mellitus, hyperlipidemia, non-Alzheimer's Disease, Parkinson's, respiratory failure, anoxic brain damage, Gastronomy status and right eye blindness. He had trouble breathing when lying flat, at risk of developing pressure ulcers and had MASD (moisture associated skin damage) and needed application ointments on his skin. And he had a G-tube. Record review of Resident #1's Care plan dated 04/11/25 revealed, altered respiratory status/difficulty breathing, ADL self-care performance deficit, bladder incontinence, oxygen therapy related to stoma, anticoagulant therapy, bowel incontinence, dehydration or potential fluid deficit, alteration in neurological status, tracheostomy related to impaired anoxic brain injury, altered cardiovascular disease, swallowing problem related to altered airway (stoma) and 03/18/25 pressure ulcer prevention. (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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #1's Physician Orders dated 04/30/25 revealed, ASPIRATION PRECAUTIONS every 4 hours MONITOR FOR S&S OF ASPIRATION AND ALERT MD AS APPROPRIATE. Nebulizer: Assess prior to administering Nebulizer Treatment four times a day Document Lung Sounds. Nebulizer: Clean Mask and Rinse Chamber every day and evening shift After each use, wipe nebulizer mask with a clean damp cloth. Rinse nebulizer chamber with warm tap water and allow to air dry. Nursing Intervention: Turn and Reposition every 2 hours every shift Oxygen: Oxygen at 2 L per MIN VIA TRACH COLLAR as needed MONITOR OXYGEN SATURATION ON ROOM AIR, IF OXYGEN SAT LESS THAN 90% PLACE BACK ON OXYGEN, Pain Monitoring - Assess for pain every shift Preventative Treatment - Barrier Cream every day shift Apply Barrier Cream to (abdomen) for preventative treatment, Proactive Health Check: Obtain and record temperature and PSO2 [sic]. Evaluate the resident for presence of any of the following signs or symptoms. Document presence of S/S (Y/N): Abdominal Pain Chills or Repeated shaking with chills Cough Diarrhea or other GI upset Headache Loss of Smell Loss of Taste Muscle Pain Nausea Red shadowed eyes or pink eyes SOB Sore Throat Tingling sensation of face or hands every day shift, Trach - Tracheobronchial Suctioning - Suction every 3 hours as needed Notify MD if more frequent suctioning required. May use 3cc NS for lavage when suctioning AND six times a day May use 3cc NS for Lavage when suctioning, Trach Care -STOMA CARE every shift CHECK STOMA SITE FOR SIGNS AND SYMPTOMS OF INFECTION ; CHECK STOMASITE FOR ANY SKIN INTEGRITY ISSUES (CRACKING; DRYNESS); CLEANSE STOMA AND SURROUNDING AREA WITH NORMAL SALINE AND LEAVE OPEN TO AIR. Treach [sic] - Tracheostomy Care every shift, Vital Signs every shift, Wound Treatment - Barrier Cream every shift Cleanse _____BUTTOCKS_____ with Normal Saline or Skin Cleanser. Pat Dry. Apply Barrier Cream. Leave open to air. Wound Treatment - Dry Dressing every 6 hours Clean gtube stoma with mild soap and water. May use gauze and Q-Tip to help clean the area. Dry area apply DESITIN or BUTT paste and place a new piece of gauze. Record review of Resident #1's April 2025 MARS revealed no initials were documented by his nurse for, Dayshift: Trach care - Stoma care every shift check stoma site for signs and symptoms of infection, check stoma site for any skin integrity issues, tracheostomy care every shift, wound Treatment: Barrier cream every shift cleanse buttocks with normal saline or skin cleanser. Pat dry apply barrier cream, leave open to air. And at 11:00 am: Nebulizer: Assess after administering nebulizer treatment four times a day, document lung sounds and Aspiration precautions: every 4 hours monitor for signs and symptoms of aspiration and alert MD as appropriate, Ipratropium-Albuterol Solution 0.5-2.5 mg/ml 1 vial inhale orally four times a day for respiratory failure. Record review of Resident #1's TARS revealed no initials were documented by his nurse for, Barrier cream every day shift apply barrier cream to abdomen. For Dayshift: check preventative treatment: barrier cream every dayshift. Apply barrier cream to (abdomen) for preventative treatment. Proactive health check: obtain and record temperature and SPO2. Evaluate the resident for presence of any of the following symptoms ., Dayshift: Clean mask and rinse chamber, turn and reposition every 2 hours, Obtain SP02, vital signs checked, tracheobronchial suctioning six times a day may use 3 cc NS for lavage when suctioning. Pain management, communications problem related to anoxic brain injury. Record review of Resident #1's Nurse Progress note dated 04/27/25 written by RN A or any other nurses did not reveal documentation about the resident's care and medication was administered on this date. Observation on 04/29/25 at 12:34 pm revealed Resident #1 was not interviewable and he had a small size hole in his throat (size of a pencil eraser), he was lying in bed at a 30 degree angle and he did not have any signs or symptoms of distress. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 04/30/25 at 2:11 pm, the FM stated RN A used to be a good nurse but over this past weekend (04/27/25), she noticed Resident #1 needed to be suctioned when she came to visit. She stated RN A told her he had already been suctioned but it did not appear that way to her. Interview on 04/30/25 at 2:01 pm, LVN E stated Resident #1 was a total care patient and he used to have a trachea (windpipe in the throat for airway exchange) when he first admitted , his Doctor discontinued the trachea and it was taken out. She stated he still had the hole in his throat they had to still provide care and treatment to and he also received G-tube nourishment. Interview on 04/30/25 at 4:30 pm, MDS B stated to her knowledge they had no issues with administering and documenting of the resident's TARs and MARs. Interview on 04/30/25 at 4:57 pm, the DON stated she was not sure of any missed resident's treatments or medications. She stated she knew the new EMR system was a little wonky (not working properly) and the nurses had issues logging into it and would follow up with the HHSC (Health and Human Services) Investigator after she reviewed Resident #1's EMR. Interview on 04/30/25 at 5:49 pm, the Administrator stated the FM complained about Resident #1 not being suctioned properly in the past and thought it had been resolved. She stated the FM said Resident #1 was not suctioned over this past weekend (04/26/25 and 04/27/25) and she was not told about it until 04/30/25. She stated she asked the FM why did they not report their concern to her sooner. She stated she planned on talking to Weekend Supervisor C. She stated she was not aware of any issues with the nurses not documenting after they administered Resident #1's medications and treatments. Interview on 04/30/25 at 6:26 pm, the DON stated after review she saw that RN A worked the 6:00 am to 10:00 pm shift on 04/27/25. She stated she asked RN A why she did not document giving Resident #1 medications and care. She stated RN A said she worked all day and that there must have been a computer glitch. The DON stated she saw some parts of Resident #1's MARs/TARs RN A documented on giving his medications and treatments but not for all of them. She stated she could see RN A did not document applying barrier cream to Resident #1 and other tasks. She stated she asked RN A had she not toggled back and forth and said she believed RN A did Resident #1's care but did not document what she did. She stated RN A kept saying they must have had a glitch but in the EMR system the treatments were in red to show they were not documented on. She stated she saw where RN A documented on 04/27/25 in some sections and asked her did she go back to check her initials were saved. She stated RN A really did not have a lot of explaining left as to what happened other than that. She stated the nursing staff were trained on the facility's new EMR system and she was not aware of this issue with the nurses. She stated she would start doing audits of the resident's records to see if there were any other issues. She stated the Weekend Supervisor C usually reviewed the nurses documentation but she worked a hall this past weekend because a nurse called out and may not have done the audit checks by checking dashboard and orders. She stated Weekend Supervisor C was new to their new EMR system and may have not known how to access the dashboard to do the audits. She stated she was not making excuses for the nurses but they planned to do 1:1 training with RN A and Weekend Supervisor C on medication and administration documentation. She stated if the resident's documentation were not in the system it could appear that the tasks was not completed. She stated if the MARs/TARs records were not initialed for completion, it could cause the resident to have a change of condition and all types of things could happen. She stated it was possible the resident could develop shortness of breath and their vitals could be off. She stated they were going to also do Medication administration and documentation trainings with all staff. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 04/30/25 at 6:40 pm, RN A stated she worked last Sunday 04/27/25 between two halls and she provided all of Resident #1's care. She stated for Resident #1 she suctioned, did his oral care and nebulizer treatments. She stated in the afternoon time the FM visited Resident #1 and did not say anything to her about any concerns. She stated the DON called her not too long ago today 04/30/25 about the EMR system being in red that she did not sign off on providing care to Resident #1. She stated from her standpoint on 04/27/25, the EMR system did not process her initials even though she thought everything was signed off. She stated not documenting care given could cause a delay in care and create complications with the resident. She stated she could not really say what complications could happen to a resident if the documentation was not done to confirm giving resident's their medications and treatments. She stated this issue must have been a technical problem and added if the documentation was not there, she did not know what that meant in nursing terms. She stated it did not make since the EMR system did not turn green after she initialed completing Resident #1's tasks. She stated again this must have been a technical issue but she should have made sure she triple checked what she entered into the EMR to ensure the information was in there. She stated she had not had any training on how to use the facility's new EMR system and felt comfortable using it enough to get going. She stated she was not an expert with navigating the facility's new EMR system and planned to do triple checks when moving from the old EMR system to the new one and with ensuring the information was saved. Interview on 04/30/25 at 7:12 pm, the Weekend Supervisor C stated she was not aware Resident #1's documentation was not completed. She stated she was not sure when but at some time during the day 04/27/25, she went to talk to RN A who was in Resident #1's room providing care at his bedside. She stated RN A usually did all of his care at the same time and believed she saw her in Resident #1's room earlier during the morning time. She stated she saw and spoke to the FM about Resident #1's treatments and the FM did not report any issues to her. She stated she did not check to see if Resident #1's MARs/TARs had been signed off on 04/27/25 or had any issues. She stated she checked in on Resident #1 also and he did not require suctioning and appeared he had been suctioned when she checked him around midday. She stated nurse management educated the staff on how to sign off on the resident's MARs and TARs. She stated she did all sorts of audits like admissions and nurse documentation and that the charge nurses were responsible for resident charting. She stated she was not aware RN A did not document what she did for Resident #1 on 04/27/25 until today 04/30/25 by the DON. She stated not documenting what medication and care had no effect on the patient as long as the resident received the care by making rounds and checking the residents. She stated as long as the nurse gave a full report to the oncoming nurse it would not affect the residents. She stated it depended on the situation on how it could affect the residents, when not documenting the administration of their medications and treatments. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 04/30/25 at 7:20 pm, the Administrator stated she was not aware on 04/27/25 RN A did not document the care she provided Resident #1 until now (04/30/25). She stated they planned to have more EMR trainings since the facility had a new EMR system. She stated they were going to do a 1:1 EMR training with Weekend Supervisor C to ensure she was educated. She stated they wanted to see if Weekend Supervisor C had any questions on how to review the nurse's documentation and resident vitals on her checklist of things to do. She stated they were going to do a 1:1 training with RN A and added they just started trainings with all of their nursing staff about documentation and medication administration. She stated the nurses providing care to the residents was responsible for their documentation. She stated ultimately it was the DON, Administrator, and Weekend Supervisor C were responsible for ensuring the nurses documentation was accurate to ensure the residents received services. She stated nurse management had IDT meetings Monday - Friday and they went over things happening in building. She stated in the IDT meetings they looked at the previous day's activity and reviewed the entire EMR dashboard, including the MARs and TARs. She stated when resident's MARs and TARs was incomplete depended on what was going on. She stated she believed what happened was RN A did not sign on to the new EMR system when she switched from the old EMR system to the new one. She stated not documenting resident care performed could appear that the treatment or medications was not provided. She stated if the documentation was not completed there was no proof it was done. She stated the nurses needed to sign off and back on when they switch to the new EMR system. She stated LVN D worked the 500 hall where Resident #1 resided, but the FM did not want LVN D providing care to Resident #1 so RN A came from the 600 hall to provide his care. Record review of the facility's Charting and Documentation policy revised July 2017 revealed, Policy Statement All services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional, or psychosocial condition, shall be documented in the resident's medical record. The medical record should facilitate communication 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 observations; b. Medications administered; c. Treatments or services performed; d. Changes in the resident's condition; e. Events, incidents or accidents involving the resident; and f. Progress toward or changes in the care plan goals and objectives. 3. Documentation in the medical record will be objective (not opinionated or speculative), complete, and accurate. 4. Entries may only be recorded in the resident's clinical record by licensed personnel (e.g., RN, LPN/LVN, physicians, therapists, etc.) in accordance with state law and facility policy. Certified nursing assistants may only make entries in the resident's medical chart as permitted by facility policy. 7. Documentation of procedures and treatments will include care-specific details, including: a. the date and time the procedure/treatment was provided; b. the name and title of the individual(s) who provided the care; c. the assessment data and/or any unusual findings obtained during the procedure/treatment; d. how the resident tolerated the procedure/treatment; e. whether the resident refused the procedure/treatment; f. notification of family, physician, or other staff, if indicated; and g. the signature and title of the individual documenting. Record review of the facility's Administering Medications Policy revised April 2019 revealed, Policy heading Medications are administered in a safe and timely manner, and as prescribed.4. Medications are administered in accordance with prescriber orders, including any required time frame. 22. The individual administering the medication initials the resident's MAR on the appropriate line after giving each medication and before administering the next ones. 2324. Topical medications used in treatments are recorded on the resident's treatment record (TAR).