STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675439	A. Building B. Wing	04/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mullican Care Center	105 N Main St Savoy, TX 75479

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 - 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. 45810 Based on observation, interview, and record review, the facility failed to provide a safe, functional, sanitary, and comfortable environment for residents, staff, and the public, for 1 of 5 halls (C hall) reviewed for physical environment. The facility failed to ensure the flooring on the C hall was free from trip hazards. This failure could place residents who reside in the facility at-risk of falls and further injuries due to an unsafe environment. The findings were: During an Observation on 04/09/24 at 3:05 PM the flooring on the C hall was raised and split across the hallway. During an Observation and interview on 04/10/24 at 05:07 PM The ADON was shown the place on the floor that was raised, and she said she did not realize it had gotten worse. The ADON said she was not responsible for the floor but said she would notify the correct person to ensure it was addressed. She said the failure placed a risk for residents falling. During an observation and interview on 04/10/24 at 05:35 PM The DON She said she could see potential for someone to fall. The DON said she was not aware of the floor but would notify the maintenance director. During an observation and interview with the Maintenance Director on 04/10/24 at 05:50 PM he stated the floor had a raised split area that was spread across the entire hallway. The Maintenance director said the floor has been shaved 3 times since 2009 and he did not realize the floor had gotten as bad as it was. He said the failure could have been a risk for falls for residents and staff. The Maintenance Director said he was responsible for ensuring the floors were safe but regional maintenance would be responsible for ensuring the floor was fixed because the facility would be going through remodeling soon. The Maintenance Director said at that time he was going to mark the floor so that residents and staff were aware until the floor was fixed. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675439	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/10/2024
NAME OF PROVIDER OR SUPPLIER: Mullican Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 105 N Main St, Savoy, TX 75479	

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 04/10/24 at 06:10 PM The Administrator said he was not aware that the floor was raised but was notified on 04/10/24. He said floor was a risk for falling and he would make it a priority. He said he would have the maintenance man to highlight the raised area with yellow tape to ensure it is noticed to prevent falls. During an interview on 04/10/24 at 6:55 PM the administrator stated the facility did not have a policy for environment or homelike environment.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45879 Based on observation, interview, and record review the facility failed to ensure assessments accurately reflected the resident status for 3 of 12 residents (Resident # 17, Resident #4, Resident 11) reviewed for MDS assessment accuracy. The facility failed to ensure Resident # 17's, Resident #4's, and Resident #11's, restraints were accurately coded. These failures could place residents at risk of not receiving care and services to meet their needs. Findings included: 1.Record review of Resident #17's face sheet, dated 03/10/24 indicated Resident #17 was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses which included seizures, Bipolar (a mental illness that causes unusual shifts in a person's mood, and energy), Schizophrenia (severe mental disorder can result in hallucinations, delusions, and extremely disordered thinking disorder), and generalized anxiety (a feeling of fear, dread, and uneasiness). Record review of Resident #17's quarterly MDS assessment, dated 02/05/24, indicated Resident #17 was usually understood and sometimes understood by others. Resident #17's BIMs score was 15, which indicated he was cognitively intact. Resident #17 required extensive assistance with toileting, personal hygiene, transfer, and bathing. The MDS indicated he used bed rails daily as a restraint during the 7-day look-back assessment period. Record review of Resident #17's physician's orders dated 01/04/24 indicated the resident may use a U-shaped grab bar/rail on the bed for repositioning and transfers to the Wheelchair related to his stroke. Record review of Resident #17's comprehensive care plan, dated 10/19/23 Resident #17 used bed rails to assist with ADLs. The care plan interventions were grab/assist bar to be used, resident used a rail on the right side of the bed. During an observation on 04/09/24 at 4:09 p.m., Resident #17 used his grab bars on his right side to transfer with MA F to his chair. 45810 2. Record review of Resident #4's face sheet date 04/10/24 indicated he was a [AGE] year-old male who admitted to the facility on [DATE] with the diagnoses epilepsy (a disorder in which nerve cell activity in the brain is disturbed causing seizures), dementia, high blood pressure, and heart failure. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #4's annual MDS dated [DATE] indicate he had a BIMS score of 13, which indicated he was cognitively intact. Resident #4 required supervision or touching assistance with toileting, personal hygiene, transfer, and bathing. The MDS indicated he used bed rails daily as a restraint during the 7-day look-back assessment period. Record review of Resident #4's order summary report date 04/10/24 did not indicated resident had an order for side rails. Record review of Resident #4's care plan indicated his care plan did not include side rail use. During an observation on 04/10/24 at 10:00 AM Resident #4 did not have side rails on his bed. 47612 3. Record review of the face sheet, revised 04/10/2024, indicated Resident # 11 was a [AGE] year-old male who admitted to the facility on [DATE] with diagnoses of complete traumatic amputation at knee level unspecified lower leg (loss of a body part, that occurs as the result of an accident or injury), muscle wasting and atrophy, multiple sites (decrease in size and wasting of muscle tissue), abnormal posture (rigid body movements and chronic abnormal positions of the body). Record review of the comprehensive MDS assessment dated [DATE], indicated Resident #11 had unclear speech but was usually understood by others. Record review of the MDS assessment indicated Resident #11 had a BIMS score of 12, which indicated moderate cognitive impairment. The MDS assessment indicated Resident #11 needed partial/ moderate assistance with all ADLs. The MDS assessment indicated the use of bed rails. Record review of the care plan dated 04/08/2024, indicated Resident #11 used bed rails to assist with ADL's. The care plan goal was for the resident to maintain or improve independence with ADL's and not be injured related to bed rail use. The care plan interventions were grab/assist bar to be used, resident used a rail on the left side of the bed. Record review of the order summary dated 04/10/2024, indicated Resident #11 may utilize bed rail for repositioning. During an observation on 04/09/2024 at 10:00 a.m., Resident #11 transferred himself from the bed to his wheelchair using the grab bar. During an interview on 04/10/24 at 4:12 p.m., the MDS nurse said she was responsible for the completion of the MDS assessments. She looked at section P on Resident # 17, Resident #11, and Resident #4 and said she coded them incorrectly. She said they use assist bars, and they were not being used as restraints. She said it was a misunderstanding of the meaning of restraints when she did those assessments. She said it was important to code the MDS assessment correctly because it reflected their care. She said she would update their assessments and resend them to the state. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 04/10/2024 at 4:31 p.m. the ADON stated they were a restraint free facility. The ADON stated MDS Coordinator was responsible for completing the MDS assessments. The ADON stated she did not know why the MDS indicated Resident # 11 had a restraint. The ADON stated it was important for the MDS assessments to be accurately coded to make sure they could provide the residents the care they needed. The ADON stated there was no harm, he used the grab bar to pick himself up and move around. The grab bar was not a restraint. The resident asked for the grab bar. During an interview on 04/10/2024 at 5:20 p.m. the DON stated that it was a mistake in the MDS coding. The DON stated MDS Coordinator was responsible for completing the MDS assessments. The DON stated the MDS assessment was important to ensure the care was going right, and the bill was correct as well. The DON stated there was no harm to the resident because they are a restraint free facility. The DON stated she Believes this was a mistake that the MDS coordinator just looked at the question wrong. The DON stated she would monitor through the interdisciplinary team meeting. During an interview on 04/10/2024 at 5:54 p.m. the Administrator stated Resident #11 had a grab bar so he can ambulate the way he wants. The Administrator stated expected for the coding on the MDS assessments to be accurate, however something must have triggered wrong. The Administrator stated the MDS Coordinator was responsible for completing the MDS assessments. The Administrator stated he would put a system in place to review the way the MDS coordinator was coding and educate her on what was and wasn't a restraint. The Administrator stated there was no harm to the resident as far as an inaccurate MDS. Record review of the Resident Assessment Instrument nursing policy and procedure manual 2023, the facility will examine each resident and review the minimum data set expanded core elements specified in RAI no less than once every three months and as appropriate. Results must be recorded to assure continued accuracy of the assessment

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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** 45879 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 for 1 of 3 residents (Resident #17) whose records were reviewed for mental disorders. The facility failed to refer Resident #17 for a PASARR evaluation based on mental disorder diagnoses of Psychosis. This deficient practice could affect residents with mental illness and contribute to a delay in services needed. The findings included: Record review of Resident #17's face sheet, dated 03/10/24 indicated Resident #17 was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses which included seizures, Bipolar (a mental illness that causes unusual shifts in a person's mood, and energy), Schizophrenia (severe mental disorder can result in hallucinations, delusions, and extremely disordered thinking disorder), and generalized anxiety (a feeling of fear, dread, and uneasiness). Record review of Resident #17's quarterly MDS assessment, dated 02/05/24, indicated Resident #17 was usually understood and sometimes understood by others. Resident #17's BIMs score was 15, which indicated he was cognitively intact. Resident #17 required extensive assistance with toileting, personal hygiene, transfer, and bathing. The MDS indicated he had a diagnosis of Schizophrenia and bipolar. Record review of Resident #17's physician's orders dated 07/03/23 indicated, Quetiapine Fumarate Tablet 250 MG Give 1 tablet by mouth two times a day related to schizoaffective disorder, bipolar. Record review of Resident #17's comprehensive care plan, dated 03/09/24 indicated Resident #17 required anti-psychotic medications for schizoaffective disorder. The interventions were to give medication as ordered. Record review of Resident #17's PASRR Level 1 screening completed on 5/22/23 did not reflect Resident #17 had a diagnosis of Psychosis or an indicator that Resident #17 had a mental illness. During an interview on 04/10/24 at 4:12 p.m., the MDS nurse stated when she started at this facility as the MDS nurse she did not have a lot of knowledge on PASARRs. She said she would call her regional nurse and see what she needed to do for Resident #17s PASARR. During an interview on 04/10/24 at 5:57 p.m., the MDS nurse said she had called her regional nurse and she explained the process. She looked at Resident #17 chart and said he had a diagnosis of Psychosis which should trigger a referral for PASARR evaluation. She said she had filled out the 1012 form (Mental Illness/Dementia Resident Review) and the physician had signed it. She said she would get the form submitted for review to the local authority. (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 04/10/24 at 6:00 p.m., The Administrator said the MDS nurse was responsible to complete the level 2 if needed. He said a level 2 was done to determine to see if they could benefit from any services offered. He said if the PASRR Level 1 had a discrepancy it should have been corrected. He said a resident could lose on receiving services if the PASRR was not completed correctly. During an interview on 04/10/24 at 6:04 p.m., the DON said the MDS nurses were responsible for the PASRR and she was not sure when a 1012 form was needed. She said Resident #17 did have a diagnosis of schizophrenia and bipolar which was considered a mental illness. Review of a facility policy, titled, PASRR Level 1 Screen Policy and Procedure, dated 03/06/19, indicated, Policy: It is the policy of Creative Solutions in Healthcare facilities to obtain a PL1 screening form from the RE (referring entity) prior to admission to the NF. The PL1 will be submitted via Simple LTC timely per PASRR Regulatory timeframes. PASRR is a federally mandated program requiring all states to pre-screen all individuals seeking admission to a Medicaid-certified nursing facility, regardless of payor source or age. The PASRR Program is important because it provides options for individuals to choose where they live, who they live with, and the training and therapy they need to live as independently as possible. PASRR Program has 3 Goals: 1. To identify individuals with MI, ID, or DD/RC (this includes adults and children). 2. To ensure appropriate placement, whether in a community or in a NF. 3. To ensure individuals receive the required services for their MI, ID, or DD. Procedure: 1. The Facility Admissions process will ensure a PL1 Screening Form is obtained from the RE on day of admission or prior to admission. A PL1 is obtained for every individual, regardless of payment. type, seeking admission to a Medicaid-certified NF. (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. The PL1 Screening Form is completed by the RE (referring entity) using the paper copy of the PL1 Screening Form. 3. The Facility will review the PL1 Screening Form for completion and correctness prior to admission and submit the PL1 form per regulations. The Type of Admission is reviewed for correctness. Ensure the Name, SS number, Medicare/Medicaid numbers, and DOB is correct. The Date of the PL1 is correct (i.e., correct day, month, and year), and review each item on the PL1 to ensure accuracy and prevent a regulatory problem. 4. The Facility will enter the PL1 Form exactly as written except for corrections to identifying data. It is critical to submit timely PL1s due to the following: It is the policy of this facility to ensure that all residents are screened and appropriately addressed via the PASARR process as outlined by regulations. The results of this process will be used to develop, review, and revise the resident's care plan. Procedures: 1. The facility's designated staff will review all potential admissions for possible positive PASARR conditions and ensure that CMS Preadmission guidelines are followed Review the PL1 Form for completion and correctness before admission. Record review of facility policy titled, PASRR Nursing Facility Specialized Services Policy and Procedure, revised 3-6-19 indicated, Policy: It is the policy of Creative Solutions in Healthcare facilities to ensure NFSS Forms are submitted timely and accurately. 1.PL1 is completed. 2.If PL1 is coded as suspicion of MI, ID, or DD, then a PE is required. 3.The LA completes the PE and if Positive, a PCSP Initial Meeting is scheduled. 4. NF PCSP meetings scheduled within 14 days of admission and annually. Note: The Annual PCSP NF meeting must be at least 334 days from previous NF PCSP.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45810 Based on interviews and record reviews the facility failed to develop and implement a comprehensive person-centered care plan for each resident, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment for 1 of 14 residents (Residents #2) reviewed for care plans. 1.The facility failed to include Resident #2's diagnosis and interventions for post-traumatic stress disorder (PTSD) in the care plan. This failure could have placed residents at risk for not having their needs met. The findings included: A record review of Resident #2's face sheet dated 04/10/24 indicated she was a [AGE] year-old female who originally admitted to the facility on [DATE] and last admitted [DATE] with diagnosis PTSD (anxiety and flashbacks triggered by a traumatic event). A record review of Resident #2's significant change MDS assessment dated [DATE] indicated Resident #2 was rarely/never understood and sometimes understood others, and she had a BIMS score of 0 out of 15 which indicated severe cognitive impairment. The MDS also indicated Resident #2 had an active diagnosis of PTSD. A record review of Resident #2's care plan last revised on 03/04/24 did not indicate Resident #2's diagnosis of PTSD. During an interview on 04/10/24 at 04:20 PM LVN B said she was not aware that Resident #2 had PTSD. She said that it was important for the diagnosis of PTSD. LVN B said the failure could place the Resident #2 at risk of staff not being aware of triggers and ways to prevent reactions to the PTSD. During an interview on 04/10/24 at 04:31 PM The ADON said the department head nurses were responsible for care plans. She said they have a daily meeting where they discuss new orders and changes and update care plans. The ADON said It was just missed. She said the MDS nurse was responsible for completing the comprehensive care plans. She said the risk was the resident not receiving the appropriate care. During an interview on 04/10/24 at 05:33 PM The DON said she was not aware of a diagnosis of PTSD for Resident #2. She said it was important for the staff to know what triggers are and the staff be capable of preventing mental anguish and staff would be in-serviced on that as well. The DON said all of the nursing department heads were responsible for care plans. She said they would normally capture most new orders or changes during their daily interdisciplinary team meeting. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 04/10/24 at 06:08 PM The Administrator said he expected the PTSD to be on the care plan. He said the social worker would have been responsible for placing on the MDS because each department were responsible. The Administrator said they have the care plan meeting with interdisciplinary team to ensure everything was included in the care plans. The Administrator said the failure placed Resident #2 at risk for potential triggers happening and the staff were not able to provide trauma enforced care. The Administrator said care plans should include personalized care. A record review of the facility's undated Comprehensive Care Planning policy revealed, The facility will develop and implement a comprehensive person centered care plan for each resident, consistent with the residents rights that includes measurable objectives and time frames to meet a residence medical, nursing, mental, and psychosocial needs that are identified in the comprehensive assessment . when developing the comprehensive care plan, facility staff will, at a minimum, use the minimum data set to assess the residents clinical condition, cognitive and functional status, and use of services

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 45879 Based on observation, interview, and record review the facility failed to review and revise the person-centered care plan to reflect the current condition for 3 of 3 (Resident #17, Resident #15, and Resident #25) residents reviewed for care plan revisions. 1.The facility failed to revise Resident #17's care plan to include he removed his Foley catheter leg strap (a device used to reduce the risk of tension or pulling on the catheter, which could cause some very unpleasant trauma within the bladder or urethra) as ordered at times. 2. The facility failed to revise Resident #15 care plan to remove her wander guard. 3. The facility failed to revise Resident #25 care plan to remove he was a smoker. These deficient practices could affect residents by placing them at risk of not receiving appropriate interventions to meet their current needs. Findings included: 1.Record review of Resident #17's face sheet, dated 03/10/24 indicated Resident #17 was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses which included seizures, Bipolar (a mental illness that causes unusual shifts in a person's mood, and energy), Schizophrenia (severe mental disorder can result in hallucinations, delusions, and extremely disordered thinking disorder), and generalized anxiety (a feeling of fear, dread, and uneasiness). Record review of Resident #17's quarterly MDS assessment, dated 02/05/24, indicated Resident #17 was usually understood and sometimes understood by others. Resident #17's BIMs score was 15, which indicated he was cognitively intact. Resident #17 required extensive assistance with toileting, personal hygiene, transfer, and bathing. The MDS indicated he had an indwelling catheter during the 7-day look-back assessment period. Record review of Resident #17's physician's orders dated 07/02/23 indicated, Urinary Catheter 16 FR, 30 CC. Diagnosis: retention of urine. Record review of Resident #17's physician's orders dated 07/03/23 indicated, Secure catheter with a leg strap every shift. Record review of Resident #17's comprehensive care plan, dated 07/06/23 indicated Resident #17 had a catheter. The interventions of the care plan were for staff to keep the drainage bag below bladder level, cover the bag for dignity; give catheter care as ordered, and report immediately if the catheter comes out, and if the resident was in pain. Resident #17's care plan did not address his care for the leg strap, his refusal, or the removal of the leg strap. Record review of Resident #17's medication administration (MAR) record dated 04/01/24 through 04/09/24 revealed nurses were signing that Resident #17's was wearing his leg strap as ordered. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and interview on 04/09/24 at 4:09 p.m., MA F was providing Resident #17 with peri-care. She said Resident #17 did not have on his leg strap. She said it was important for Resident #17 to have on his leg strap to prevent pulling but he often removed his leg strap. She said she thought the nursing staff was aware of the removal of his leg strap. During an interview on 04/09/24 at 4:30 p.m., Resident # 17 did not say he had removed his Foley leg strap today (04/09/24) but said he did not like them. During an interview on 04/10/24 at 12:09 pm LVN C said Resident #17 should have a leg strap or some type of anchor in place to prevent dislodgement or pulling of his Foley catheter. She said she had applied his leg strap many times but he would take them off. She said she had told the ADON that he did not like to wear the leg strap about 2 months ago. She said she did not add the removal of his leg strap to his care plan because she did not do anything to any resident's care plan. During an interview on 04/10/24 at 3:45 p.m., LVN B said Resident #17 should have a leg strap to prevent his Foley catheter from pulling or dislodgement. She said Resident #17 told her last week he did not want to wear a leg strap anymore. She said she could not remember if she had reported his removal or refusal of his leg strap to anyone or documented it. During an interview on 04/10/24 at 4:12 p.m., the MDS nurse said she was responsible for updating care plans after each MDS assessment. She said she updated care plans based on the information she received during her quarterly, significant changes, and/or annual assessments. The MDS nurse said any acute care plan updates were done by the ADON/DON. The MDS nurse verified by looking at Resident #17's care plan and said he did not have anything related to his leg strap. She said it was important to update the care plan because it indicated how to take care of the residents. During an interview on 04/10/24 at 4:31 p.m., the ADON said the MDS nurse was responsible for the care plans but the IDT worked on care plans. She said she updated acute care plans based on the information she received from morning or clinical meetings, 24-hour reports, and physician's orders. She said she was not aware Resident #17 was removing or refusing his leg strap until questioned by the surveyor. She said the care plan intended to show what needs to be done to meet the resident's needs and if care plans were not being updated some vital information could be missed. During an interview on 04/10/24 at 5:20 p.m., the DON said all nurses could update a care plan. She said the IDT worked on care plans to ensure they were complete and accurate. She said she was not aware Resident #17 refused or removed his Foley catheter. She said it was important to place this on his care plan because it reflected the care he should be receiving. During an interview on 04/10/24 at 6:00 p.m., The Administrator said care plans were updated by the IDT team. He said they had a morning meeting, clinical meetings, and standard of care meetings. He said they had plenty of time to identify and update Resident #17's care plan. He said he did not know why Resident #17's care plan was not updated but said his care plan should have been updated to reflect his removal or refusal of the leg strap. the care plan should reflect a picture of the resident's care needs. He said if a resident had a change of medication, then his/her care plan should reflect the change. 47612 (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2.Record review of face sheet, dated 10/10/23 indicated Resident #15 was an [AGE] year-old female admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety (person was presenting signs and symptoms of dementia and has a dementia diagnosis, but they lack any symptoms of behavioral disturbance), Cognitive communication deficit (difficulty with thinking and how someone uses language), other schizophrenia (category applies to presentations in which symptoms predominate that are characteristic of a schizophrenia spectrum and other psychotic disorder that cause clinically significant distress or impairment in social, occupational, or other important). Record review of the order summary, dated 04/04/24, indicated Resident #15 had a wander guard with function check every night shift. Record review of the care plan, revised 12/19/2023, indicated Resident #15 was at moderate risk for falls related to decreased safety awareness, wandering. Interventions included ensure resident was wearing proper footwear and provide a clear path for wandering to help avoid stumbling while wandering. Record review of the quarterly MDS assessment, dated 03/07/2024, revealed Resident #15 was sometimes understood and sometimes understood by others. Resident #15's BIMs score was 03, which indicated she was cognitively severely impaired. Resident #15 MDS indicated no wandering. Record review of Resident #15's medication administration record dated 04/10/2024, indicated wander guard check every day on night shift was checked off by the nurse. 3. Record review of the face sheet, dated 04/09/2024, revealed Resident #25 was a [AGE] year-old male who admitted to the facility on [DATE] with diagnoses of hemiplegia and hemiparesis following cerebral infarction affecting right dominant side (complete paralysis, while hemiparesis refers to partial paralysis), vascular dementia, unspecified severity with agitation (major neurocognitive disorder due to vascular disease), other abnormalities of gait and mobility(injury or underlying medical condition can cause an abnormal gait). Record review of the care plan, revised 02/26/2024, indicated Resident #25 was a smoker, with intervention for smoking risks and hazards, and smoking cessation aids available. Record review of the quarterly MDS assessment, dated 03/07/2024, revealed Resident #25 has unclear speech and responds adequately to simple, direct communication. The MDS revealed Resident #25 had a BIMS of 5, which indicated severe cognitive impairment. The MDS assessment did not indicated Resident #25 was a smoker. During an interview on 04/10/2024 at 4:21 p.m., LVN B stated the MDS coordinator and the ADON were responsible for updating the care plan. LVN B stated Resident # 15 no longer had a wander guard and Resident # 25 had not smoked in a long time. LVN B stated it was important for the care plan to be accurate so the residents would get the appropriate care. LVN B stated she didn't feel there was a risk to the residents with the care plan not being update for Resident # 15 no longer needing a wander guard or resident # 25' care plan not being updated to reflect he was no longer a smoker. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 04/10/2024 at 4:21 p.m., the ADON stated all the interdisciplinary team was responsible for updating the care plans. The ADON stated Resident # 15's care plan for the wander guard and Resident #25's care plan for smoking should had been updated months ago. The ADON stated it was important for the care plans to be updated for resident care. The ADON stated she did not feel there was a harm to the residents. The ADON stated she would monitor during morning meetings. During an interview on 04/10/2024 at 5:20 p.m., the DON stated the care plans are done during the interdisciplinary team meetings. The DON stated this was an oversight. The DON stated it was important for the care plan to updated to provide true and accurate care. The DON stated there was no harm to the residents. The DON stated she would monitor by doing order audits. During an interview on 04/10/2024 at 5:54 p.m., the Administrator stated care done during the morning meetings. The Administrator stated it was important for each care plan to be person center care. The Administrator stated he believed this was an oversight. The Administrator stated he did believe there was any harm to the resident. The Administrator stated they would monitor by doing audits. Record review of facility undated policy titled, Comprehensive Care Plans, indicated residents' preferences and goal may change throughout their stay, so facilities should have on going discussions with the residents and resident representative, if applicable, so that changes can be reflected in the comprehensive care plan .

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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** 45879 Based on observation, interview, and record review the facility failed to ensure that residents requiring respiratory care were provided such care, consistent with professional standards of practice for 2 of 12 residents (Resident #8 and #31) reviewed for respiratory care. 1. The facility failed to ensure Resident #8 had oxygen orders. 2. The facility failed to ensure Resident #31 oxygen concentrator filters were cleaned. These failures could place residents who receive respiratory care at risk of developing respiratory complications and a decreased quality of care. The findings included: 1. Record review of Resident #8's face sheet, dated 04/10/24, indicated a [AGE] year-old female who was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included chronic obstructive pulmonary disease (no airflow for breathing), high blood pressure, Dementia (impaired ability to remember, think, or make a decision) and Depression (feeling of sadness). Record review of Resident #8's quarterly MDS assessment, dated 01/01/24, indicated Resident #8 was usually understood and was usually understood by others. Resident #8's BIMS score was 09, which indicated she was moderately cognitively impaired. The MDS indicated Resident #8 required limited assistance with dressing, personal hygiene, toileting, bathing, bed mobility, transfers, and set-up for eating. The MDS during the 7-day look-back period did not indicate Resident #8 was receiving oxygen. Record review of Resident #8 physician orders dated 04/30/24 did not indicate any oxygen orders. Record review of Resident#8's care plan dated 12/17/23 indicated, Resident #8 had a diagnosis of COPD. The intervention was for staff to administer aerosol or bronchodilators as ordered and encourage the head of the bed to be elevated. The care plan did not indicate any oxygen orders. During an observation on 04/08/24 at 12:29 p.m., Resident # 8 was lying in her bed with her eyes closed. Resident #8's oxygen was set at 4.5 L per mask. During an interview on 04/09/24 at 9:43 a.m., CNA E said Resident #8 started wearing oxygen for almost 2 weeks. She said she had been sick. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 04/10/24 at 3:45 p.m., LVN B said Resident #8 had been ill with an upper respiratory infection. She said she could not remember the exact day Resident #8 was wearing oxygen but when she came on her 2-10 pm shift about a week or so ago she had it on. She said they had standing orders (things the doctor was okay with them writing without calling him/her) but the nurses were still required to write the order. She said she never checked to see if Resident #8 had an order written for her oxygen. She said when nurses receive new orders or standing orders, they should be written and placed on the 24-hour report so that other nurses would know how Resident #8 should be receiving her oxygen. She said the standing order was for oxygen to be placed between 2-4 liters. She said it was important to write orders to ensure residents were receiving the correct amount of oxygen and if not, it could lead to further respiratory issues. During an interview on 04/10/24 at 4:31 p.m., the ADON said she expected nurses to put orders in the computer system when they received new orders. She said Resident #8 should have had an oxygen order with the correct flow rate of oxygen since she was wearing oxygen. She said she received the orders for the chest x-ray and other things but she did not receive an oxygen order and was not sure who received the order. She said if the staff was not following the process of orders, then it could cause residents who required oxygen to have some respiratory issues. During an interview on 04/10/24 at 5:20 p.m., the DON said the charge nurses were responsible for placing orders in the computer when they received a new order. She said the nurses should be reported during shift change and communicated so others could check as well. She said an unknown nurse took a verbal oxygen order and did not transcribe the order. She said it was important to have orders in the system because if a nurse looked in the computer system and did not see an order, they could potentially remove Resident #8's oxygen and cause respiratory issues. During an interview on 04/10/24 at 6:00 p.m., the Administrator said nurse managers were the overseers of orders. He said oxygen should not be applied without an order. He said without a written order staff would not know the correct oxygen rate and that could cause respiratory issues. 47612 2. Record review of the face sheet, dated 04/09/2024, revealed Resident #31 was a [AGE] year-old female who admitted to the facility on [DATE] with diagnoses of Schizoaffective disorder, bipolar type (a mental illness that can affect your thought, mood and behavior), anxiety disorder(condition in which a person has excessive worry and feelings of fear, dread, and uneasiness), hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side (paralysis of partial or total body function on one side of the body, whereas hemiparesis was characterized by one?sided weakness). Record review of the quarterly MDS assessment, dated 03/12/2024, revealed Resident #31 had clear speech and was understood by staff. The MDS revealed Resident #31 was able to understand others. The MDS revealed Resident #31 had a BIMS of 9, which indicated a moderate cognitive impairment. The MDS revealed Resident # 31 received oxygen while a resident at the facility during the 14-day look-back period. Record review of the comprehensive care plan, revised 03/13/2024, revealed Resident #31 used oxygen therapy routinely related to shortness of breath. The interventions included: maintain oxygen settings per physician's orders. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the order summary report, dated 04/09/2024, revealed Resident #31 had an order, which started on 03/30/2024, for oxygen at 2-4 LPM via N/C. During an observation and interview on 04/08/2024 at 11:40 a.m., Resident #31 was lying in bed watching tv. Resident #31 was wearing oxygen via nasal cannula at 3 liters per minute. Resident #31's oxygen concentrator filter had a thick grey, fuzzy material. Resident #31 stated she wore oxygen all the time because she was short of breath. During an observation on 04/09/2024 at 8:55 a.m., Resident #31 was lying in bed watching TV. Resident #31 was wearing oxygen via nasal cannula at 3 liters per minute. Resident #31's oxygen concentrator filter had a thick gray, fuzzy material. During an interview on 04/9/2024 at 9:30 a.m., LVN G stated the filters on the oxygen concentrators were required to be cleaned on the night shift. LVN G stated he was not sure if it was the nursing staff's responsibility to clean the oxygen concentrator. LVN G stated it was important to clean the oxygen concentrator so Resident # 31 had proper ventilation. LVN G stated he did not know why the oxygen concentrator filter was not cleaned. LVN G stated the harm was obstructive breathing and possible infection. During an interview on 04/10/2024 at 4:31 p.m., the ADON stated she expected the oxygen concentrator filters to be changed or cleaned weekly on Sundays and as needed. The ADON stated the 6p-6a charge nurse was responsible for cleaning the filters. The ADON stated it was important to change and clean the oxygen filters to ensure proper air flow. The ADON stated rounds would be done randomly to monitor oxygen filters. The ADON stated the harm associated with not changing the filters could keep Resident # 31 from receiving the oxygen she needed. During an interview on 04/10/2024 at 5:20 p.m., the DON stated she expected the oxygen concentrator filters to be cleaned on Sundays. The DON stated nursing staff was responsible for cleaning the filters. The DON stated it was important for the oxygen concentrator filter to be clean so Resident #31 was getting the oxygen she needed. The DON stated the oxygen concentrators had an alarm that will sound off if not working properly. The DON stated the harm associated with not changing the filters, the resident may not get the oxygen they required. The DON stated she would monitor by doing rounds on Monday mornings to ensure the oxygen concentrator filters were changed and cleaned. During an interview on 04/10/2024 at 5:54 p.m., the Administrator stated he expected filters to be cleaned/changed weekly and as needed. The Administrator stated it was important for good respiratory care and goo customer service. The Administrator stated the risk associated with not changing the filters could cause a respiratory infection and illness. The Administrator stated he would monitor by doing champion rounds to check the oxygen concentrator. Record review of the facility's policy titled Oxygen Administration last reviewed on 03/21/2023, indicated, Procedure 1. change and clean oxygen concentrator filters according to manufactures recommendations' .

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 45879 Based on interview and record review the facility failed to maintain medical records on each resident that were complete and accurately documented, in accordance with accepted professional standards and practices, for 1 (Resident #17) of 4 residents whose records were reviewed for accuracy and completeness. The facility failed to maintain accurate documenation in the MAR for April 2024 for Resident #17. This deficient practice could place residents at risk of having incomplete or inaccurate records and inadequate care. Findings included: Record review of Resident #17's face sheet, dated 03/10/24 indicated Resident #17 was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses which included seizures, Bipolar (a mental illness that causes unusual shifts in a person's mood, and energy), Schizophrenia (severe mental disorder can result in hallucinations, delusions, and extremely disordered thinking disorder), and generalized anxiety (a feeling of fear, dread, and uneasiness). Record review of Resident #17's quarterly MDS assessment, dated 02/05/24, indicated Resident #17 was usually understood and sometimes understood by others. Resident #17's BIMs score was 15, which indicated he was cognitively intact. Resident #17 required extensive assistance with toileting, personal hygiene, transfer, and bathing. The MDS indicated he wandered 1-3 times during the 7-day look-back assessment period. Record review of Resident #17's physician's orders dated 09/24/23 indicated, Place wander guard on the resident's w/c for safety and risk of elopement, check every shift. Record review of residents' MAR dated 04/01/24 through 04/09/24 revealed the nurses had been signing Resident #17's MAR indicating he had on a wander guard. Record review of Resident #17's comprehensive care plan, dated 07/06/23 indicated Resident #17 was at risk of wandering. The interventions were for staff to distract the resident from wandering by offering pleasant diversions, structured activities, food, conversation, television, and books, If the resident was exit seeking, stay with the resident and notify the charge nurse by CNA calling out, sending another staff member, call system, etc., the care plan did not indicate anything about a wander guard. Record review of Resident #17's elopement risk assessment dated [DATE], revealed his score was a 15, indicating he was a high risk of elopement. During an interview on 04/09/24 at 4:09 p.m., CNA A said Resident #17 did not have on a wander guard bracelet on his chair or any part of his body. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 04/10/24 at 12:09 pm LVN C said Resident #17 would sometimes want to leave on his own. She said he had not displayed any attempts to leave the facility lately. She said if a resident had a wander guard bracelet on, it would populate in their computer system for them to check for placement. She said she thought the wander guard bracelet was on Resident #17's chair yesterday (04/09/24) when she signed the MAR indicating it was on his chair. During an interview on 04/10/24 at 3:45 p.m., LVN B said the elopement risk assessment was done by the ADON/DON. She said an elopement risk assessment score of 15 was high (indicating they were at risk of elopement). She said Resident #17 had a wander guard bracelet for a brief time (unknown time) but he did not have one anymore. She said she did not realize she was signing the MAR for Resident #17 indicating he had a wander guard bracelet in place. She reviewed his MAR and saw the order to check the wander guard every shift and her initials indicating the wander guard bracelet was in place. She said the purpose of a wander guard bracelet was for safety and to ensure the resident did not wander out of the facility without staff knowledge. During an interview on 04/10/24 at 4:31 p.m., the ADON said the nurses were responsible for ensuring what they were signing on the MAR before they signed it. She said Resident #17 had attempted to leave the facility a while back (unknown time) but he had not attempted to leave the facility anymore. She said herself and the nurses did the elopement risk assessments. She said at first, she did not know what a score of 15 meant on an elopement risk screen and then she indicated it was high. She said although Resident #17 had a high score he was not at risk. She said Resident #17 could leave anytime because he was his responsible party and she did not see any risk of him leaving the facility. She said the only thing she could see was the residents who required a wander guard being at risk because the staff was not monitoring the wander guard bracelets as they should. During an interview on 04/10/24 at 5:20 p.m., the DON said all nurses were supposed to check the function of the wander guard bracelets at night. She said herself and the Maintenance Supervisor checked all the doors every morning to ensure they were functioning appropriately. She said she was not sure why the nurses had signed Resident #17's wander guard bracelets being in place. She said they should have discontinued his order. She said wander guard bracelets were placed so the residents would remain safe in the facility. She said they would do an audit on all wander guards and orders. During an interview on 04/10/24 at 5:49 p.m., the Maintenance Supervisor said he did not do anything with the wander guard system. He said he checked the alarms of all the doors without a wander guard system. He said all doors should be secured for the safety of the residents. During an interview on 04/10/24 at 6:00 p.m., The Administrator said the Maintenance Supervisor and the DON checked all the doors daily. He said the nurses had a UDA to check the wander guard bracelets. He said it was an oversight on the nurses to sign the MAR and not check for Resident #17's wander guard bracelet. He said the wander guard bracelets were put in place to ensure residents were safe and not wandering outside. Record review of monitoring for the wander guard system was completed from 9/26/23 through 4/09/24. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of facility policy titled, Wandering, dated 02/01/07, indicated, Policy Statement: Every effort will be made to prevent wandering episodes while maintaining the least restrictive environment for residents who are at risk for elopement. 1. The Elopement Risk Assessment will be completed on admission and then quarterly. 2. All residents who are at risk for harm because of wandering (elopement) will be assessed by the interdisciplinary care planning team. 3. The resident's current chart and assessments will be reviewed to determine what changes have occurred that would trigger elopement episodes. 4. The resident's care plan will be modified to indicate the resident is at risk for elopement episodes. Record review of facility policy titled, Elopement Prevention, dated 02/01/07, indicated, Policy Statement: Every effort will be made to prevent elopement episodes while maintaining the least restrictive environment for residents who are at risk for elopement. 1. The Elopement Risk Assessment will be completed upon admission. The assessment should be completed by reviewing the resident's medical history and social history. Information may be obtained by reviewing current medical records, if available, an interview with the resident/family, or a conference with the interdisciplinary team member. The assessment tool should be completed, and interventions implemented as indicated. The Elopement Risk Assessment is to be completed at least quarterly, after an elopement attempt, upon new exit-seeking behavior, and change of condition. Physical Plant: I.A-11 facility exits that residents have access to will have a device in place to alert staff of elopement attempts. o Examples of these devices: o Wander guard System (locking or alarming) oPlacement of the residents' device in the system will be verified each shift and documented on a treatment or other flow record. o The function of the resident's device will be verified at least daily and documented on the treatment of other flow records. o The function of the alarm system will be verified each week and documented in a maintenance log.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45810 Based on observation, interview, and record review, 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 diseases and infections for 1 of 3 residents (Resident #26) reviewed for infection control practices. CNA D failed to wash or sanitize hands when changing gloves between dirty and clean while providing peri care for Resident #26. This failure could place residents and staff at risk for cross contamination and the spread of infection. Findings included: Record review of Resident #26's face sheet dated 04/10/24 indicated he was a [AGE] year-old male who admitted to the facility on [DATE] and readmitted to the facility on [DATE] with the diagnoses diabetes mellitus type 2, epilepsy, high blood pressure, urine retention, and mood disorder. Record review of Resident #26's annual MDS dated [DATE] indicated he had a BIMS score of 11 which meant he had moderate cognitive impairment. The MDS also indicated Resident #26 required substantial/maximal assistance with toileting, dressing, bed mobility, and transfers, and required supervision for eating. Record review of Resident #26's care last revised on 08/14/22 indicated he had an ADL performance deficit with interventions in place for the staff to provide peri care as needed. During an observation on 04/09/24 at 09:17 AM CNA D went into Resident #26's room to provide peri care. She had sanitized hands and donned gloves. CNA D removed urine saturated brief and threw it in the trash. She then grabbed a wipe from the container wiped left side of peri area and then threw it in the trash bag, she grabbed another wipe and cleaned right side of peri area and threw it in the trash, and grabbed another wipe and cleaned the middle of the peri area and threw the wipe in the trash. CNA D then changed gloves but failed to use hand sanitizer. CNA D turned Resident #26 to the left side and cleaned his buttocks and removed gloves and placed new gloves on without using any hand hygiene. CNA D turned Resident #26 on his right side and cleaned his buttocks. She then threw one glove in the trash, grabbed new brief, and placed it under resident. CNA D changed gloves again no hand sanitizer used and put clothing on resident. During an interview on 04/09/24 at 09:35 AM CNA D said she thought she did well and changed her gloves, but she did not realize she did not have her hand sanitizer in her pocket to use in between changes of gloves. She said the risk to the resident is germs when going between clean and dirty. CNA D said she was just in a hurry and did not realize it. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675439	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/10/2024
NAME OF PROVIDER OR SUPPLIER Mullican Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 105 N Main St Savoy, TX 75479	

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 04/10/24 at 05:01 PM The ADON said her expectations were for the CNAs to wash their hands before and after care and to change the gloves if they become soiled. She said she did not expect them to change gloves in between peri- care. She said they should use hand sanitizer between glove changes. The ADON said the facility provided peri care proficiency checks annually and handwashing monthly. She said all nursing management is responsible for ensuring the staff know how to perform proper peri care. She said the failure placed Resident #26 at risk for the transfer of bacteria. During an interview on 04/10/24 at 05:31 PM The DON said her expectation was for the CNAs to provide hand hygiene before, after, and during care between dirty and clean. She said hand washing in-servicing was completed a lot. The DON said the management nursing staff could check the CNAs off for hand washing but she mainly provided hand washing in-services and proficiency check offs to all the staff. She said the failure place a risk of infection to Resident #26. During an interview on 04/10/24 at 06:04 PM The Administrator said his expectation was for the CNAs and all staff use good hand hygiene before and after care. The Administrator said CNAs should also stop and wash or hand sanitize between clean and dirty. He said he thought the CNA may have gotten nervous. He said the failure placed a risk for the spread of infection. He said the DON and ADON were responsible for providing training and in-servicing. Record review of the facility policy for Perineal Care created 04/25/22 indicated: Introduction-F676 An incontinent resident of urine and/or bowel should be identified, assessed, and provided appropriate treatment and services .Purpose: This procedure aims to maintain dignity and self-worth and reduce embarrassment by providing cleanliness and comfort to the resident, preventing infections and skin irritation, and observing resident's skin .Start 10) provide hand hygiene 11) don gloves .Always perform hand hygiene before and after glove use