

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  675460	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  03/27/2024
NAME OF PROVIDER OR SUPPLIER  Park Highlands Nursing & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE  711 Lucas St Athens, TX 75751	

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 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>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.</p> <p>37495</p> <p>Based on observation, interview, and record review, the facility failed to provide a safe, functional, sanitary, and comfortable environment 3 of 3 shower rooms reviewed for environment. (North Wing, East Wing and Rehabilitation hall).</p> <p>The facility failed to ensure the shower rooms on the North Wing, East Wing and Rehabilitation hall were free of a black substance in between the tiles.</p> <p>This failure could place residents at risk of living in an unsafe, unsanitary, and uncomfortable environment.</p> <p>The findings included:</p> <p>During an observation on 03/25/24 at 2:02 p.m., the Rehabilitation hall shower room had a dark black substance, about 3 inches in length on the right wall and a dark black substance, about 2 inches in length, on the back wall of the shower in between the grout where the wall tile and floor tile met.</p> <p>During an observation on 03/25/24 at 2:23 p.m., the East Wing shower room had two showers. The shower furthest from the door had a dark brown and black substance, about 3 inches in length, on the left wall of the shower in between the grout where the wall tile and floor tile met.</p> <p>During an observation on 03/25/24 at 2:30 p.m., the North Wing shower room had three showers. The shower closest to the door had a black substance, about 4 inches in length, on the right wall of the shower in between the grout where the wall tile and floor tile met.</p> <p>During an interview on 03/25/24 at 3:04 p.m., the HSKS said she managed housekeeping and was responsible for the cleanliness of the facility. The HSKS said housekeeping staff cleaned the showers daily and as needed. The HSKS said she made rounds to ensure her staff cleaned their assigned areas appropriately. The HSKS said she believed the black substance was mold. The HSKS said for the past two months she had worked the floor due to staffing and was unable to make her rounds like she should during that time. The HSKS said they had a position open for a full-time housekeeper and are currently looking to hire someone for it.</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 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Record review of the facility's Deep Cleaning Process-Bathroom/Showers dated 2015 indicated, .1. Starting in a clockwise motion from bathroom/shower door; dust, clean, polish, scrub, scrape, everything in the room including but not limited to: .3.begin cleaning, scrubbing .b. walls: clean all walls, including shower or tub walls .j. Floors .</p>		

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<p>F 0644</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 27140</p> <p>Based on interviews and record reviews, the facility failed to ensure individuals with mental health disorders were provided an accurate Preadmission Screening and Resident Review Level 1(PASRR) Screening for 1 of 5 residents reviewed for PASRR (Resident #48).</p> <p>The facility failed to ensure Resident #48 had an accurate PASRR Level 1 Screening indicating a diagnosis of mental illness on 06/30/2023.</p> <p>This failure could place residents at risk of not receiving needed assessments (PASRR Evaluation), individualized care, and specialized services to meet their needs.</p> <p>Findings included:</p> <p>Record review of an undated face sheet indicated Resident #48 was a [AGE] year-old female who admitted to the facility on [DATE] with diagnoses including anxiety, high blood pressure and diabetes.</p> <p>Record review of the admission MDS assessment dated [DATE] indicated, Resident #48 had a BIMS score of 14 (fourteen) indicating no impaired cognition. The MDS section for PASRR (A1500) indicated Resident #48 did not have a serious mental illness. The MDS section, Active Diagnoses Psychiatric/Mood Disorder, indicated Resident #48 to have diagnoses of anxiety disorder, depression, and bipolar disorder.</p> <p>Record review of physician orders current as of 03/27/2024 indicated an order dated 10/29/2022 for Resident #36 to receive one (1) buspirone 15 mg tablet two times a day for anxiety and an order dated 07/19/2023 for one (1) fluoxetine 40 mg tablet for depression one time a day.</p> <p>Record review of the Comprehensive (admission) MDS assessment dated [DATE] indicated Resident #48 was receiving antianxiety and antidepressant medications on a routine basis.</p> <p>Record review of Resident #48's PASRR Level 1 Screening completed on 06/20/2023 indicated in section C0100 this resident did not have evidence of having a mental illness.</p> <p>Record review of Resident #48's initial psychiatric evaluation visit dated 08/15/2023 indicated the resident had major depressive disorder and anxiety disorder. The psychiatric evaluation/management visit dated 02/20/2024 indicated the resident had diagnoses of bipolar disorder, depression and sleep disturbances.</p> <p>Record Review of Resident 48's admission face sheet and physician orders from the discharging facility dated 06/13/2023 indicated the resident had diagnoses including bipolar disorder, depression and anxiety.</p> <p>(continued on next page)</p>

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<p>F 0644</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview with the MDS Nurse on 03/27/2024 at 1:30 PM, she said she was responsible for tasks related to PASRR and MDS processes. She said she was not the MDS Coordinator at the time of Resident #48's admission. She viewed the admission PASRR and said the discharging long term care facility had sent an inaccurate PASRR Level 1 Screening indicating the resident was negative for mental illness. She said the LA (Local Authority) was not notified of the incorrect PASRR.</p> <p>Record review of facility policy PASRR Level 1 (PL1) Screen Policy and Procedure, revised 03/06/2019, indicated .reviewed for correctness .to ensure accuracy and prevent a regulatory problem.</p>		

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<p>F 0655</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47204</b></p> <p>Based on observations, interviews, and record reviews, the facility failed to implement a baseline care plan for each resident that included the instructions needed to provide effective and person-centered care of the resident that meets professional standards of quality care for 2 of 3 residents (Residents # 216 and 218) reviewed for care plans.</p> <p>The facility failed to address, in Resident #216's baseline care plan, his indwelling urethral catheter (tube inserted through the urethra into the bladder and left there to drain the urine), his diagnoses of Acute Renal Failure (condition in which the kidneys suddenly cannot filter waste from the blood), Inflammatory Reaction Due to Indwelling Urethral Catheter (urinary tract infection due to presence of an indwelling urethral catheter), Retention of Urine (condition wherein the bladder does not empty completely or not at all), and his antibiotic therapy (medication given to treat an infection) upon admission to the facility.</p> <p>The facility failed to address, in Resident # 218's baseline care plan, her cervical collar (a rigid device that is placed around the neck and extends from the base of the neck to the top of the back to prevent movement of the neck) and her diagnosis of Nondisplaced Fracture (one in which the bone cracks or breaks but retains its proper alignment) of 5th Cervical Vertebra (bone in the neck) upon admission to the facility.</p> <p>These failures could affect newly admitted residents and place them at risk of not receiving continuity of care and communication among nursing home staff to ensure their immediate care needs are met, promote health, and prevent a decline or injury.</p> <p>Findings included:</p> <p>Resident #216:</p> <p>Record review of Resident #216's face sheet dated 03/27/2024 indicated he was an [AGE] year-old male who admitted on [DATE] with diagnoses which included Covid and discharged home on 02/29/2024. The face sheet further indicated Resident #216 readmitted to the facility on [DATE] with new diagnoses of Acute Renal Failure, Inflammatory Reaction Due to Indwelling Urethral Catheter, and Retention of Urine. An in progress MDS dated [DATE] documented Resident #216 to have a BIMS score of 10, indicating his cognition to be moderately impaired.</p> <p>Record review of Resident #216's physician orders dated 03/25/2024 indicated instructions for the care of a urethral catheter and administration of an antibiotic medication (Bactrim DS twice daily).</p> <p>Record review of Resident #216's baseline care plan did not reflect any concerns, goals, interventions, nor instructions to address the presence of a urethral catheter, nor the physician's orders for catheter care. The baseline care plan did not address Resident #216's recent diagnoses of acute renal failure and infection associated with the use of an indwelling urethral catheter nor the prescribed antibiotic therapy to treat the urinary infection.</p> <p>(continued on next page)</p>

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<p>F 0655</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an observation and interview on 03/25/2024 at 10:57 AM, Resident #216 was noted transferring from his wheelchair to his bed. He said he was returning from therapy. Resident was observed to have a clear tube coming out of the front opening of his pajamas and draining into a closed collection bag inside a privacy covering. Resident said a doctor put in a tube in his bladder because he could not urinate. He said the catheter had to stay until he saw the doctor again. He said he had an appointment, but he couldn't remember who the doctor was nor when his appointment was. He said his family took care of those things.</p> <p>During an interview with LVN B on 03/27/2024 at 10:52 AM, she said Resident #216's urethral catheter was to stay in place until he saw the urologist and he was to be given Bactrim DS twice a day for 7 (seven) days for treatment of the urinary tract infection. LVN B said she could not locate any information in Resident #216's care plan that addressed his catheter, his diagnoses of acute renal failure, urinary infection, and urine retention, nor his antibiotic therapy. She said the purpose of a care plan was to ensure a resident's needs were managed properly and consistently.</p> <p>During an interview with the DON on 03/27/2024 at 11:10 AM, she said Resident #216's care plan from his previous stay at the facility (02/24/24-02/29/24) was re-activated by LVN C as his baseline care plan for his current admission on 03/18/2024. She said the care plan did not address Resident #216's antibiotic therapy, urethral catheter, and the new diagnoses of acute renal failure, urinary tract infection, and retention of urine. She said the diagnosis of acute renal failure associated with a urinary tract infection caused by the urethral catheter was the primary reason for Resident's admission and should have been addressed in the baseline care plan. The DON said that she and the ADON were responsible for reviewing the admission care plans. She said she was the nurse who reviewed Resident #216's baseline care plan.</p> <p>LVN C was not available for interview.</p> <p>Resident #218:</p> <p>Record review of Resident #218's face sheet indicated she was a [AGE] year-old female who admitted to the facility on [DATE] with diagnoses which included Non-displaced Fracture of the 5th Cervical Vertebra (fracture of a bone in the neck). An in progress MDS dated [DATE] documented Resident #218 to have a BIMS score of 14, indicating her cognition to be intact.</p> <p>During observation and interview on 03/25/2024 at 11:05 AM, Resident #218 was noted to be sitting in a high back wheelchair in her room with a rigid cervical (neck) collar lying on the table beside her. She said she had just taken it off. She said she had fallen at home and broken her neck. CNA E entered the room and said she would tell the nurse about the neck brace.</p> <p>During observation of Resident #218 at lunch on 03/25/2024 at 12:10 PM, she was observed to be wearing the cervical collar and having difficulty feeding herself. She said she did not want any help and added that she wasn't hungry anyway.</p> <p>During an interview with the Speech Therapist (ST) on 03/27/2024 at 10:52 AM, she said Resident #218 was supposed to wear the cervical collar when she was sitting up.</p> <p>(continued on next page)</p>		

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<p>F 0655</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview with LVN B on 03/27/2024 at 10:58 AM, she said Resident #218 was supposed to wear the cervical collar when she was out of the bed. She said Resident #218 was not compliant with wearing the collar. LVN B said she thought she read the directions for the collar use in the chart, but she could not find a physician's order for it. She said the nurses relied on information shared during change of shift report to know resident specific needs.</p> <p>A review of Resident #218's physician orders dated 03/27/24 did not reveal a physician's order for a cervical collar nor any instructions for the use or care of it.</p> <p>Review of Resident #218's baseline care plan dated 03/18/2024 did not indicate any concern, focus, goals, nor interventions for the cervical collar.</p> <p>During an interview with the DON on 03/27/2024 at 11:10 AM, she said she was aware of Resident #218's neck fracture and knew she was to wear a cervical collar when out of bed before the Resident admitted to the facility. The DON provided a copy of a physician's progress notes dated 03/12/2024 from the hospital's clinical records that indicated Resident #216 would need lots of help upon discharge and that she is significantly incapacitated by needing to wear the cervical collar. She said the ADON initiated Resident #218's baseline care plan and said the care plan should have addressed the cervical collar and Resident 218's diagnosis of non-displaced fracture of the 5th cervical vertebra. The DON confirmed that neither the physician's orders nor the care plan addressed the use of a cervical collar. She agreed that Resident #218's baseline care plan should have included interventions to promote healing and prevent decline or further injury.</p> <p>During an interview about Resident #218's baseline care plan with the ADON on 03/27/2024 at 11:15 AM, she said she overlooked the diagnosis of a fractured vertebra and the cervical collar. She said both the fracture and the collar should have been addressed in the care plan.</p> <p>Review of the facility's policy titled Base Line Care Plans indicated the following:</p> <p>The facility will develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care .</p> <p>The baseline care plan will reflect the resident's stated goals and objectives and include interventions that address his or her current needs. It will be based on the admission orders, information about the resident from the transferring provide, and discussion with the resident and resident representative, if applicable.</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47723</b></p> <p>Based on observation, interview, and record review, the facility failed to ensure the resident environment remained as free of accident hazards as possible and each resident received adequate supervision to prevent accidents for 1 of 5 residents (Resident #23) reviewed for smoking.</p> <p>The facility failed to ensure the Safe Smoking Assessment was completed and implemented for Resident #23.</p> <p>The failure placed residents at risk of cigarette burns and unsafe smoking conditions.</p> <p>Findings included:</p> <p>Record review of the Face sheet indicated Resident #23 was a [AGE] year-old male, admitted on [DATE], with diagnoses of pneumonia, chronic obstructive pulmonary disease with acute exacerbation (obstructed airflow from the lungs caused by inflammation), chronic viral hepatitis C (viral infection that affects the liver causing inflammation), acute cystitis (inflammation of the urinary bladder), hypo-osmolality and hyponatremia (low sodium levels in the blood), alcoholic cirrhosis of the liver (scar tissue on the liver caused by alcohol consumption), wedge compression fracture of the second and fourth lumbar vertebra (one side of the vertebra collapses), and muscle weakness (generalized).</p> <p>Record review of Resident #23's MDS dated [DATE] revealed he had a BIMS (Brief interview for Mental Status) summary score 13 indicating he was cognitively intact.</p> <p>Record review of Resident #23's care plan dated 03/22/2024 indicated he was a smoker and interventions included a smoking assessment monthly and to smoke in designated areas under supervision of a visitor or facility staff member.</p> <p>Record review of Resident #23's medical chart revealed there was no smoking assessment in his chart.</p> <p>During an observation and interview on 03/25/24 at 11:05 a.m., Resident #23 was outside in the designated smoking area. Resident #23 said he had been smoking for about [AGE] years. Supply employee G was in the designated smoking area monitoring the residents. Supply employee G provided distributed cigarettes, provided smoking aprons and assisted the residents with lighting their cigarette. Supply employee G said the smoking times are posted on activity room bulletin board and she had been assigned supervising residents in smoking area for over one year. Resident #23 was not provided a smoke apron.</p> <p>During an observation and interview on 03/25/24 at 11:30 a.m., the DON said the Smoking Policy was posted in the entry hallway and is a part of the admission packet. The Smoking Policy and smoking times were posted in the entry lobby.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an observation and interview on 03/26/24 at 11:32 a.m., Resident #23 was in the hallway going toward the activity room in his wheelchair. Resident #32 was wearing blue jeans with burn marks on them. Resident #23 said his blue jeans were old and he had been a smoker for [AGE] years.</p> <p>During an observation and interview on 03/27/24 at 10:30 a.m., LVN B reviewed Resident #23's electronic health records for a smoking assessment. LVN B said there was no smoking assessment in Resident #23's chart.</p> <p>During an observation on 03/27/24 at 11:00 a.m., Resident #23 was outside in the designated smoking area. Supply employee G was in the designated smoking area monitoring the residents smoking Resident #23 was not provided a smoke apron.</p> <p>During an interview on 03/27/24 at 3:00 p.m., the DON reviewed Resident #23's electronic health records for a smoking assessment. The DON said there was no smoking assessment in Resident #23's chart. The DON said she would complete Resident #23's smoking assessment and have it in his chart today.</p> <p>Record review of the facility's Smoking Policy indicated, A Safe Smoking Assessment will be done regularly for each resident who smokes .</p>		

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide enough food/fluids to maintain a resident's health.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 42190</p> <p>Based on observation, interview, and record review, the facility failed to ensure residents were offered sufficient fluid intake to maintain weight and health 1 of 8 residents (Resident # 15) reviewed for hydration.</p> <p>The facility failed to ensure Resident #15 received a daily nutritional supplement.</p> <p>This failure could place residents at risk for unplanned weight loss, malnutrition, and failure to thrive.</p> <p>Findings included:</p> <p>Record review of the Quarterly MDS dated [DATE] indicated Resident #15 was understood and understood others. Resident #15's BIMS score was 15, indicating she was cognitively intact.</p> <p>Record review of a face sheet dated 03/27/2024 indicated Resident #15 was a [AGE] year-old female who admitted to the facility on [DATE] and readmitted on [DATE] with the diagnoses of acute combined systolic (congestive) and diastolic (congestive) heart failure, dysphagia (difficulty swallowing), oropharyngeal phase (middle part of throat behind the mouth) and muscle weakness (generalized).</p> <p>Record review of Resident's #15 doctors order, dated 02/13/2024, indicated Resident #15 will receive a supplement frozen treat, daily, at lunch.</p> <p>Record review of Resident #15's dietary profile, with an effective date of 03/04/2024, indicated Resident #15 did not gain any weight in the past 6 months.</p> <p>Record review of Resident #15's weights, over the past 6 months, indicated Resident #15 had a weight loss of 14.8 pounds, in the past 6 months. Which was an 8% weight loss in 6 months.</p> <p>02/05/2024 . 159.2 Lbs .wheelchair</p> <p>01/03/2024 . 162.4 Lbs .wheelchair</p> <p>12/06/2023 . 165.2 Lbs .wheelchair</p> <p>11/01/2023 . 159.2 Lbs .wheelchair</p> <p>10/04/2023 . 169.0 Lbs .wheelchair</p> <p>09/04/2023 . 174.0 Lbs .wheelchair</p> <p>Record review of the comprehensive care plan, with a review date of 12/18/2023 indicated Resident #15 had a regular diet order, is at risk for unplanned weight loss related to diabetes, dysphagia and malnutrition. The care plan goal for Resident #15: will maintain ideal weight and receive proper nutrition daily, X 90 days.</p> <p>(continued on next page)</p>

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of Resident #15's nutritional assessment, with an effective date of 03/26/2024; risk factor #15, indicated Resident #15 was receiving a nutritional supplement.</p> <p>During an observation and interview on 03/26/2024 at 10:52 a.m., Resident #15 was sitting at a table in the dining hall, eating her noon meal. Resident#15's meal ticket indicated she was to receive a supplement, 4 oz magic cup. When asked, Resident #15 said she did not receive a magic cup. She said she the last time she received a magic cup was one day last week.</p> <p>During an observation and interview on 03/26/2024, at 10:56 a.m., the Marketer was observed picking up and removing meal trays from tables in the dining hall. When asked if Resident #15 received a magic cup, the Marketer, looked at Resident #15's meal tray, observed her meal ticket and said, no, she did not receive it.</p> <p>During an interview on 03/26/2024 at 12:50 a.m., when asked if Resident #15 received a magic cup with her noon meal, the Dietary Manager said, no, it was an oversight. She said it was really busy in the kitchen, temperatures of the foods were being taken and she was having to fill in for another dietary staff. She said the DON was checking the trays before they were taken to the dining hall. She said she would take Resident #15 a magic cup.</p> <p>During an interview on 03/27/2024 at 1:49 p.m., the DON said she checked the resident trays as they came out of the kitchen. She said she could not tell this surveyor if Resident #15 received a magic cup or not. She said she could not remember. She said could not remember if Resident #15 had a red glass on her tray, which would indicate, Resident #15, was to receive a dietary supplement.</p> <p>Record review of a Dietary Services Policy &amp; Procedure Manual, dated 2012, did not indicate any policy or procedure the facility would take to assure residents receive a nutritional supplement.</p>