

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675468	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/12/2024
NAME OF PROVIDER OR SUPPLIER Hico Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 712 Railroad Ave Hico, TX 76457	

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 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41654</p> <p>Based on observation, interview, and record review the facility failed to ensure residents are given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living (ADLs) for 2 of 6 residents (Resident #14 and Resident #35) reviewed for ADL abilities, in that:</p> <p>1) Resident #14 appeared disheveled, had ground meat covering the front of her blouse after her meal covered up with her blanket in her wheelchair 2 hours after lunch.</p> <p>2) Resident #35 was lying in a soiled bed with a brown smear approximately 12 inches by 3 inches on bed sheet.</p> <p>This deficient practice could place residents who required assistance at risk for not receiving care and services to meet their needs and avoid ADL decline.</p> <p>Findings included:</p> <p>1) Record review of Resident #14's undated admission record reflected he was a [AGE] year-old male who was admitted to the facility on [DATE] with a diagnosis of occlusion and Stenosis of bilateral carotid arteries (a clogging of the arteries), dementia (an impairment of memory), and major depressive disorder.</p> <p>Record review of Resident #14's care plan dated 04/20/17 reflected an ADL self-care performance deficit related to his diagnosis of Dementia, muscle weakness, lack coordination, and abnormality of gait and mobility.</p> <p>The care plan also reflected Resident #14 required limited assistance by 1 staff for toileting and personal hygiene .</p> <p>Record review of Resident #14's Quarterly MDS dated [DATE] reflected a BIMS score of 14 indicating he was cognitively intact. Setup or clean-up assistance x1 staff with Personal hygiene and toileting hygiene Partial/moderate assistance with Shower/bathe self. Resident used a manual wheelchair for mobility.</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 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an observation on 09/10/24 at 12:05 PM Resident #14 was lying in bed asleep with a brown smear approximately 12 inches long and 3 inches wide on the lower end of the bed, resident was not covered, and the bottom sheet was exposed. There was a soiled brief in the trashcan.</p> <p>In an observation and interview on 09/10/24 at 02:30 PM with Resident #14's bedsheets continues to have brown smear on bedsheet approximately 12 inches long and 3 inches wide on lower end of bed. Resident #14 stated he had an accident this morning when using the restroom. He stated the staff do change his sheets every several days and staff occasionally check on him. Resident #14's lunch tray was served by staff and still in the room. The soiled brief remained in the trashcan.</p> <p>In an interview on 09/10/24 at 2:39 PM with RN -A, charge nurse for Resident #14, she stated the staff make rounds every 2 hours and check on resident's needs. RN A stated the staff should not have served the lunch tray with feces on the bed. She stated the CNA should have taken the dirty trash out prior to serving the lunch tray. RN A stated negative risk to the resident could be infection, cross contamination, we are instructed on ADL care, infection control, and resident rounding upon hire and as needed by nursing management.</p> <p>In an interview on 09/10/24 at 2:42 PM The DON stated it is not normal practice to serve lunch when residents are dirty or leave smeared feces on their bed. The DON stated it was a behavior of Resident #14 to take himself to the bathroom and he will occasionally smeared feces on his bed, but it is not acceptable to leave the resident like that. She stated visually he is checked on at least every 2 hours. She stated CNAs and staff were instructed to check on all residents q 2 hours and as needed. The DON stated charge nurses were responsible for making sure resident rounds were done and she was responsible for the education of the staff. She stated the negative effects for Resident #14 having soiled sheets could have included infection, cross contamination, impaired dignity, and lack of needs being met.</p> <p>2) Record review of Resident #35's undated admission record reflected she was a [AGE] year-old female who was admitted to the facility on [DATE] with a diagnosis of Hemiplegia and Hemiparesis following a Cerebral Infarction Affecting the Right Dominant Side (paralysis of the right extremities after a stroke), Aphasia (difficulty communication or speaking), Anxiety, and Conversion Disorder (a psychiatric condition) with seizures.</p> <p>Record review of Resident #35's care plan dated 08/15/2023 revised on 09/05/2024 reflected resident #35 had impaired cognitive function, impaired thought processes, and cognitive communication deficit related to a stroke. The goal was for Resident #35 to be able to communicate basic needs daily through the review date. Interventions on the care plan included to cue, reorient and supervise as needed.</p> <p>Record review of Resident #35's Annual MDS dated [DATE] reflected a BIMS score of 03 indicating she was cognitively impaired. The MDS also reflected Resident #35 had an impairment on one side of upper extremities and Impairment on both sides' lower extremities in mobility, she used a manual wheelchair for mobility. The MDS reflected Resident #35 required supervision or touching assistance with eating, substantial/maximal assistance with personal hygiene, upper body and lower body dressing.</p> <p>In an observation on 09/11/24 at 10:53 AM Resident #35 was sitting in her wheelchair in her room with the door closed. Resident #35's call light was clipped to her pillow on her bed out of her reach. Resident #35 had food covering the front of her blouse and was crying.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 09/11/24 at 10:56 PM with CNA B 1 she stated Resident #35 was not normally left sitting in her room with the door closed. She stated she was not sure who put her in her room with food on her shirt and her call light not in reach. CNA B stated Resident #35 feeds herself but would have needed her shirt changed.</p> <p>In an interview on 09/12/24 at 1:10 PM the DON stated Residents who feed themselves should have some type of clothing protector in place. She stated the clothing protectors are readily available in the dining room. The DON stated the Nurses and CNAs should apply the clothing protector to prevent food from going all over Resident #35's blouse or changed the blouse when they saw it was soiled with food. The DON stated it was not appropriate and would cause the resident impaired dignity.</p> <p>In an interview on 09/12/24 at 01:26 PM with the ADM he stated his expectation was that if a resident had soiled sheets or clothing it should be taken care of and cleaned up. The ADM stated no residents should be left in that condition. He stated the CNAs and nurses were responsible for making rounds and monitoring for those types of needs. He stated having soiled sheets and clothing could lead to a decline in health, impaired dignity, and infection.</p> <p>Record review of facility policy titled Activities of Daily Living dated February 2023 reflected the facility will, based on the resident's comprehensive assessment and consistent with the residents needs and choices ensure a resident's ability in ADLs do not deteriorate unless deterioration is unavailable.</p> <p>Care and services will be provided for the following activities of daily living including bathing, dressing grooming and oral care and toileting.</p> <p>3. A resident who is unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming and personal hygiene.</p>		