

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675484	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/12/2024
NAME OF PROVIDER OR SUPPLIER Woodland Park Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 101 Woodland Park Dr Shepherd, TX 77371	

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 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives an accurate assessment.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33460</p> <p>Based on interview and record review, the facility failed to ensure assessments accurately reflected the status for 3 of 13 residents reviewed for assessments. (Residents #04, #10, and #41).</p> <p>The facility failed to complete an accurate resident assessment for Resident #04, #10, and #41's. The resident assessment indicated they received anticoagulant medications; however, the residents did not receive anticoagulants.</p> <p>This failure could place residents at risk of not having individual needs met and a decreased quality of life.</p> <p>Findings included:</p> <p>1. Record review of a face sheet dated 06/11/24 indicated Resident #04 was a [AGE] year-old male admitted on [DATE] and readmitted [DATE]. His diagnoses included anxiety and infection of his lower right leg.</p> <p>Record review of physician orders dated June 2024 for Resident #04 included aspirin (antiplatelet medication) 81 MG daily and clopidogrel (antiplatelet medication) 75 MG daily both with a start date of 04/10/24. There was not an order for an anticoagulant.</p> <p>Record review of the significant change MDS dated [DATE] indicated Resident #04 received an anticoagulant medication during the last seven days and received no antiplatelet medication.</p> <p>Record review of the care plan dated 04/22/24 indicated Resident #04 was on anticoagulant therapy with medications of aspirin and clopidogrel.</p> <p>2. Record review of a face sheet dated 06/11/24 indicated Resident #10 was an [AGE] year-old female admitted on [DATE] and with a readmitted [DATE]. Her diagnoses included diabetes (high blood sugar) and chronic kidney disease.</p> <p>Record review of physician orders dated June 2024 for Resident #10 included clopidogrel 75 MG daily and aspirin 81 MG daily with start date of 05/21/24. There was not an order for an anticoagulant medication.</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 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of an admission MDS assessment dated [DATE] indicated Resident #10 received anticoagulant therapy and no antiplatelet medication.</p> <p>Record review of the care plan dated 05/20/24 indicated Resident #10 was at risk for bleeding, injury associated with daily use of antiplatelet medications. The goal indicated she would be free from discomfort or adverse reactions related to anticoagulant use.</p> <p>3. Record review of a face sheet dated 06/11/24 indicated Resident #41 was a [AGE] year-old male admitted on [DATE] with readmitted [DATE]. His diagnoses included heart failure.</p> <p>Record review of physician orders dated June 2024 for Resident #41 indicated he received aspirin 81 MG daily with a start date of 04/10/24. There was not an order for an anticoagulant medication.</p> <p>Record review of the quarterly MDS assessment dated [DATE] indicated Resident #41 received anticoagulant and no antiplatelet during the last 7 days.</p> <p>Record review of the care plan dated 05/20/24 indicated Resident #41 was at risk for bleeding, injury associated with daily use of antiplatelet medications. The goal indicated he would be free from discomfort or adverse reactions related to anticoagulant use.</p> <p>During an interview and record review on 6/11/24 at 2:45 p.m., the MDS Nurse said she was responsible for MDS assessments. She viewed the MDS and physician's orders for Residents #04, #10 and #41 and said those residents' MDS were not coded correctly. She said during the 7 days prior to MDS assessments the 3 residents did not receive anticoagulant. She said aspirin and clopidogrel should have been coded as an antiplatelet as she viewed the instructions of the RAI (Resident Assessment Instrument) manual. She said RAI manual was their policy. She said she had been trained on the RAI manual.</p> <p>During an interview on 6/11/24 at 3:00 p.m., the DON said her expectation was for the MDS assessments to be correct. She said if incorrect the care plan would not be correct, and the errors could affect resident care.</p> <p>During an interview on 6/11/24 at 3:30 p.m., the Administrator said she expected the MDS assessment to be correct. She said if the MDS was incorrect and it could affect resident care.</p> <p>Record review of the Long -Term Care Facility Resident Assessment Instrument 3.0 User's manual Version 1.18.11 dated October 2023 indicated . 1. Anticoagulant (e.g., warfarin, heparin, or low-molecular weight heparin): Check if an anticoagulant medication was taken by the resident at any time during the 7-day look-back period (or since admission/entry or reentry if less than 7 days). Anticoagulant: Check if there is an indication noted for all anticoagulant medications taken by the resident any time during the observation period (or since admission/entry or reentry if less than 7 days). 1. Antiplatelet: Check if an antiplatelet medication (e.g., aspirin/extended release, dipyridamole, clopidogrel) was taken by the resident at any time during the 7-day observation period (or since admission/entry or reentry if less than 7 days). Antiplatelet: Check if there is an indication noted for all antiplatelet medications taken by the resident any time during the observation period (or since admission/entry or reentry if less than 7 days). Do not code antiplatelet medications such as aspirin/extended release, dipyridamole, or clopidogrel as Anticoagulant.</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>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** 33460</p> <p>Based on observation, interview and record review, the facility failed to ensure residents who were unable to carry out activities of daily living received the necessary services to maintain grooming, and personal and oral hygiene for 1 of 13 residents (Resident #10) reviewed for ADLs.</p> <p>The facility failed to ensure Resident #10 received a shower on 06/01/24, 06/04/24 and on 06/06/24.</p> <p>This failure could place the residents at risk of not receiving the care and services to maintain their highest level of physical, mental, and psycho-social well-being.</p> <p>Findings included:</p> <p>Record review of Resident #10's face sheet dated 06/11/24 indicated she was [AGE] years old, admitted on [DATE] and readmitted on [DATE], with diagnoses including muscle weakness and unsteady gait.</p> <p>Record review of the admission MDS assessment dated [DATE] indicated Resident #10's BIMS score was 13 indicating intact cognition. She made herself understood and understood others and required partial/moderate assistance from staff for showering. No behaviors of refusing care.</p> <p>Record review of Resident #10's care plan dated 05/20/24 indicated he required assistance from staff with showering.</p> <p>Record review of the undated shower list indicated Resident #10 was to be given a shower on Monday, Wednesday and Friday.</p> <p>Record review of Resident #10's electronic CNA task sheet dated June 2024 indicated no bath or shower was provided for Resident #10 on 06/01/24 (Saturday), 06/04/24 (Tuesday), or 06/06/24 (Thursday). The task sheet indicated she received one shower on 06/08/24 (Saturday).</p> <p>Record review of Resident #10's electronic record indicated no documentation of Resident #10 refusing care.</p> <p>During observation and interview on 06/10/24 9:39 a.m., Resident #10 said she had not received her 3 showers last week and said her last shower was last Sunday (06/02/24). She said her hair needed to be cleaned. Resident #10 was sitting in her bed in her room. Her hair was unkempt and greasy, and she was scratching her head.</p> <p>During an interview on 06/11/24 at 8:00 a.m., the DON said the charge nurse and the ADON were responsible for ensuring showers were given and her expectation was for the residents to be given showers on their scheduled days.</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>During a phone interview on 6/11/24 at 9:47 a.m., the ADON said she had noticed a problem with showers not being given last week and she had performed an in-service last week on Monday (06/03/24). She said the facility did not use shower aides so the CNAs must give the showers now. She said her expectation was for the showers to be given 3 times a week for each resident. She said if day shift was unable to get to all showers evening must finish the showers. She said there must still be an issue with Resident #10 and the DON would have staff help her with a shower today and they would investigate why she had not been given a shower 3 x a week.</p> <p>Record review of the Bath, Shower/Tub dated February 2018 indicated Purpose The purpose of this procedure are to promote cleanliness, provide comfort to the resident and to observe the condition of the resident's skin.</p>

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<p>F 0689</p> <p>Level of Harm - 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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36214</p> <p>Based on observation, interview, and record review, the facility failed to ensure each resident received adequate assistance to prevent accidents for 1 of 13 residents (Resident #32) reviewed for accidents.</p> <p>The facility failed to ensure the Van Driver transferred Resident #32 safely out of the facility transport van using the mechanical wheelchair lift. Resident #32 fell out of the facility van and sustained a hematoma (a collection of blood outside of a blood vessel, which is caused by injury or trauma) to the back of her head.</p> <p>This failure could place residents at risk of injuries.</p> <p>Findings included:</p> <p>Record review of a face sheet dated 06/11/24 indicated Resident #32 was an [AGE] year-old female, admitted to the facility on [DATE], and her diagnoses included acute pyelonephritis (a bacterial infection that causes inflammation of the kidneys), cirrhosis of the liver (chronic liver damage from a variety of causes leading to scarring and liver failure), muscle weakness, and difficulty walking.</p> <p>Record review of a care plan revised 11/09/23 indicated Resident #32 used a wheelchair for locomotion and required assistance of one to transfer.</p> <p>Record review of a quarterly MDS dated [DATE] indicated Resident #32 was usually understood and had moderately impaired cognition. She had functional limitation in range of motion to her lower extremities, required assistance with transfers, and used a wheelchair for mobility.</p> <p>Record review of a nurse's note dated 06/07/24 at 12:25 p.m. and signed by LVN B indicated the Van Driver came running into the facility saying Resident #32 fell while unloading and was hurt. LVN B went to the parking lot, to the van. Resident #32 was in her wheelchair, on her back, on the ramp which was on the concrete. The resident was alert and complaining that her head and her back were hurting. The resident had a large lump on the back of her head. Resident #32 said she fell out of the back of the van and hit her head. Staff gently removed the wheelchair. LVN B called the ambulance and printed paperwork for transfer. MA A cradled the resident's head on a pillow. Resident #32 was joking with staff. The ambulance arrived quickly. The resident's neck was secured with a brace, and she was carefully transferred to a stretcher and transported to a hospital.</p> <p>Record review of an incident report dated 06/07/24 at 12:25 p.m. and signed by LVN B indicated the Van Driver failed to raise the lift, pushed Resident #32 backwards from the rear of the van causing the resident to fall. The resident was immediately assessed and remained conscious and still until EMS arrived. Resident #32 had a hematoma to the back of her head, but no other major injuries were identified in the emergency room. Staff education was initiated immediately regarding resident rights, incidents/accidents, and abuse/neglect. The van would not be used until all staff that are cleared to drive the van had been re-educated. Education would include:</p> <p>(continued on next page)</p>

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>-Proper use of the lift.</p> <p>-If two or more residents were transported at one time the van driver must have another staff member present.</p> <p>-No resident was to be left alone on the van.</p> <p>-When exiting the van via the back door the driver must re-enter the van through the back door to ensure that the lift is in place for the exit of additional resident.</p> <p>-Van drivers/staff are responsible for the safety and well-being of residents in transport.</p> <p>Record review of CT scans dated 06/07/24 indicated Resident #32 had no acute posttraumatic abnormalities (no injuries) of her brain, chest, spine, abdomen, pelvis, hips. or face.</p> <p>Record review of an ER physician note dated 06/07/24 at 7:36 p.m., indicated Resident #32 was stable and was being discharged back to the facility with her RP's consent.</p> <p>During an observation and interview on 06/10/24 at 11:05 a.m., Resident #32 was lying in her bed. She said she had fallen out of the van and hurt the back of her head. She said she went to the hospital, and they did not find any broken bones. She said she had some pain to her back and the back of her head, but the nurses were giving her pain medications. She said the fall was an accident.</p> <p>During an interview on 06/11/24 at 9:05 a.m., Resident #32's RP said the facility notified him immediately after the incident. He said the facility sent her to the ER and CT scans showed no broken bones and no brain bleed. He said Resident #32 had experienced some soreness to the back of her head and her back, but she had been able to sleep and rest and was receiving pain medication. He said he was a retired EMT and was familiar with transporting. He said the incident occurred because the van driver forgot to raise the lift. He said he had spoken with the Administrator after the incident and the Van Driver was re-educated on transferring resident into and out of the van.</p> <p>During an interview on 06/11/24 at 9:50 a.m., the DON said the Van Driver had two residents on the van on 06/07/24 and had taken one into the facility and forgot to raise the lift back up for Resident #32. She said the van driver was transferring Resident #32 out of the van and the ramp was still down. The resident fell backwards and hit her head. The Van Driver also fell out of the van while attempting to stop Resident #32 from falling. She said the hospital determined the resident had no broken bones or brain bleed. She said the fall was due to driver error. She said all staff that were insured to drive the van were being re-educated on transport training and loading and unloading residents with the lift to prevent further incidents.</p> <p>During an interview on 06/11/24 at 9:55 a.m., the Administrator said the van and the wheelchair lift were tested on [DATE] by the Maintenance Director and found to have no mechanical issues. He said Resident #32's fall was due to driver error and not putting the lift back up for descent to the ground. He said the Van Driver was re-educated on loading and unloading residents in and out of the van. He said she demonstrated competency with van transport and the lift. He said his expectation for van transport was for residents to be transported safely and without incident.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 06/11/24 at 2:25 p.m., the Van Driver said she had been driving the van for about 6 months and had received training on van transport safety before she started driving. She said on 06/07/24 she had transported two residents to physician appointments. When she arrived back at the facility there was a vehicle parked in the spot where she usually parked and unloaded residents off the van. She said she got the first resident out of the van using the wheelchair lift and took him inside the facility. She said she left Resident #32 in the van alone. She said she returned to the van and entered through the side door and unfastened Resident #32's wheelchair from the safety belts. The resident was upset and complaining of being hot and asked her to hurry up. She then rolled Resident #32 backwards toward the wheelchair lift while standing in the front of the wheelchair. The resident then put her hands on the wheels of the chair pushing herself back. The Van Driver said she realized the lift was not up and grabbed the wheelchair to keep Resident #32 from falling. The resident fell backward out of the van hitting her head on the pavement and the Van Driver fell with her still holding onto the wheelchair. She said she ran into the facility yelling for help. Staff immediately ran outside to help the resident. The wheelchair was moved while MA A held Resident #32's head and neck steady. The ambulance was called, and Resident #32 was sent to the hospital. The Van Driver said she should have kept the lift in view while pushing the wheelchair onto it.</p> <p>During an observation and interview on 06/11/24 at 2:35 p.m., the Van Driver transferred the Maintenance Director sitting in a wheelchair onto the Wheelchair lift, lifted him up and into the van, and transferred him back down to the ground using the wheelchair lift. No mechanical issues were observed with the wheelchair lift. The Maintenance Director said he had examined and tested the van and the lift on 06/10/24 and found no mechanical issues.</p> <p>During an interview on 06/12/24 at 11:45 a.m., MA A said she was the first one out to the van when the Van Driver called for help. She said Resident #32 was laying with her head and back on the ground and her legs up on the wheelchair. She said she held the resident's head stable while staff removed the wheelchair and she continued to hold her head until ambulance arrival.</p> <p>During an interview on 06/12/24 at 1:06 p.m., LVN B said she went outside to check on Resident #32 after the incident and the resident was on her back on the ramp and had a large bump on the back of her head. Resident #32 said she fell out of the back of the van because the ramp was on the ground. She said the resident was awake and alert and never lost consciousness after the fall. LVN B said the ambulance arrived quickly and a neck brace was secured in place by EMS for transport to the hospital.</p> <p>Record review of an in-service dated 09/08/23 indicated the Van Driver had received training and performed satisfactory return demonstrations of van and lift operations which included: Load the resident by rolling the resident onto the lift always keeping the lift in view.</p> <p>Record review of an in-service dated 06/10/24 indicated the Van Driver was re-educated and performed a satisfactory return demonstration which included: Load the resident by rolling the resident onto the lift always keeping the lift in view.</p> <p>(continued on next page)</p>		

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F 0689 Level of Harm - Actual harm Residents Affected - Few	<p>Record review of the facility policy Safety and Supervision of Residents revised July 2017 indicated Our facility strives to make the environment free from accident hazards as possible. Resident safety and supervision and assistance to prevent accident are facility-wide priorities.3. The care team shall target interventions to reduce individual risks related to hazards in the environment, including adequate supervision and assistive devices.4. Implementing interventions to reduce accident risks and hazards shall include the following: a. communicating specific interventions to all relevant staff; d. ensuring interventions are implemented . Resident Risks and Environmental Hazards-1. Due to their complexity and scope, certain risk factors and environmental hazards are addressed in dedicated policies and procedures. These risk factors and environmental hazards include: .b. Safe Lifting and Movement of Residents .</p>

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<p>F 0727</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis.</p> <p>36214</p> <p>Based on interview and record review, the facility failed to use the services of a registered nurse for 8 at least consecutive hours 7 days a week for 2 of 4 quarters of 2023 (Quarter 4 July 01, 2023 through September 30, 2023 and Quarter 1 October 01, 2023 through December 31, 2023) PBJ reports reviewed for RN coverage.</p> <p>The facility did not have RN coverage for 07/08/2023, 10/07/2023, and 10/08/2023.</p> <p>This failure could place residents at risk of lack of nursing oversight and a higher level of care.</p> <p>Findings included:</p> <p>Record review of the CMS PBJ reports indicated:</p> <p>* Quarter 4 2023 (July 01, 2023 through September 30, 2023) there were no RN hours on 07/08/23 (Saturday).</p> <p>* Quarter 1 2023 (October 01, 2023 through December 31, 2023) there were no RN hours on 10/07/23/10 (Saturday) and 01/08/23 (Sunday).</p> <p>During an interview on 06/12/24 07:50 a.m., the DON said PBJ reports were submitted by the facility's corporate office. She said on 07/08/23 the facility had contracted an agency RN to work, and the RN did not call to say she could not work and did not show up for her shift. She said she did not recall why the facility did not have RN coverage for on 10/07/23 and 10/08/23. She said the possible negative outcome of not having an RN working 8 hours a day 7 days a week was the facility not having a supervisor present in the facility to oversee resident care.</p> <p>During an interview on 06/12/24 at 08:05 a.m. the Administrator said the facility had a difficult time hiring RNs at the facility. He said the facility had hired a new RN in October and RN coverage at the facility had become less of a problem, but the facility had no RN coverage for 07/08/23, 10/07/23, and 10/08/23. He said possible negative outcome of not having 8 consecutive hours of RN coverage daily was the facility had no supervisor present to oversee resident care.</p> <p>Record review of facility policy titled Staffing, Sufficient and Competent Nursing, revised August 2022, indicated, . A registered nurse provides services at least eight (8) consecutive hours every 24 hours, seven (7) days a week. RNs may be scheduled more that eight (8) hours depending on the acuity needs of the resident.</p>		