STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675553	A. Building B. Wing	03/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Caraday of Quitman	1026 E Goode St Quitman, TX 75783

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 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** 35295 Based on record review and interview, the facility failed to develop and implement a comprehensive person-centered care plan for each resident that included measurable objectives and timetables to meet residents highest practicable physical, mental, and psychosocial needs for 1 of 17 residents reviewed for care plans, (Resident #4). Resident #4 was not have a care planned for her DNR (a medical order instructing healthcare providers not to perform CPR or other resuscitative measures if a patient's heart or breathing stops). Her care plan indicated she was a full code. This failure could place residents at risk of not receiving the care required to meet their physical, mental, and psychosocial needs for each to attain or maintain their highest practicable physical, mental, and psychosocial outcome. Findings included: Record review of the undated face sheet indicated Resident #4 was a [AGE] year-old female that admitted [DATE] and readmitted [DATE]. The face sheet indicated she had diagnoses that included: cerebral infarction (blood flow to the brain is interrupted, causing tissue to die), heart failure (the heart does not pump blood as well as it should), and vascular dementia with behaviors (blood flow disruptions to the brain causing changes in behavior and mood including depression, agitation, and anger, along with difficulties in thinking, memory, and daily activities.) Record review of the physician's orders dated [DATE] for Resident #4 indicated: [DATE] DNR Record review of the quarterly MDS dated [DATE] indicated Resident #4 had unclear speech, rarely understood others, and was rarely understood. The MDS indicated she had short- and long-term memory problems. Record review of the Care Plan dated [DATE] indicated Resident #4 had impaired cognitive function with impaired thought processes related to dementia. The care plan indicated she was a Full Code status with an initiated date of [DATE] and a revision date of [DATE]. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of an OOH-DNR dated [DATE] indicated Resident #4 was a DNR. During an interview on [DATE] at 9:50 AM, LVN B looked in the electronic health record for Resident #4. LVN B said Resident #4 was a DNR. He looked at her care plan and said it indicated she was a full code and that was wrong. He said the care plan should indicate she was a DNR. He said the care plan should have been updated when Resident #4 got the DNR order and signed the OOH-DNR. During an interview on [DATE] at 9:55 AM, the ADON checked Resident #4's electronic chart and said Resident #4 was a DNR. She looked at the care plan and said the care plan indicated she was a DNR and had been updated today ([DATE]). The ADON was shown Resident #4's care plan from earlier today that indicated she was a full code. The ADON said a full code was wrong for Resident #4. She said the care plan for Resident #4 should have been updated on [DATE] when she got the order for the DNR and the OOH-DNR. During an interview on [DATE] at 10:28 AM, the MDS nurse looked at Resident 4's electronic chart and said she was a DNR. She looked at the care plan and said her care plan had been updated to a DNR today, [DATE]. She said she only worked 2 days per week. She said if the care plan indicated a full-code, it was wrong. She said the care plan should have indicated a DNR from the date Resident #4 got the DNR, ([DATE]). She said she was responsible for the mistake and should have caught it. She said the SW usually updated advance directives. She said she usually found out about a change from the DON or SW verbally or by email. The MDS nurse did not remember anyone telling her or sending an email indicating Resident #4 got a DNR on [DATE]. During an interview on [DATE] at 10:33 AM, the SW said she worked 2 days per week. She said if she had assisted with an advance directive, she would have care planned it. She said the DON or ADON would usually notify her if there was a change in a resident's advance directive. She said she did not know Resident #4 had gotten a DNR. She said she was responsible for making sure the advance directive was correct in the care plan. She said she did not work [DATE] and no one notified her of the change from a full code to a DNR. She said the person that assisted with the advance directive, the DON or ADON, should have let her know about a change. She said the DON would double check care plans to make sure they were correct. During an interview on [DATE] at 12:52 PM, the DON said she agreed that when surveyors entered the building the care plan for Resident #4 indicated a full code and that was wrong. She said she corrected the care plan on [DATE]. She said the care plan should have been changed to a DNR as soon as Resident #4 became a DNR on [DATE]. She said the person responsible for making sure the care plan was correct was her. She said she, the MDS nurse, and the SW worked on the care plans and somehow Resident #4's DNR got missed. She said there was not really a risk to the resident if the care plan was wrong because the book on the crash cart was correct and when her electronic record was pulled up it indicated Resident #4 was a DNR. She said in the event of a code (resident stopped breathing) nurses would not go to the care plan to check her status because they used the book on the crash cart which indicated she was a DNR. (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 [DATE] at 1:04 PM, the ADM said Resident #4's care plan should have been updated on [DATE], when she got the DNR. He said there was really not a risk to the resident, but the care plan documentation was incorrect. He said the crash cart book had her DNR correctly identified, and her electronic chart showed she was a DNR. He said if a resident coded, the nurses would look at the crash cart book which indicated she was a DNR. He said the final responsibility for the care plan being correct was the DON. Record review of a Care Plans, Comprehensive, Person Centered policy with a revised date of [DATE], provided by the ADM indicated: Policy Statement A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident . 13. Assessments of residents are ongoing and care plans are r revised as information about the residents and the residents' conditions change. 14. The Interdisciplinary Team must review and update the care plan: a. When there has been a significant change in the resident's condition; b. When the desired outcome is not met .

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46929 Based on observation, interviews, and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety in the facility's only kitchen reviewed for food safety requirements. 1. The facility failed to ensure foods stored in the kitchen walk-in refrigerator were thrown away when expired. 2. The facility failed to ensure foods stored in the kitchen walk-in freezer were thrown away when expired. 3. The facility failed to ensure a mixing bowl with a pink and white substance was labeled and dated. 4. The facility failed to properly store raw meat in the kitchen walk-in refrigerator. These failures could place residents at risk of foodborne illness and food contamination. Findings included: During an observation on [DATE] at 09:08 AM, an initial tour of the kitchen was conducted. The following items were observed: 1) 1 mixer bowl half-full of a white and pink frozen substance in the freezer. It was not covered, labeled or dated. 2) 1 container labeled peas in the freezer, dated [DATE], expiration date of [DATE]. 3) 1 container labeled pinto beans in the freezer, dated [DATE], expiration date of [DATE]. 4) 1 container labeled cottage cheese in the refrigerator, expiration date of [DATE]. 5) 1 pan of raw bacon found in the refrigerator. The pan was on the top shelf of the refrigerator above bags of bread and cooked meat on the shelf. During an interview on [DATE] at 9:15AM, [NAME] A said that she was not sure why the items were in the freezer and refrigerators. She pulled the items out of the freezer and refrigerator and threw them away. She also moved the raw bacon to the bottom shelf. During an interview on [DATE] at 12:47 PM, the Dietary Manager said she expected the expired foods to be thrown away when they were found. She said she expected the raw meat to be kept on the bottom shelf. She said everyone that worked in the kitchen was responsible for throwing out the expired food. She said she usually checked the kitchen Monday and Friday mornings for expired foods. she was not working on [DATE] and was unable to check the kitchen. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on [DATE] at 01:44 PM, the Administrator said his expectation was that food be labeled and dated and raw meat should have been on the bottom shelf. He said the risk was foodborne illness. Record review of the Facility's policy, Food Storage, dated 2018, stated: Policy: To ensure that all food served by the facility is of good quality and safe for consumption, all food will be stored according to the state, federal and US Food Codes and HACCP guidelines . .Procedure: . .2. Refrigerators . .d. Date, label and tightly seal all refrigerated foods using clean, nonabsorbent, covered containers that are approved for food storage. e. Use all leftovers within 72 hours. Discard items that are over 72 hours old. f. Store raw meats and eggs on the bottom shelf to prevent contamination of other foods. To avoid cross-contamination, store raw or uncooked food and produce away from and below prepared or ready-to-eat food . .3. Freezers . .e. Store frozen foods in moisture-proof wrap or containers that are labeled and dated .