STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675599	A. Building B. Wing	09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Robert Lee Care Center	307 West 8th St Robert Lee, TX 76945

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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 0641 Level of Harm - Potential for minimal harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30057 Based on interview and record review, the facility failed to ensure the assessment accurately reflected the resident status for 1 of 12 residents (Resident #3) whose MDS assessments were reviewed, in that: Resident #3's MDS assessment dated [DATE] was coded as not being PASRR positive when the resident was positive. This failure could affect residents in the facility and put them at risk of inadequate care based on inaccurate assessment. The findings were: Record review of Resident #3's admission record dated 09/26/2024 indicated she was admitted to the facility on [DATE]. Diagnoses included schizoaffective disorder and mild intellectual abilities. She was [AGE] years of age. Record review of Resident #3's PASRR level 1 screening dated 05/25/2021 indicated in part: Is there evidence or an indicator this is an individual that has a mental illness? Yes. Is there evidence or an indicator this is an individual that has an intellectual disability? Yes. Is there evidence or indicators that this is an individual that has a developmental disability (related condition) other than an intellectual disability (e.g., Autism, Cerebral palsy, Spina bifida)? Yes. Review of Resident #3's MDS assessment dated [DATE], indicated in part: Is the resident currently considered by the state level II PASRR process to have serious mental illness and/or intellectual disability or a related condition? Coded 0 indicating No. Level II Preadmission Screening and Resident Review (PASRR) Conditions. Check all that apply A. Serious mental illness. B. Intellectual Disability - None checked. Active Diagnoses - checked for Schizophrenia (e.g., schizoaffective and schizophreniform disorders). (continued on next page)

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F 0641 Level of Harm - Potential for minimal harm Residents Affected - Some	During an interview on 09/26/24 at 02:56 PM the MDS coordinator said Resident #3 was indeed PASRR positive as she would be seen for PASRR services although Resident #3 had refused them. The MDS coordinator said Resident #3 had been PASRR positive since admission. The MDS coordinator was asked regarding Resident #3's annual MDS assessment having Resident #3 coded as no for the resident having a have serious mental illness or intellectual disability. The MDS coordinator said she had not noticed that she had accidentally coded the wrong answer and that it should have been coded yes for PASRR for Resident #3. The MDS coordinator said she would change that to the correct code. The MDS coordinator said they did not have particular policy for MDS, and they went based on the Resident Assessment Instrument (RAI) manual instructions. During an interview on 09/26/24 at 03:18 PM the DON was made aware of Resident #3's MDS being coded as no for PASRR when it should have been yes. The DON said it was due to human error and they would get that fixed. During an interview on 09/26/24 at 03:22 PM the Administrator was made aware of Resident #3's MDS being coded as no for PASRR when it should have been yes. The Administrator said he was aware of the error and that they would get that fixed. Record review of CMS's RAI version 3.0 manual dated October 2019 indicated in part: A1500: Preadmission Screening and Resident Review (PASRR). Code 1, yes: if PASRR Level II screening determined that the resident has a serious mental illness and/or ID/DD or related condition, and continue to A1510, Level II Preadmission Screening and Resident Review (PASRR) Conditions.

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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** 26221 Based on observation, interview and record review the facility failed to develop and implement a comprehensive, person-centered care plan for each resident that included measurable objectives and time frames to meet, attain, and/or maintain the resident's highest practicable physical, mental, and psychosocial well-being for 1 of 5 residents (Resident #24) reviewed for care plans in that: Resident #24 did not have a care plan addressing the use of her ankle splint. This failure could affect resident by placing her at risk of not receiving individualized care and services to meet her needs. The findings included: Review of Resident #24's Admission Record dated 9/26/24 revealed she was a [AGE] year-old female admitted to the facility for paralysis following a stroke affecting her dominant side. Review of Resident #24's Quarterly MDS Assessment, dated 9/12/24 revealed: She scored a 13 of 15 on her mental status exam (indicating she was cognitively intact); She had range of motion impairment of the upper and lower extremities on one side; She used a walker and wheelchair; She needed supervision to walk 150 feet. She received 170 minutes of physical therapy in the previous 7 days. Splint use was not identified. Review of Resident #24 Care Plan, last reviewed 9/19/24, revealed no care plan for the splint. Review of Resident #24' 9/26/24 revealed no order for the splint. Observation and interview on 9/24/24 at 10:26 a.m. revealed Resident #24 had a hard ankle splint at the end of her bed. Resident #24 stated it was bed because she had a stroke, and her foot did not work right. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 09/26/24 at 1:38 PM the MDS Coordinator and DON stated Resident #24 was a stroke victim who came to the facility within the last three months. The DON stated Resident #24's main issue was balance. The DON stated Resident #24 used a specialized walker with therapy and an electric wheelchair when not with therapy. The DON stated Resident #24 did have a brace. The MDS Coordinator stated she was unaware of a brace. The DON told the MDS Coordinator it was to prevent drop foot (a condition where the front of the foot/toes drag). The MDS Coordinator said she did not see the brace on Resident #24's care plan or MDS. The MDS Coordinator stated Resident #24 just had a care plan update on 9/19/24. The DON said Resident #24 came in with the brace, but now that surveyor asked, she could picture Resident #24 wearing it. The DON stated Resident #24 took it on and off at will. Review of the facility's policy and procedure on Care Planning - Interdisciplinary Team, revised March 2022, revealed: The interdisciplinary team is responsible for the development of resident care plans. Policy Interpretation and Implementation. Resident care plans are developed according to the timeframes and criteria established by regulation. Comprehensive, person-centered care plans are based on resident assessments and developed by an interdisciplinary team. Review of the facility's policy and procedure on Resident Mobility and Range of Motion, revised July 2017, revealed: Residents with limited mobility will receive appropriate services, equipment, and assistance to maintain or improve mobility unless reduction in mobility is unavoidable. The care plan will be developed by the interdisciplinary team based on the comprehensive assessment and will be revised as needed. The care plan will include specific interventions, exercises, and therapies to maintain, prevent avoidable decline in, and/or improve mobility and range of motion. Interventions may include therapies, the provision of necessary equipment, and/or exercises and will be based on professional standards of practice and be consistent with state laws and practice acts. The care plan will include the type, frequency, and duration of interventions, as well as measurable goals and objectives.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26221 Based on observation, interview and record review, the facility failed to ensure that residents received treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices for 1 of 5 residents reviewed for quality of care. (Resident #24) The facility did not assess, obtain orders or monitor Resident #24's ankle splint. This failure could place the residents at risk of not receiving the care and services to maintain their highest practicable physical, mental, and psychosocial well-being. Findings included: Review of Resident #24's Admission Record dated 9/26/24 revealed she was a [AGE] year-old female admitted to the facility for paralysis following a stroke affecting her dominant side. Review of Resident #24's Quarterly MDS Assessment, dated 9/12/24 revealed: She scored a 13 of 15 on her mental status exam (indicating she was cognitively intact); She had range of motion impairment of the upper and lower extremities on one side; She used a walker and wheelchair; She needed supervision to walk 150 feet. She received 170 minutes of physical therapy in the previous 7 days. Splint use was not identified. Review of Resident #24 Care Plan, last reviewed 9/19/24, revealed no care plan for the splint. Review of Resident #24's Order Summary Report, dated 9/26/24, revealed orders: There was no order for the ankle splint. OT/PT evaluate and treat for decline in personal hygiene, toileting and bed mobility beginning 6/17/24. Observation and interview on 9/24/24 at 10:26 a.m. revealed Resident #24 had an ankle splint at the end of her bed. Resident #24 stated it was bed because she had a stroke, and her foot did not work right. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 09/26/24 at 01:38 PM the MDS Coordinator and DON stated Resident #24 was a stroke victim who came to the facility within the last three months. The DON stated Resident #24's main issue was balance. The DON stated Resident #24 used a specialized walker with therapy and an electric wheelchair when not with therapy. The DON stated Resident #24 did have a brace. The MDS Coordinator stated she was unaware of a brace. The DON told the MDS Coordinator it was to prevent drop foot (a condition where the front of the foot/toes drag). The MDS Coordinator said she did not see the brace on Resident #24's care plan or MDS. The MDS Coordinator stated Resident #24 just had a care plan update on 9/19/24. The DON said Resident #24 came in with the brace, but now that surveyor asked, she could picture Resident #24 wearing it. The DON stated Resident #24 took it on and off at will. The DON said the nurses checked Resident #24's skin to make sure there was no break down from the brace. In an interview on 09/26/24 at 01:48 PM the DON said Resident #24 got the splint from an outpatient rehabilitation provider prior to coming to the facility. The DON said the staff were aware Resident #24 had the splint but were not aware that therapy did not initiate the order for the splint. The DON said Resident #24 could take the splint on and off at will so she was probably not wearing it when Resident #24 was admitted . In an interview on 09/26/24 at 01:56 PM the DON stated the therapist who originally worked with Resident #24 and was aware of the splint no longer worked with the facility. The DON said the nurses were educated about taking on and off the splint and checking skin integrity. The DON said they called for orders that just didn't get initiated here. Review of the facility's policy and procedure on Resident Mobility and Range of Motion, revised July 2017, revealed: Residents with limited mobility will receive appropriate services, equipment, and assistance to maintain or improve mobility unless reduction in mobility is unavoidable. During the resident's assessment, the nurse will identify the underlying factors that contribute to his or her range of motion or mobility problems, if any, including: conditions that limit or immobilize movement of limbs or digits (e.g. splints). The care plan will be developed by the interdisciplinary team based on the comprehensive assessment and will be revised as needed. The care plan will include specific interventions, exercises, and therapies to maintain, prevent avoidable decline in, and/or improve mobility and range of motion. Interventions may include therapies, the provision of necessary equipment, and/or exercises and will be based on professional standards of practice and be consistent with state laws and practice acts. The care plan will include the type, frequency and duration of interventions, as well as measurable goals and objectives.

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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** 48593 Based on observation, interview, and record review, the facility failed to ensure that a resident who needs respiratory care is provided such care, consistent with professional standards of practice for 1 (Resident #19) of 6 residents observed for oxygen management. The facility failed to ensure Oxygen (O2) in use signage was on Resident #19's doorway. This failure could place residents at risk of not receiving appropriate respiratory care. The findings were: Record review of Resident #19 's admission record dated 09/26/2024 revealed Resident #19 was a [AGE] year-old male with an admitted to the facility of 07/19/2024. Admission record revealed Resident #19 had diagnoses that included Chronic obstructive pulmonary disease (progressive lung disease characterized by chronic respiratory symptoms and airflow limitation), shortness of breath, heart failure, dependence on supplemental oxygen, and muscle weakness. Record review of Resident #19 's MDS revealed the resident had a BIMS of 14 indicating the resident was cognitively intact. Record review of Resident #19 's order summary dated 09/26/24 revealed an order of OXYGEN AT 2-5 LITERS PER NASAL CANNULA. every day and night shift related to CHRONIC OBSTRUCTIVE PULMONARY DISEASE, UNSPECIFIED (COPD). Record review of Resident #19 's Care plan dated 08/15/2024 revealed a focus of is dependent on staff for meeting physical and social needs. He has Heart Failure. SOB (Shortness of breath) r/t (Related to) COPD and is on oxygen. chooses not to attend activities or monthly events. He prefers to stay in his room. Observation on 09/24/24 at 09:52 AM during revealed that there was not a No smoking oxygen in use sign on Resident #19's door. Interview on 09/26/24 at 01:55 PM the DON stated that the residents who had an oxygen sign on the doorway was to inform anyone who entered the resident's, room that the resident was on oxygen. The DON stated that the sign was for safety, even though no one was supposed to smoke inside the facility, they had to put the sign indicating there was a combustible material in the room. The DON stated the sign was on the room that Resident #19 was in previously to being moved on 09/11/2024. The DON states that the medical record staff was responsible for ensuring the residents had a No smoking oxygen in use sign on the door. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 09/26/24 at 02:16 PM with the Medical Records, stated that she was responsible for ensuring the residents who were admitted into the facility that were on oxygen received the sign for the door. The Medical Records stated that she was aware that the resident had moved rooms but did not know the sign was not moved. The Medical Records stated that if the residents were moved when she was off that the floor staff would move the sign to the new room. The Medical Records stated that the sign was used to indicate who was using oxygen in the building. The Medical Records did not think there was a negative outcome of not having the sign on the door. Record review of the facility's policy titled Oxygen Administration with a revision date of October 2010 revealed that under the section steps in the procedure - 2. Place an Oxygen in Use sign on the outside of the room entrance door.

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. 30057 Based on observation, interview, and record review, the facility failed to post daily information that included the facility name, total number and actual hours worked by registered nurses, licensed practical or licensed vocational nurses, certified nurse aides directly responsible for resident care per shift and the resident census for 2 days (09/25/2024 to 09/26/2024) of 3 days observed for staff posting. The facility failed to post the daily staffing information for 09/25/2024 and 09/26/2024. This failure could place all residents, their families, and facility visitors at risk of not having access to information regarding staffing data and the facility census. The findings included: During an observation and record review on 09/25/2024 and 09/26/2024 at 11:50 a.m. revealed the facility's daily nursing posting located behind the nurses' station failed to indicate the actual hours worked for each direct care staffing, the facility name, the total number and actual hours worked by the staff and resident census. The posting indicated the following CMA - 2, CNA-4, LVN-1, RN-1, Admin - 1, RN-1 and LVN 2. During an interview on 09/26/24 at 11:22 AM the DON and Administrator said the postings boards placed behind each nurse's station was their daily staffing post. They said the number by each staff title was the number of that particular staff working the floor. They said they were not aware the posting had to indicate the number of hours, the facility name and census. Record review of the facility's policy titled Nurse staffing posting information and dated August 2024 indicated in part: It is the policy of this facility to make sure staffing information readily available in a readable format to residents and visitors at any given time. The nurse staffing sheet will be posted on a daily basis and will contain the following information: Facility name. The current date. Facility's current census. The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: Registered Nurses. Licensed Practical Nurses/Licensed Vocational Nurses. Certified Nurse Aides.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 26221 Based on observation, interview 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 one of one kitchen. The facility failed to ensure: Food debris was not on the floor in the freezer. Staff did not transport dishes by holding them against their body. Staff completed hand hygiene appropriately. Dishes were stored in a manner to prevent contamination. Prevention of contamination of salad bar containers by staff handling practices. Frozen meat was stored in a manner to prevent contamination in the event of thawing. These failures could affect residents who received meals prepared from the kitchen at risk for food borne illness and cross contamination. Findings included: Observation on 9/24/24 between 9:18 a.m. and 9:36 a.m. revealed: Bowls stored against the long wall of the kitchen were stored face up. The outside walk-in refrigerator had a bucket of pickles on the ground. The walk-in freezer had meat stored over vegetables and bread. The dry storage had individual serving of jelly and packets of sugar on the floor under the shelves. The inside of the walk-in refrigerator had a brisket thawing over pickles, eggs and bacon. During the noon meal preparation on 9/25/24 beginning at 9:50 a.m. and 11:35 a.m. revealed: Cook B was observed washing her hands turning off the faucet with her bare hands three times. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	DA D had a stack of dishes she was putting up from the clean dish area. DA D had the plates stacked directly against her body as she brought them to the storage area. DA C had containers for the salad bar that she carried from the clean dish area to the food preparation area with her bare hands and her fingers in each container touching the food surface. DA D returned from outside of the kitchen, did not wash her hands, did don gloves and continued with food preparation. In an interview on 9/26/24 at 2:03 p.m. the Dietary Manager said the staff knew to have dishes face down, she clarified which bowls were face up and stated those were the bowls used for the salad bowls. The Dietary Manager said the pickle bucket was the only thing that would be on the floor in the refrigerator, but everything needed to be at least six inches off the floor due to contamination. The Dietary Manager said staff needed to wash their hands when they returned in from the kitchen due to cross contamination issues. The Dietary Manager asked for clarification on the salad bar container food surface being touched all at once, she said she had previously had numerous conversations with that staff member about that and that putting clean dishes against dirty scrubs just contaminated the dishes. The Dietary Manager said it did not matter what kind of container the meat was being thawed in it still could not be thawed over other food. In an interview on 9/26/24 at 2:22 p.m. the Administrator was informed of the kitchen observations, he stated they were pretty straight forward, and they would monitor it. Review of the Cleaning Schedule revealed the cook was responsible for cleaning the refrigerator and freezer and the outside coolers were last documented as completed on 9/24/24. Review of the 5/24/24 in-service on Maintaining a Clean Kitchen revealed: food items are not stored on the floor. Example of Monthly list: clean under and behind equipment Review of the Dietary In-service dated 1/25/24 revealed: Dry storage - what items, how far off the ground and proper storage methods. Store food at least 6 inches from the floor to prevent contamination and allow cleaning. Cold Storage - Don't store any items on the floor. Keeping appliances and equipment clean - cleaning interior and exterior Floors - keeping floors free of debris and trash to prevent accidents and help to prevent rodent and pest infestations. Keeping interior walk-ins free of spills, meat or food drippings etc. Personal Hygiene - when and how often to wash hands. Avoid cross-contamination - letting microorganisms from one food get into another store meats on the bottom shelf of your refrigerator so juices will not contaminate other foods.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48593 Based on observations, interviews, and record reviews the facility failed to establish and 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 4 residents (Resident #34) reviewed for infection control. The DON failed to follow EBP procedures by not wearing a gown while providing Resident #34 wound care. This failure could place residents at risk for cross contamination and infection. The findings include: Record review of Resident #34 's admission record dated 09/26/2024 revealed Resident #34 was a [AGE] year-old male with an admitted to the facility of 08/01/2024. Admission record revealed Resident #34 had diagnoses list that included laceration of unspecified muscle left arm, cutaneous abscess of left upper limb, postprocedural hematoma of skin and subcutaneous tissue following other procedure. Record review of Resident #34 's MDS revealed the resident had a BIMS of 12 indicating the resident was cognitively intact. M1200 the skin and ulcer/injury treatment the resident to have a surgical wound, application of a non surgical dressing. And application of ointments and medications. M1040 other ulcers, wounds and skin problems is E. Surgical wounds Record review of Resident #34 's order summary revealed an order of Wound Care- LT forearm- Clean with wound cleanser- Apply Collagen AG to wound bed, and secure with soft silicon border dressing. one time a day every Mon, Wed, Fri related to POSTPROCEDURAL HEMATOMA OF SKIN AND SUBCUTANEOUS TISSUE FOLLOWING OTHER PROCEDURE. Record review of Resident #34 's Care plan dated 08/16/2024 revealed a focus of The resident admitted from hospital with lacerations from fall while at home. With the interventions of 8/16/24 Resident dcd (discharged) to hospital r/t (related to) abscess to left arm. admitted with sepsis. Resident had an incision and drained to abscess in hospital. Returned to facility on 8/24/24 with orders for Doxycycline antibiotic x3 days- see MAR (Medication Administration Record) and Neosporin x10days. Resident is also seen by In-house wound care doctor weekly. Observation on 09/25/24 at 09:58 AM revealed the DON performing wound care for Resident #34. The DON did not put on any EBP person protective equipment before or during care. Interview on 09/26/24 at 10:26 AM with the DON whom was also the infection preventionist stated that Resident #34 does not need EBP due to wound not being a chronic wound. The DON stated that her understanding was that the wound has to be chronic, greater than three months, or chronic in etiology like a venous ulcer. She stated that she did not think the resident needed to be on precautions because of the way the regulation was worded. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675599	A. Building B. Wing	09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Robert Lee Care Center	307 West 8th St Robert Lee, TX 76945

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Record Review of the facility's policy titled Enhanced Barrier Precautions dated 2024 reads in part GUIDANCE Enhanced Barrier Precautions (EBP) refer to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and glove use during high contact resident care activities., and , Wounds generally include chronic wounds, not shorter-lasting wounds, such as skin breaks or skin tears covered with an adhesive bandage (e.g., Band-Aid(R)) or similar dressing. Examples of chronic wounds include, but are not limited to, pressure ulcers, diabetic foot ulcers, unhealed surgical wounds, and venous stasis ulcers.