STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675633	A. Building B. Wing	10/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Holland Lake Rehabilitation and Wellness Center	1201 Holland Lake Dr Weatherford, TX 76086

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44728 Based on observation, interview and record review, the facility failed to ensure residents have the right to formulate an advance directive for 1 of 24 residents (Resident #279) reviewed for advanced directives. The facility failed to maintain medical records on each resident that are complete, and accurately documented for Resident #279. This failure could affect residents by not having their preferences honored concerning advanced directives . Findings included: Record review on [DATE] of Resident #297's electronic face sheet revealed an [AGE] year-old female, admitted on [DATE] with a DNR status and a diagnosis of, unspecified fracture of right femur, and heart disease. Resident #297's Record Review on [DATE] of Resident #297's MDS Section C Cognitive Status, indicated the residents BIMS was 13 (cognitively intact). Record review on [DATE] of Resident #297's physician's orders dated [DATE] revealed there was an order for DNR. Resident #297's CP (Care Plan) dated [DATE] revealed she had a MPA (Medical Power of Attorney) on file with a Full Code status. Record review on [DATE] of Resident #297's electronic health record from [DATE] through [DATE] revealed there was no evidence of the following: *Advanced Directive for Out of Hospital Do Not Resuscitate Order (OOH-DNR) form; *Progress notes related to the DNR status; *Preadmission Advanced Directive Information form; *Advanced Directive for Out of Hospital Do Not Resuscitate Order (OOH-DNR) verbal assessment. (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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview and Record Review on [DATE] at 10:30 AM the DON stated Resident #297's code status was DNR and had documentation of the Physician order in the electronic chart. The DON stated there was a book at the nurse's station that revealed if residents had a DNR code status DNR, indicated by a RED paper, and Full code status, indicated by a green paper. She stated the SW may have the signed consent on her desk if she was a new admission. The DON reviewed Resident #297's CP and stated the resident was a Full Code status, she must have placed the DNR order on the wrong resident and would go take it out of PCC (electronic charting) immediately. During an interview on [DATE] at 10:48 AM the SW stated Resident #297 was a Full Code and did not have a DNR status or a consent form for her. She stated Resident #297's CP also revealed a Full Code status. The SW stated she did not know what the floor nurses looked at during a code, whether it be the book at the nurse's station or the electronic charting. Record Review of the DNR book dated [DATE] revealed Resident #297 had a green paper that indicated a full code status. During an interview on [DATE] at 11:05 AM, LVN A stated when a resident had a code she looks at the electronic charting for that resident. She revealed in PCC where she would have looked for the resident code status (DNR/Full code) under resident name. LVNA stated, if the resident was sent to the ER, the code status would then have looked at the code status book. She stated if there was a DNR status for that resident there would have also been an order, which would verify a consent that the status would be correct. LVN A stated there would be a negative impact to resident with time lost to being resuscitated. During an interview on [DATE] at 1:15 PM the DON stated she was at home and misunderstood her SW when she called to place the code status order and was a mistake on her part. The DON stated the negative impact for resident would have been, residents have not gotten the correct medical treatment such as CPR if a Full code. She stated it was a typo on her (DON) part, as she misunderstood the SW's text message to place an order for DNR status for Resident #297. The DON stated her expectations was for the resident to fill out the paperwork on admission as well as not relying on texts. She stated the nurse placing the order for the DNR status would be present to verify the consent form. Record review of the facility's undated DNR policy on [DATE] revealed there was no evidence that addressed entering the wrong code status on a Resident.