Printed: 09/27/2024
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675664	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sunny Springs Nursing & Rehab	1200 Jackson St N Sulphur Springs, TX 75482

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45810 Based on interview and record review, the facility failed to provide pharmaceutical services, including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals, to meet the needs of each resident for 1 of 16 residents reviewed for pharmacy services. (Resident #1) The facility failed to ensure RN F, CMA G, and LVN C were able to account for the missing 30 count card of Resident #1's Hydrocodone-Acetaminophen 7.5-325mg tablet used for pain management. This failure could place residents at risk for decreased quality of life, misappropriation of property, misappropriation of physician ordered medications and dignity. Findings included: Record review of Resident #1's face sheet dated 07/11/24 indicated she was an [AGE] year-old female who originally admitted to the facility on [DATE] and readmitted on [DATE] with the diagnoses chronic obstructive pulmonary disease (a progressive lung disease characterized by long-term respiratory symptoms and airflow limitation), Parkinson's (neurogenerative disease of mainly the central nervous system that affects motor and non-motor systems of the body), chronic pain, and anxiety. Record review of Resident #1's quarterly MDS dated [DATE] indicated she usually understood others and she was usually understood. The MDS also indicated she had a BIMS score of 7 which meant she had severe cognitive impairment. Record review of Resident #1's care plan initiated on 03/29/23 indicated she required pain management for chronic pain related to a recent fracture, and surgical procedure pain with interventions in place to administer pain medications as per orders. Record review of the Pharmacy proof of delivery packing slip form dated from 11/23/23 indicated Resident #1 had Hydrocodone-Acetaminophen 115 tablets delivered and signed for by LVN C with no date or time. Record review of the photocopies of the blister packs dated 11/23/23 of the Hydrocodone-Acetaminophen 7.5/325mg tabs indicated card #2 of 4 cards was missing from the 115 tabs. (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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #1's medication administration record dated 11/1/23-11/30/23 indicated she did not miss any doses of the Hydrocodone-Acetaminophen 7.5/325mg tablets. During an interview on 07/11/24 at 3:14 PM LVN C she said she recalled the incident, and the medication was miscounted from the pharmacy. LVN C said there were 90 tabs of hydrocodone delivered instead of 120 tabs. She said she was not paying attention and she thought it was 4 cards she had signed in, but it ended up being 3 when CMA H and RN F counted the cards. LVN C said after she signed the hydrocodone in, she placed the medications in the medication room on the counter. LVN C said the Hydrocodone-Acetaminophen 7.5/325mg tabs should have been locked in the controlled box on the medication cart. She said the failure placed a risk of others having access to the medications. During an interview on 07/11/24 at 4:20 PM the facility pharmacy pharmacist confirmed the 115 pills of Hydrocodone-Acetaminophen 7.5/325mg tablets were dispensed and delivered to the facility on [DATE]. Attempted to call RN F on 07/15/24 at 3:45 PM with no answer. During an interview on 07/15/24 at 3:45 PM CMA H said she no longer worked at the facility and did not remember much about the missing Hydrocodone-Acetaminophen 7.5/325mg tablets. She said she started her shift on 11/24/23 and began to count the cart and the Hydrocodone-Acetaminophen 7.5/325mg tablet count was not correct. She said a card of 30 tablets were missing. CMA H said she was told the cart had not been counted the night before, but she could not recall who told her that. She said the medication carts should have been counted by staff at shift change. CMA H said RN F and herself searched the medication room and the other medication carts. During an interview on 07/15/24 at 4:15 PM CMA G said LVN C counted the Hydrocodone-Acetaminophen 7.5/325mg tablets from the pharmacy, signed for the medication, and laid the medication on the medication room counter. She said she picked the Hydrocodone-Acetaminophen 7.5/325mg tablets up from the counter in the medication room and locked them on the medication cart, but she failed to count the medication at the time. During an interview on 07/15/24 at 6:04 PM the DON said he thought they never had 4 cards of the Hydrocodone-Acetaminophen 7.5/325mg tablets. He said he would have expected the nurse to have signed the medications in from the pharmacy and keep the medications until they were locked into the medication cart. The DON said the failure placed a risk for the nurses and medication aides the facility trusted with medications every day to get the medications. He said he provided re-education and in-servicing to change the process on the medication being signed in to ensure failure did not happen again. The DON said upon receipt of the medications from the pharmacy, the medications would be secured in the medication cart they belonged to and 2 nurses or certified medication aides were to sign off on the medications when received. The DON said the pharmacy told him that they sent the shit (referring to the Hydrocodone-Acetaminophen 7.5/325mg tablets) as the pharmacy would say to cover themselves. He said he felt the Hydrocodone-Acetaminophen 7.5/325mg tabs were likely not packed the way it was supposed to, and the facility nurse and medication aide failed to count to ensure it was there. The DON said the facility replaced the medications and there were no missed doses. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 07/15/24 at 6:40 PM the Administrator said the facility completed an investigation for the missing Hydrocodone-Acetaminophen 7.5/325mg tablets and could not account for the missing card of 30 Hydrocodone-Acetaminophen 7.5/325mg tabs. She said they called the police, drug tested all involved, and provided disciplinary actions on 3 staff involved. The Administrator said her expectation was for LVN C to count the medications from the pharmacy, sign the medications in and place them in the narcotic box and count off with another nurse each shift to prevent the failure. The Administrator said the failure placed a risk for the medications to go missing. Record review of the facility undated policy for Abuse Prevention and Prohibition Program indicated: Purpose To ensure the Facility establishes, operationalizes, and maintains an Abuse Prevention and Prohibition Program designed to screen and train employees, protect the residents, and to ensure a standardized methodology for prevention, identification, investigation, and reporting of abuse, neglect, mistreatment, misappropriation of property, and crime in accordance with federal and state requirements. Policy I. Each resident has the right to be free from mistreatment, neglect, abuse, involuntary seclusion and misappropriation of property .Staff must not permit anyone to engage in verbal, mental, sexual, or physical abuse, neglect, mistreatment, or misappropriation of resident property .

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45810 Based on observation, interview, and record review, the facility failed to collaborate with hospice representatives and coordinate the hospice care planning process for each resident receiving hospice services, to ensure quality of care for the resident, ensuring communication with the hospice medical director, the resident's attending physician, and others participating in the provision of care for 1 of 2 residents (Resident #9) reviewed for hospice services. The facility failed to ensure Hospice Aide A performed a proper transfer when she failed to use a mechanical lift, as ordered by the physician and per Resident #9's care plan, to transfer Resident #9 from her wheelchair to her bed on 07/15/2024. This failure could place residents at risk for falls, injuries, and a decreased quality of life. Findings included: Record review of a face sheet dated 07/11/2024 indicated, Resident #9 was a [AGE] year-old female initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety (loss of memory, language, problem solving and other thinking abilities that were severe enough to interfere with daily life without behaviors) and Parkinson's disease with dyskinesia, without mention of fluctuations (progressive disorder that affects the nervous system and the parts of the body controlled by the nerves causes unintended or uncontrollable movements). Record review of the Quarterly MDS assessment dated [DATE] indicated Resident #9 was rarely/never understood by others and was rarely/never able to understand others. The MDS assessment indicated Resident #9 had a short and long-term memory problem. The MDS assessment indicated Resident #9 did not reject care. The MDS assessment indicated Resident #9 was dependent on staff for all ADLs. The MDS assessment indicated Resident #9 was dependent for transfers to and from a bed to a chair or wheelchair. Record review of Resident #9's care plan with date initiated 04/18/2024 indicated she was dependent and required 2 staff participation with transfers with the use of a mechanical lift. Record review of Resident #9's Order Summary Report dated 07/11/2024 indicated, may use mechanical lift for transfers with date initiated 04/25/2024. During an interview on 07/11/2024 at 2:50 PM, LVN C said in the last few months Resident #9 had declined and was not assisting with transfers. LVN C said staff was having difficulty transferring her and for Resident #9's safety the decision had been made to start using a mechanical lift for transfers. During an observation on 07/15/2024 at 10:08 AM, Resident #9 was in her wheelchair and Hospice Aide A was observed taking Resident #9 into her room and closed the door to provide care. Hospice Aide A did not take a mechanical lift into the room and there was no facility staff with her. (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 07/15/2024 at 10:30 AM, Hospice Aide A was observed providing a bed bath to Resident #9. During an interview on 07/15/2024 at 10:52 AM, Hospice Aide A said she provided bed baths to Resident #9 three times a week. Hospice Aide A said Resident #9 required assistance of 2 staff if she was resistant to care, but if she was not, she was able to transfer her on her own. Hospice Aide A said today (07/15/2024) she transferred her on her own from the wheelchair to her bed to give Resident #9 her bed bath. Hospice Aide A said if Resident #9 required a transfer by mechanical lift it would be on her hospice aide care plan. Hospice Aide A said her hospice aide care plan said assist with transfers. Hospice Aide A said facility staff had not notified her Resident #9 required the use of a mechanical lift for transfers. Hospice Aide A said if Resident #9 required the use of a mechanical lift it was important not to transfer her without it for safety purposes. During an interview on 07/15/2024 at 11:20 AM, Hospice RN B said she was Resident #9's hospice case manager. Hospice RN B said Resident #9 was assist with transfers, and if the hospice aide required assistance, she would ask one of the facility staff for help. Hospice RN B said if there was a change from transferring with assistance to the use of a mechanical lift for transfers the charge nurse at the facility should send hospice an order and be in communication with them regarding the new order. Hospice RN B said it had not been communicated that Resident #9 required the use of a mechanical lift for transfers. Hospice RN B said it was important for the mechanical lift to be used for transfers for safety reasons and fall precautions. During an interview on 07/15/2024 at 5:23 PM, the DON said Resident #9 required the use of a mechanical lift for transfers due to Resident #9 being totally dependent on staff for transfers and for safety. The DON said the charge nurse was supposed to call hospice to let them know Resident #9 required the use of a mechanical lift for transfers. The DON said if a mechanical lift was required for transfers and not used this placed the residents at risk for skin tears, bruises, and falls. During an interview on 07/15/2024 at 5:47 PM, LVN C said she only called the hospice when there was a change in the resident's medical condition. LVN C said she did not recall calling the hospice to notify them Resident #9 required the use of a mechanical lift for transfers or notifying the hospice when they completed their visits. LVN C said she did not usually notify the hospice for changes such as a resident requiring the use of a mechanical lift. During an interview on 07/15/2024 at 6:19 PM, the Administrator said Resident #9 had a change or decline in her abilities and the IDT decided it would be better for her to use a mechanical lift for transfers. The Administrator said she expected for the charge nurse to notify the hospice of the change. The Administrator said not using the mechanical lift to transfer residents when required placed the residents at risk for injuries and bruises. Record review of the facility's policy titled, Total Mechanical Lift, revised 06/2020, indicated, A mechanical lift is used appropriately to facilitate transfers of residents. I. Nursing Staff will be trained to use the mechanical lift. II. The resident will have a physician's order for the use of a mechanical lift. III. At least two people are present while resident is being transferred with the mechanical lift .

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45810 Based on observation, interview, and record review, the facility failed to 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 1 resident (Resident #2) reviewed for infection control. 1. The facility failed to ensure CNA D performed hand hygiene when she changed gloves while providing perineal care for Resident #2. This failure could place residents and staff at risk for cross contamination and the spread of infection. Findings included: 1.Record review of Resident #2's face sheet dated 07/11/24 indicated she was a [AGE] year-old female who readmitted to the facility on [DATE] with the diagnoses dementia(a syndrome characterized by a general decline in cognitive abilities that affects a person's ability to perform daily tasks), high blood pressure, chronic obstructive pulmonary disease (a progressive lung disease characterized by long-term respiratory symptoms and airflow limitation), and diabetes mellitus (disease causing too much sugar in the blood). Record review of Resident #2's Quarterly MDS assessment dated [DATE] indicated she was usually able to make herself understood and usually understood others. The MDS assessment indicated Resident #2 had a BIMS score of 15, which indicated her cognition was intact. The MDS assessment indicated Resident #2 was dependent with dressing, bathing, and toileting hygiene and required partial to moderate assistance with personal hygiene. Record review of Resident #2's care plan revised on 11/18/22 indicated she had an ADL self-care deficit related to pain and decreased mobility that required 2 staff for toileting. During an observation on 07/11/2024 at 2:46 PM CNA D and CNA E came into Resident #2's room. Both CNA D and CNA E washed hands and applied gloves at this time. CNA D provided privacy with a towel over resident. CNA D wiped the top of perineal area with a wipe and discarded it into a trash bag, CNA D wiped the left groin of perineal area with a wipe and discarded it into a trash bag, CNA D wiped the right groin of perineal area with a wipe and discarded it into a trash bag, CNA D wiped the middle of perineal area with a wipe and discarded it into a trash bag, and then she grabbed a clean towel to pat dry and said she should have changed gloves. CNA D then removed dirty gloves and applied new gloves and rolled resident over and cleaned the buttocks using a different wipe with each swipe and changed gloves. CNA D applied barrier cream and changed gloves again. CNA D removed gloves and applied new gloves and cleaned up supplies. CNA D failed to wash hands or use hand sanitizer in between glove changes. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 07/11/24 at 2:56 PM CNA D said she normally used the hand sanitizer in between glove changes, but she was not prepared and forgot to bring hand sanitizer into Resident #2's room. She said the purpose of the hand sanitizer use is to prevent germs and bacteria from the resident. During an interview on 07/15/24 at 5:49 PM the DON said he expected the CNAs to wash their hands or use hand sanitizer between glove changes and change their gloves between dirty and clean. The DON said the risk to the resident was contamination. He said the ADON was responsible for perineal care proficiency check offs to ensure the CNAs are properly providing perineal care. During an interview on 07/15/24 6:39 PM the Administrator said CNAs should wash and use hand sanitizer in between care and changing gloves. The Administrator said the failure placed a risk of infection for the resident. She said the DON and ADON were responsible for ensuring the CNAs provided perineal care correctly and the proficiencies were usually completed upon hire, annually and as needed. During a telephone interview on 07/15/24 at 7:07 PM the ADON said she was responsible for ensuring the CNAs provided the proper perineal care for residents and she completed perineal care proficiency check offs at least annually, and the ADON and the lead CNA periodically performed spot checks. The ADON said when she found issues, she would usually retrain the CNA. She said when performing perineal care, the CNAs should complete frequent hand washing or hand sanitizer especially between clean and dirty and between changing gloves. The ADON said the failure placed the resident at risk for infections and urinary tract infections. Record review of the facility policy Perineal Care revised 06/2020 indicated: Purpose To maintain cleanliness of the genital area, to reduce odor, and to prevent infection or skin breakdown . Procedure I. Wash hands .V. Put on gloves. VI. Wash the pubic area .XII. Remove gloves. Wash hands or use alcohol-based hand sanitizer .XIII. Put on clean gloves.