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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675664	A. Building B. Wing	01/28/2025

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43047 Based on interviews, and record review the facility failed to ensure residents were free from abuse for 3 of 13 residents (Resident #1, #2 and Resident #3) reviewed for resident abuse. 1. The facility did not ensure Resident #1 was free from abuse when Resident #3 struck Resident #1 on the shoulder 11/8/24. 2. The facility did not ensure Resident #2 was free from abuse when Resident #4 reached out and grabbed Resident #2 under the arm on 12/9/24. 3. The facility did not ensure Resident #3 was free from abuse when Resident #5 pushed Resident #3 head on 12/9/24. The noncompliance was identified as PNC. The past noncompliance began on 11/8/24 and ended on 12/14/24. The facility had corrected the noncompliance before the survey began. These failures could place residents at risk of abuse, physical harm, mental anguish, and emotional distress. Findings included: 1. Resident #1 Record review of Resident #1's face sheet, dated 11/12/24, reflected Resident #1 was an [AGE] year-old female, admitted to the facility on [DATE] with diagnoses which included Type 1 fracture of sacrum and dementia (loss of memory, language, problem solving and other thinking abilities that were severe enough to interfere with daily life). Record review of the quarterly MDS assessment, dated 1/12/25, indicated Resident #1 usually made herself understood and usually understood others. Resident #1 BIMS score was 00, which indicated her cognition was severely impaired. Resident #1 used a wheelchair for mobility and required either setup/clean or supervision/touching assistance for most ADLs. (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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the undated comprehensive care plan reflected Resident #1 had impaired cognitive function/dementia or impaired thought processes related to dementia. The care plan interventions included: engage the resident in simple, structured activities that avoid overly demanding tasks, keep the resident's routine consistent and try to provide consistent care givers as much as possible to decrease confusion, and use task segmentation to support short term memory deficits. Resident #3 Record review of Resident #3's face sheet, dated 11/12/24, reflected Resident #3 was a [AGE] year-old female, admitted to the facility on [DATE] with diagnoses which included dementia (loss of memory, language, problem solving and other thinking abilities that were severe enough to interfere with daily life). Record review of Resident #3's quarterly MDS assessment, dated 12/17/24, indicated Resident #3 usually made herself understood and usually understood others. The MDS assessment did not address Resident #3's BIMS score. Resident #3 did not have any indicators of psychosis or exhibited any behaviors during the look back period. Resident #3 used a wheelchair for mobility and required wither substantial/maximum assistance or dependent for most ADLs. Record review of the undated comprehensive care plan reflected Resident #3 had impaired cognitive function/dementia or impaired thought processes related to dementia. The care plan interventions included: administer medications as ordered, engage her in simple, structured activities that avoid overly demanding tasks and provide a program of activities that accommodates her ability. Record review of the facility's PIR dated 11/12/24 with an incident category of abuse was signed by the Administrator on 11/13/24. The PIR reflected the Dietary Manager heard commotion in the dining room, went in and noted two residents (Resident #1 and #3) in an altercation. Resident #6 was present and reported Resident #3 struck Resident #1 on the left shoulder. The PIR included a form titled Witness Statement completed on 11/8/24 for Resident #6 who stated Resident #3 hit Resident #1 in the left shoulder. Resident #1 attempted to push Resident #3's arm away. The Dietary Manager immediately separated the residents. The DON conducted the interview. The PIR included a skin assessment completed 11/8/24, pain evaluation completed 11/8/24, trauma screen completed 11/8/24, incident report for both residents completed 11/8/24 and a 1:1 monitoring log for Resident #3 completed 11/8/24. The PIR reflected staff was in-serviced promptly on resident-to-resident abuse, customer service, intervention for Resident #3, and dementia related diseases dated 11/8/24. Record review of the physical aggression report dated 11/8/24 indicated Resident #6 witnessed Resident #3 hit another resident (Resident #1) in the left shoulder and Resident #1 pushed Resident #3 arm away. The Dietary Manager immediately separated the residents. Record review of undated handwritten statement, the Dietary Manager indicated she came into the dining room, Resident #1 pushed back Resident #3 hand from her, and Resident #3 was saying that stuff was hers. Moved Resident #3 and reported to the nurse. During an interview on 1/28/25 at 8:12 a.m., Resident #3 was sitting in bed eating breakfast. Resident #3 stated repeatedly I don't remember when asked about the incident between her and Resident #1. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 1/28/25 at 9:13 a.m., the Dietary Manager stated she heard something in the dining room and went out and saw Resident #1 had a fingernail file and lip gloss in her hand. The Dietary Manager stated they both were saying the items were theirs. The Dietary Manager stated Resident #1 pushed Resident #3 hand back and stated, no it's mine. The Dietary Manager stated she removed Resident #3 from the situation and brought her to the hallway by the nursing station and grabbed a nurse. During an interview on 1/28/25 at 10:38 a.m., Resident #1 stated, It's been so long ago, I don't remember when asked about the incident between her and Resident #3. 2. Resident #2 Record review of Resident #2's face sheet, dated 12/10/24, reflected Resident #2 was a [AGE] year-old male, admitted to the facility on [DATE] with diagnoses which included acute respiratory failure with hypoxia (low levels of oxygen in the body tissues). Record review of Resident #2's quarterly MDS assessment, dated 12/16/24, indicated Resident #2 usually made himself understood and usually understood others. Resident #2's BIMS score was 15, which indicated his cognition was intact. Resident #2 required setup/clean up assistance for most ADLs. Record review of the undated comprehensive care plan reflected Resident #2 had an ADL Self Care Performance Deficit related to activity intolerance. The care plan interventions included: praise all efforts of care and encourage him to fully participate possible with each interaction. Resident #4 Record review of Resident #4's face sheet, dated 12/10/24, reflected Resident #4 was a [AGE] year-old male, admitted to the facility on [DATE] with diagnoses which included atherosclerotic heart disease of native coronary artery without angina pectoris (buildup of cholesterol plaque in the walls of arteries causing obstruction of blood flow). Record review of a Medicare 5-day assessment, dated 12/9/24, indicated Resident #4 sometimes made himself understood and sometimes understood others. Resident #4's BIMS score was 00, which indicated his cognition was severely impaired. Resident #4 exhibited hallucinations, delusions and physical behavior directed toward others one to three days during the look back period. Resident #4 required substantial/maximum assistance for most ADLs. Record review of the undated comprehensive care plan reflected Resident #4 was physically and verbally towards staff and residents. The care plan interventions included: keep all residents safe, psych referral with increased behaviors and redirect in times of agitation. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the facility's PIR dated 12/9/24 with an incident category of abuse was signed by the Administrator on 12/10/24. The PIR reflected while passing each other in the hallway Resident #4 swung at Resident #2. When the nurse asked Resident #2 did, he gets you, Resident #2 responded no, approximately 4 hours later Resident #2 reported to the nurse that Resident #4 did grab him under his arm but did not hit him. The PIR included a skin assessment completed 12/9/24, trauma screen completed 12/9/24, 1:1 monitoring log for Resident #4 started on 12/9/24 and ended 12/10/24, safe surveys with no areas of concerns dated for 12/9/24. The PIR reflected staff was in-serviced promptly on resident-to-resident abuse/neglect dated for 12/9/24. During a telephone interview on 1/27/25 at 10:45 p.m., RN A stated Resident #4 and Resident #2 was both in a wheelchair in the hallway. RN A stated Resident #4 swung at Resident #2 as Resident #2 was passing him. RN A stated there was an aide standing there during the incident and she heard her holler out and that was when RN A went to see what was going on. RN A stated she asked Resident #2 while she was standing between both residents did, he get you and he responded, no he didn't get me. RN A stated she separated both residents and then had one of the aides to stay with Resident #4 while she contacted the DON and Administrator. RN A stated 1:1 was provided for Resident #4 because he was very agitated. RN A stated she completed assessment with no injury noted. RN A stated approximately 4 hours Resident #2 came to her and reported that Resident #4 did grab him under his arm but did not hit him. RN A stated she completed another skin assessment to check for injuries, no injuries noted. RN A stated she contacted the DON/Administrator and responsible parties to inform them of the change. During a telephone interview on 1/27/25 at 11:07 p.m., CNA B stated she witnessed Resident #4 touching Resident #2 shirt while passing each other in the hallway. CNA B stated she did not see Resident #4 grabbed Resident #2's arm. CNA B stated Resident #4 was new to the facility. CNA B stated she went immediately to RN A and reported the incident. CNA B stated RN A immediately came to intervene. CNA B stated there was a sitter with Resident #4 throughout the night. During an interview on 1/28/25 at 9:45 a.m., Resident #2 stated Resident #4 grabbed him under his armpit while passing him in the hallway. Resident #2 stated Resident #4 did not want him to pass him. 3. Resident #3 Record review of Resident #3's face sheet, dated 11/12/24, reflected Resident #3 was a [AGE] year-old female, admitted to the facility on [DATE] with diagnoses which included dementia (loss of memory, language, problem solving and other thinking abilities that were severe enough to interfere with daily life). Record review of Resident #3's quarterly MDS assessment, dated 12/17/24, indicated Resident #3 usually made herself understood and usually understood others. The MDS assessment did not address Resident #3's BIMS score. Resident #3 used a wheelchair for mobility and required wither substantial/maximum assistance or dependent for most ADLs. Record review of the undated comprehensive care plan reflected Resident #3 had impaired cognitive function/dementia or impaired thought processes related to dementia. The care plan interventions included: administer medications as ordered, engage her in simple, structured activities that avoid overly demanding tasks and provide a program of activities that accommodates her ability. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #5 Record review of Resident #5's face sheet, dated 12/10/24, reflected Resident #5 was a [AGE] year-old female, admitted to the facility on [DATE] with diagnoses which included anxiety disorder. Record review of Resident #5's annual MDS assessment, dated 12/26/24, indicated Resident #5 usually made herself understood and usually understood others. Resident #5's BIMS score was 13, which indicated her cognition was intact. Resident #3 did not have any indicators of psychosis or exhibited any behaviors during the look back period. Resident #5 required setup/cleanup assistance for most ADLs. Record review of the undated comprehensive care plan reflected Resident #5 had a potential to demonstrate physical behaviors related to anger, poor impulse control. The care plan interventions included: assess/address for contributing sensory deficits, modify environment: reduce noise and when the resident became agitated to intervene before agitation escalates. Record review of the facility's PIR dated 12/12/24 with an incident category of abuse was signed by the Administrator on 12/12/24. The PIR reflected that LVN C looked up and saw Resident #5 push Resident #3 head and yelled at her, I said to shut up and go away. Resident #5 stated, she was getting on my nerves, and I wanted her to go away. The PIR included a skin assessment completed 12/9/24 &12/10/24, trauma screen completed 12/10/24, psychiatric assessment for both residents completed 12/10/24, 1:1 monitoring log for Resident #5 started on 12/9/24 and ended 12/10/24, safe surveys with no areas of concerns dated for 12/10/24. The PIR reflected staff was in-serviced promptly on resident-to-resident abuse/neglect dated for 12/9/24. During an interview on 1/28/25 at 8:12 a.m., Resident #3 was sitting in bed eating breakfast. Resident #3 stated repeatedly I don't remember when asked about the incident on 11/8/24 between her and Resident #5. During an interview on 1/28/25 at 10:41 a.m., Resident #5 was lying in bed. Resident #5 stated she did not recall hitting anyone upside their head. Resident #5 stated if I did say go way, I did not mean it that way. Resident #5 stated, I'm not mean. During an interview on 1/28/25 at 11:40 a.m., LVN C stated Resident #5 was sitting in the front lobby on the couch with her peers. LVN C stated Resident #3 family member came in and stopped to talk to the group on the couch. LVN C stated Resident #3 saw him and rolled over to see him. LVN C stated Resident #3 bumped the table next to the door and almost knocked over the monitor on top of it. LVN C stated Resident #5 became upset and stated something to Resident #3. LVN C stated she told Resident #5 that it was ok, she did not break anything she just wanted to talk to her family member. LVN C stated Resident #5 started mumbling under her breath about Resident #3. LVN C stated Resident #3 then rolled backwards and was rolling behind the couch, Resident #3 was talking to her family member when Resident #5 turned around, pushed Resident #3 head, and told her I said shut up and go away. LVN C stated she immediately separated the residents, making sure the other resident was ok. LVN C stated Resident #3's family member was next to her. LVN C stated she had a CNA took Resident #3 to her room so she could lay down and visit with her family. LVN C stated she contacted the abuse coordinator which was the Administrator and informed her of the incident. LVN C stated the other nurse on duty went and performed a skin assessment on the other resident. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During interviews on 01/27/25 and 01/28/25 with 10 residents regarding abuse and neglect with a focus presented on physical abuse revealed they all denied abuse with the exceptions of the above mentioned. During interviews on 1/27/25 and 1/28/25 beginning at 8:30 a.m., RN (A, K, L), LVN (C, G, N, O), CNA (B, D, E, F, H, M,P), MA Q, COTA R, ADON, DON, Administrator, Dietary Manager, Maintenance Supervisor were able to define abuse, when to report, and whom to report. During an interview on 1/28/25 at 2:49 p.m., the DON stated he was knowledgeable of the abuse allegations. The DON stated the victims did not have any changes in behavior since the incident. The DON stated personality wise none of the perpetrators showed any type of behaviors. The DON stated Resident #4 was a new admission prior to his incident. The DON stated residents were immediately separated and aggressor kept on 1:1 monitoring until a psychiatric evaluation was completed. The DON stated the investigation for Resident #3 and #6 was completed on 11/13/24. The DON stated the investigation for Resident #2 and #4, Resident #3 and #5 was completed was on 12/14/24. The DON stated staff were provided education on abuse and neglect related to all situations. The DON stated the Administrator was the abuse coordinator. The DON stated the last in-service on abuse and neglect was within the last few weeks. During an interview on 1/28/25 at 3:05 p.m., the Administrator stated she was the abuse coordinator for the facility. The Administrator stated abuse was monitored daily during rounds asking questions about abuse and monitoring for abuse. The Administrator stated once the facility learned of any allegation, they acted appropriately to protect all the residents. Record review of the facility's policy titled Abuse Prevention and Prohibition Program revised 10/24/22 indicated . each resident has the right to be free from . abuse . The facility has zero-tolerance for abuse .

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 43047 Based on observations, interviews, and record review, the facility failed to provide pharmaceutical services, including procedures that assure the accurate dispensing and administering of all drugs and biologicals to meet the needs of each resident for 1 of 3 residents (Residents #7) reviewed for pharmacy services. 1. The facility did not ensure Resident #7 medications were administered during the scheduled time. 2. The facility did not ensure Resident #7 was given Estrace Vaginal Cream 0.01 mg/gm as scheduled. 3. The facility did not ensure Resident #7 was given Vitamin B-12 2000 mcg. These failures could place the residents at risk of not having medications available for use, drug diversion, not receiving their medications as ordered, and exacerbation of their disease processes. Findings included: 1. Record review of Resident #7's face sheet, dated 01/28/25, reflected Resident #7 was a [AGE] year-old female, originally admitted to the facility on [DATE] with diagnoses which included dementia (loss of memory, language, problem solving and other thinking abilities that were severe enough to interfere with daily life). Record review of the order summary report dated 01/28/25 indicated Resident #7 was ordered: _Calcium 600: give 1 tablet by mouth two times a day for osteoporosis (disease that weakens bone to the point where they break easily) at 8:00 a.m. _Pantoprazole sodium 20 mg: give 1 tablet by mouth two times a day for heartburn at 5:00 p.m. _Sitagliptin-metformin HCI 50-500 mg: give 1 tablet by mouth two times a day for diabetes mellitus at 9:00 a. m. and 5:00 p.m. _Calcium 600: give 1 tablet by mouth two times a day for osteoporosis at 5:00 p.m. Record review of the Medication Administration Audit Report dated 1/28/25 indicated Resident #7 received her medications on 12/07/24 by MA Q as listed: _Calcium 600 at 9:49 a.m. _Pantoprazole sodium 20 mg at 7:29 p.m. _Sitagliptin-metformin HCI 50-500 mg at 7:29 p.m. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	_Calcium 600 at 7:29 p.m. 2. Record review of a telephone order, dated 12/06/24, indicated Resident #7 had an order for Estrace vaginal cream 0.1 mg/gm applicator at bedtime every Monday, Wednesday, Friday for atrophy vaginitis. Record review of the MAR dated 12/1/24-12/31/24 indicated Resident #7 was given Estrace vaginal cream 0. 1 mg/gm applicator at bedtime every Monday, Wednesday, Friday for atrophy vaginitis (vaginal tissue thins due to low estrogen levels) on 12/25/24 by the ADON. During a confidential interview, the interviewee stated Resident #7's medications were administered late on 12/07/24. The interviewee stated Resident #7 was not given the vaginal suppository on 12/25/24. During a telephone interview on 1/28/25 at 2:09 p.m., MA Q stated sometimes Resident #7 refused her calcium until she has had breakfast. MA Q stated she could not recall if that had occurred on 12/7/24 at 8:00 a.m. MA Q stated medications that were scheduled at 5:00 p.m. should have been given between 4:00 p.m. -6:00 p.m. MA Q stated she did not remember given Resident #7 anything that late. MA Q stated this failure could potentially cause an adverse effect. During an interview on 1/28/25 at 12:08 p.m., the ADON stated on 12/25/24 she was the charge nurse for Resident #7. The ADON stated she went to give her the suppository and something happened (unable to recall) and forgot to administer the medication. The ADON stated she did click off the task as completed prior to administering the medication but the medication was not given. The ADON stated she was not aware until Resident #7 family member told her that she did not give her the suppository on 12/25/24. The ADON stated she did offer to move the date, but the family member stated do not worry about it. During an interview on 1/28/25 at 2:49 p.m., the DON stated he expected medications to be administered one hour before or one hour after the scheduled time. The DON stated he was responsible for monitoring and overseeing by reviewing the 24-hour progress noted Monday-Friday and on Monday the weekend was reviewed. The DON stated it was important to ensure medications were administered timely to ensure the dosage stay consistent in the bloodstream. During an interview on 1/28/25 at 3:05 p.m., the Administrator stated she expected the medications to be administered according to the schedule to ensure effectiveness. The Administrator stated the DON, and the ADONs were responsible for overseeing and monitoring. The Administrator stated it was important to follow the physician orders to prevent an adverse effect. 3. Record review of Resident #7's face sheet, dated 01/28/25, reflected Resident #7 was a [AGE] year-old female, originally admitted to the facility on [DATE] with diagnoses which included dementia (loss of memory, language, problem solving and other thinking abilities that were severe enough to interfere with daily life). Record review of the order summary report dated 01/28/25 indicated Resident #7 was ordered: Vitamin B-12 1000 mcg; give 2000 mcg by mouth in the morning related to anemia. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During observation and interview on 1/28/25 at 9:18 a.m., MA S was preparing Resident #7's medication for administration. MA S obtained a bottle of Vitamin B-12 1000 mcg and placed 1 tablet (1000mg) in a plastic cup. MA S finished preparing the remainder of Resident #7's morning medications. MA S stated she should have given 2 tablets of Vitamin B12 1,000 mcg. MA S stated this failure could potentially cause more of a vitamin deficiency. During an interview on 1/28/25 at 2:49 p.m., the DON stated he expected medications to be given per the physician orders. The DON stated he was responsible for monitoring and overseeing by reviewing the 24-hour progress noted Monday-Friday and on Monday the weekend was reviewed. The DON stated he has not been aware of medications not been administered correctly. The DON stated the risk associated with not giving the correct dose was the desired effect not achieved. During an interview on 1/28/25 at 3:05 p.m., the Administrator stated she expected the correct dose to be given. The Administrator stated the DON, and the ADONs were responsible for overseeing and monitoring. The Administrator stated it was important to follow the physician orders to prevent a medication error. Record review of the facility's undated policy titled, Medication-Administration indicated, . to provide practice standards for safe administration of medications for residents in the facility . IV. The licensed nurse must know the following information about any medication they are administering E. the drugs usual dosage . V. Medications may be administered one hour before or after the scheduled medication administered time. IV. Nursing staff will keep in mind the seven rights of medication when administering medication: B. the right amount . D. The right time .