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	04/09/2025

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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45879 Based on interview and record review, the facility failed to develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and establish policies and procedures to report and investigate such allegations, for 1 of 6 residents (Resident #3) reviewed for abuse. The facility did not implement the policy on investigating an injury of unknown origin to the state agency for Resident #3 when Resident # 3 was found with bruising and a skin tear on 02/11/2025 on the left arm. This failure could place the residents at increased risk of abuse and neglect. Findings included: Record review of Resident #3's face sheet, dated 04/09/25, indicated an [AGE] year-old female who was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included dementia (diseases that affect memory, thinking, and the ability to perform daily activities), diabetes (is a chronic condition that happens when you have persistently high blood sugar levels), and depression (mood disorder that causes a persistent feeling of sadness and loss of interest and can interfere with your daily living). Record review of Resident #3's annual MDS assessment, dated 02/26/25, indicated Resident #3 rarely understood and was rarely understood by others. Resident #3's BIMS score was 00, which meant she was severely cognitively impaired. The MDS indicated Resident #3 required extensive help with toileting, bed mobility, dressing, transfers, personal hygiene, and supervision with eating. The MDS did not indicate Resident #3 had wounds or skin problems. Record review of Resident #3's progress note dated 2/11/25 at 6:22 pm, written by LVN A, revealed Resident #3's family member reported 2 open areas to her left arm, both less than 0.25 x 0.25 in diameter. Both showed no signs of infection. The nurse provided first aid to both, and neither area showed signs of infection. The resident denied pain. The call light was in reach. Record review of Resident #3's progress note updated 2/11/25 at 6:42 pm, written by LVN A revealed Resident #3 had one open area and one bruise to her left arm. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #3's progress note dated 2/12/25 at 2:40 am, written by LVN C revealed to continue to monitor skin tear and bruising to the left arm for Resident #3. No signs or symptoms of infection, pain, or discomfort were noted. Record review of Resident #3's physician orders, dated 02/01/25 through 02/28/23, did not reveal any orders for monitoring bruise to the left arm. Record review of Resident #3's physician orders, dated 02/01/25 through 02/28/25, did not reveal any orders for treating a skin tear to her left arm. Record review of Resident #3's skin assessment dated [DATE] did not indicate a skin assessment was done after the bruise and skin tear were noted. Record review of Resident #3's skin assessment dated [DATE] charted by LVN C did not indicate a bruise or skin tear to her left arm. Record review of Resident #3's care plan revised on 03/26/25 did not indicate a bruise or skin tear to her left arm on 02/11/25. During an interview on 04/08/25 at 1:44 p.m., LVN B said she was the treatment nurse. She said if a resident had a skin tear or a bruise, it should be reported to the nurse, the nurse would then report it to her, and she would assess and determine what type of treatment was needed, if any. She said if a skin tear were noted, she would look at it daily and document it in the TAR. If a bruise were noted, she would put in an order to monitor weekly till resolved. LVN B said that Resident #3 had several bruises over time because she would attempt to get up by herself. She said she could not recall this particular bruise or skin tear. She said part of her process was if a bruise or skin tear were reported, she would investigate to see what happened. She said Resident #3 was not normally able to say what happened related to her cognitive status. LVN C said if she could not figure out what happened, she would report it to the Administrator or DON. During an interview on 04/08/25 at 1:44 p.m., LVN A said she was the charge nurse on duty when a family member reported Resident #3 had a skin tear and bruise on her left arm. LVN C said she was not aware how Resident #3 received the bruise or skin tear. She said she did not ask the staff or the family member who reported the skin tear or bruise if they knew what happened. LVN A said if an unknown skin tear or bruise was reported to her, she was supposed to notify the Administrator, DON, the physician, and the family. LVN A said she reported the bruise and skin tear to the Administrator and the DON. She said she was new to the facility during the incident and was told to do a progress note. She said she did not recall the Administrator or the DON questioning her about the incident once she reported it. She said since this incident, she had been educated to do an incident report and progress note, notify management, the physician, and the family. (continued on next page)

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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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 04/09/25 at 6:55 a.m., LVN C said she was the 10 pm-6 am nurse for Resident #3. She said she could not recall the skin tear or bruise from 02/12/25 on Resident #3. LVN C said if she charted it, then it was either given to her in the report or was on the 24-hour report. She said if a bruise or skin tear occurred and staff was unaware of how it occurred, staff would report it to the ADON or DON, and they would investigate it. She said the nurses were supposed to do an incident report, document a progress note, and notify the physician, the family, the Administrator, and the DON of any skin tears or bruises of unknown origin. She said even if the nurses did not report something, it was on the 24-hour report, and management was supposed to review it daily. She said she did not recall being asked about Resident #3's skin tear or bruise by the Administrator or DON. During an interview on 4/9/25 at 10:00 a.m., the ADON said if a resident had a bruise or skin tear of an unknown origin, she would investigate to see if she could figure out what happened. She said the nurses should document the incident in the progress notes, do an incident report, and notify the physician, the family, the Administrator, and the DON. She said the nurses were to chart the incident for 72 hours. She said even if a nurse forgot to report the incident, she would see it on the 24-hour report or while reading the nurses' notes. She said she could recall the incident on 02/11/25 but could not remember the details. The ADON reviewed Resident #3's chart and did not see an incident report on 02/11/25. During an interview on 04/09/25 at 10:53 a.m., LVN B said she was the treatment nurse, and she had done a skin assessment on Resident #3 earlier on the 6 am-2 pm shift on 02/11/25. She said Resident #3 did not have any skin tears or bruises during her assessment. She said LVN A charted the skin tear and bruise at 6:22 pm after her shift. During an interview on 04/09/25 at 11:03 a.m., the DON said he expected if a resident had a bruise or skin tear of an unknown source that staff would report it to him and the Administrator. He said they would do an internal investigation to see if they could see what happened, and if they could not figure out what happened, they would report it to the State of Texas. He said he could not recall the skin tear or bruise for Resident #3 around 02/11/25. He said Resident #3 had often scratched herself, or she could have bumped it on the wall, but since he did not remember investigating it, he could not say what happened. He said they do review the 24-hour reports in the morning meeting, and it must have been overlooked. He said that although he did not feel like abuse occurred, it was important to report and investigate abuse/neglect to prevent further abuse/neglect from occurring. During an interview on 04/09/25 at 4:37 p.m., the Administrator said she was unaware of Resident #3's skin tear or bruise; therefore, it was not investigated or reported. She said she was not contacted for all skin tears or bruises, only if suspicion of abuse. She said if there was suspicion of abuse, the nurses should have called and reported it to her, and then they would have investigated and reported if needed. She said, after looking at Resident #3's chart, that LVN A was a new nurse during the incident and did not follow all the necessary steps, such as notification. She said they would educate LVN A. The Administrator said when injuries of unknown origin were not reported promptly, abuse could continue to occur. (continued on next page)

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

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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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the facility policy titled Abuse Prohibition Policy, revised 08/2020, indicated, Purpose: To ensure the facility established, operationalizes, and maintains an Abuse Prevention and Prohibition Program designed to screen and train employees, protect residents, and to ensure a standardized methodology for the prevention, identification, investigation, and reporting of abuse, neglect, mistreatment, misappropriation of property, and crime in accordance with federal and state requirements. VI. Investigation: A. The facility promptly and thoroughly investigates reports of resident abuse, mistreatment, neglect, injuries of an unknown source, or criminal activity. IX. Reporting: The facility will report allegations of abuse, neglect, exploitation, mistreatment, and injuries of unknown source, etc . immediately but no longer than two hours

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45879 Based on interview, and record review the facility failed to ensure that all alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of unknown source and misappropriation of resident property, were reported immediately, but no later than 2 hours after the allegation was made, for 1 of 6 residents (Resident #3) reviewed for abuse and neglect. The facility staff did not report to the state agency that Resident #3 had a bruise and a skin tear to the left arm of unknown origin on 02/11/25. This failure could place the residents at increased risk for abuse and neglect or further potential abuse due to unreported allegations of abuse and neglect. Findings included: Record review of Resident #3's face sheet, dated 04/09/25, indicated an [AGE] year-old female who was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included dementia (diseases that affect memory, thinking, and the ability to perform daily activities), diabetes (is a chronic condition that happens when you have persistently high blood sugar levels), and depression (mood disorder that causes a persistent feeling of sadness and loss of interest and can interfere with your daily living). Record review of Resident #3's annual MDS assessment, dated 02/26/25, indicated Resident #3 rarely understood and was rarely understood by others. Resident #3's BIMS score was 00, which meant she was severely cognitively impaired. The MDS indicated Resident #3 required extensive help with toileting, bed mobility, dressing, transfers, personal hygiene, and supervision with eating. The MDS did not indicate Resident #3 had wounds or skin problems. Record review of Resident #3's progress note dated 2/11/25 at 6:22 pm, written by LVN A, revealed Resident #3's family member reported 2 open areas to her left arm, both less than 0.25 x 0.25 in diameter. Both showed no signs of infection. The nurse provided first aid to both, and neither area showed signs of infection. The resident denied pain. The call light was in reach. Record review of Resident #3's progress note updated 2/11/25 at 6:42 pm, written by LVN A revealed Resident #3 had one open area and one bruise to her left arm. Record review of Resident #3's progress note dated 2/12/25 at 2:40 am, written by LVN C, revealed to continue to monitor skin tear and bruising to the left arm for Resident #3. No signs or symptoms of infection, pain, or discomfort were noted. Record review of Resident #3's physician orders, dated 02/01/25 through 02/28/23, did not reveal any orders for monitoring bruising to the left arm. Record review of Resident #3's physician orders, dated 02/01/25 through 02/28/25, did not reveal any orders for treating a skin tear to her left arm. (continued on next page)

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #3's skin assessment dated [DATE] did not indicate a skin assessment was done after the bruise and skin tear were noted. Record review of Resident #3's skin assessment dated [DATE], charted by LVN C, did not indicate a bruise or skin tear to her left arm. Record review of Resident #3's care plan, revised on 03/26/25, did not indicate a bruise or skin tear to her left arm on 02/11/25. During an interview on 04/08/25 at 1:44 p.m., LVN B said she was the treatment nurse. She said if a resident had a skin tear or a bruise, it should be reported to the nurse, the nurse would then report it to her, and she would assess and determine what type of treatment was needed, if any. She said if a skin tear were noted, she would look at it daily and document it in the TAR. If a bruise were noted, she would put in an order to monitor weekly till resolved. LVN B said that Resident #3 had several bruises over time because she would attempt to get up by herself. She said she could not recall this particular bruise or skin tear. She said part of her process was if a bruise or skin tear were reported, she would investigate to see what happened. She said Resident #3 was not normally able to say what happened related to her cognitive status. LVN C said if she could not figure out what happened, she would report it to the Administrator or DON. During an interview on 04/08/25 at 1:44 p.m., LVN A said she was the charge nurse on duty when a family member reported Resident #3 had a skin tear and bruise on her left arm. LVN C said she was not aware how Resident #3 received the bruise or skin tear. She said she did not ask the staff or the family member who reported the skin tear or bruise if they knew what happened. LVN A said if an unknown skin tear or bruise was reported to her, she was supposed to notify the Administrator, DON, the physician, and the family. LVN A said she reported the bruise and skin tear to the Administrator and the DON. She said she was new to the facility during the incident and was told to do a progress note. She said she did not recall the Administrator or the DON questioning her about the incident once she reported it. She said since this incident, she had been educated to do an incident report and progress note, notify management, the physician, and the family. During an interview on 04/09/25 at 6:55 a.m., LVN C said she was the 10 pm-6 am nurse for Resident #3. She said she could not recall the skin tear or bruise from 02/12/25 on Resident #3. LVN C said if she charted it, then it was either given to her in the report or was on the 24-hour report. She said if a bruise or skin tear occurred and staff were unaware of how it occurred, staff would report it to the ADON or DON, and they would investigate it. She said the nurses were supposed to do an incident report, document a progress note, and notify the physician, the family, the Administrator, and the DON of any skin tears or bruises of unknown origin. She said even if the nurses did not report something, it was on the 24-hour report, and management was supposed to review it daily. She said she did not recall being asked about Resident #3's skin tear or bruise by the Administrator or DON. (continued on next page)

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Sunny Springs Nursing & Rehab	1200 Jackson St N Sulphur Springs, TX 75482

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/9/25 at 10:00 a.m., the ADON said if a resident had a bruise or skin tear of an unknown origin, she would investigate to see if she could figure out what happened. She said the nurses should document the incident in the progress notes, do an incident report, and notify the physician, the family, the Administrator, and the DON. She said the nurses were to chart the incident for 72 hours. She said even if a nurse forgot to report the incident, she would see it on the 24-hour report or while reading the nurses' notes. She said she could recall the incident on 02/11/25, but could not remember the details. The ADON reviewed Resident #3's chart and did not see an incident report on 02/11/25. During an interview on 04/09/25 at 10:53 a.m., LVN B said she was the treatment nurse, and she had done a skin assessment on Resident #3 earlier on the 6 am-2 pm shift on 02/11/25. She said Resident #3 did not have any skin tears or bruises during her assessment. She said LVN A charted the skin tear and bruise at 6:22 pm after her shift. During an interview on 04/09/25 at 11:03 a.m., the DON said he expected if a resident had a bruise or skin tear of an unknown source that staff would report it to him and the Administrator. He said they would do an internal investigation to see if they could figure out what happened, and if they could not figure out what happened, they would report it to the State of Texas. He said he could not recall the skin tear or bruise for Resident #3 around 02/11/25. He said Resident #3 had often scratched herself, or she could have bumped it on the wall, but since he did not remember investigating it, he could not say what happened. He said they do review the 24-hour reports in the morning meeting, and it must have been overlooked. He said that although he did not feel like abuse occurred, it was important to report and investigate abuse/neglect to prevent further abuse/neglect from occurring. During an interview on 04/09/25 at 4:37 p.m., the Administrator said she was unaware of Resident #3's skin tear or bruise; therefore, it was not investigated or reported. She said she was not contacted for all skin tears or bruises, only if suspicion of abuse. She said if there was suspicion of abuse, the nurses should have called and reported it to her, and then they would have investigated and reported if needed. She said, after looking at Resident #3's chart, that LVN A was a new nurse during the incident and did not follow all the necessary steps, such as notification. She said they would educate LVN A. The Administrator said when injuries of unknown origin were not reported promptly, abuse could continue to occur. Record review of the facility policy titled Abuse Prohibition Policy, revised 08/2020, indicated, Purpose: To ensure the facility established, operationalizes, and maintains an Abuse Prevention and Prohibition Program designed to screen and train employees, protect residents, and to ensure a standardized methodology for the prevention, identification, investigation, and reporting of abuse, neglect, mistreatment, misappropriation of property, and crime in accordance with federal and state requirements. VI. Investigation: A. The facility promptly and thoroughly investigates reports of resident abuse, mistreatment, neglect, injuries of an unknown source, or criminal activity. IX. Reporting: The facility will report allegations of abuse, neglect, exploitation, mistreatment, and injuries of unknown source, etc . immediately but no longer than two hours

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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 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** 45879 Based on observations, interviews, and record review, the facility failed to develop and implement a comprehensive person-centered care plan for each resident, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs, for 2 of 4 (Resident #1 and Resident #2) residents reviewed for the care plan. 1. The facility failed to ensure urinalysis results on 04/05/2025 for Resident #1's contact isolation was care planned on 04/06/2025 for a diagnosis of Extended-Spectrum Beta-Lactamase, also known as ESBL (a bacteria that can be spread from person to person on contaminated hands of both patients and healthcare workers. 2. The facility failed on 04/03/2025 to ensure Resident #2's contact isolation was care planned for methicillin-resistant Staphylococcus aureus also known as MRSA (an infection caused by a type of staph bacteria that's become resistant to many of the antibiotics used to treat ordinary staph infections) and for her refusal to stay in her room related to her being on isolation. These failures could affect residents by placing them at risk of not receiving appropriate care and interventions to meet their needs. Findings included: 1.Record review of Resident #1's face sheet, dated 04/09/25 indicated she was a [AGE] year-old female admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included urinary tract infection also known as UTI (is an infection of the urinary tract, which includes the kidneys, bladder, ureters, and urethra), extended-spectrum beta-lactamase also known as ESBL (occurs when bacteria producing the enzyme ESBL, which renders them resistant to many common antibiotics, causes an infection), diabetes (a chronic condition where the body either doesn't produce enough insulin or can't effectively use the insulin it produces, leading to high blood sugar levels), and stroke. Record review of Resident 1's quarterly MDS assessment, dated 02/26/25, indicated Resident #1 understood and was understood by others. Resident #1's BIMS score was 03, indicating she was severely cognitively impaired. The MDS indicated Resident #1 required assistance with her transfers, toileting, dressing, hygiene, and supervision for eating. The MDS indicated she was always incontinent of urine and was on an antibiotic. Record review of Resident #1's electronic medical records revealed a urinalysis dated 04/05/25 which detected extended-spectrum beta-lactamase, also known as ESBL. Record review of Resident #1's comprehensive care plan dated 04/06/25 indicated Resident #1 had a UTI. The intervention was for staff to encourage adequate fluids and monitor side effects. The care plan did not mention anything about being on contact isolation for ESBL. Record review of Resident #1's physician's order dated 04/07/25 indicated: Doxycycline 100mg, give 1 capsule by mouth two times a day related to Urinary tract infection for 5 days. (continued on next page)

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #1's Physician order dated 04/07/25 indicated Contact isolation precautions in place related to ESBL. During an observation on 04/08/25 at 12:09 p.m., a contact isolation sign was noted on Resident #1's door. The isolation cart was noted 1 door to the right of Resident #1's room. 2.Record review of Resident #2's face sheet, dated 04/09/25 indicated she was a [AGE] year-old female admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included dementia(a general term for a group of diseases that cause a decline in memory, thinking, and reasoning abilities, significantly affecting a person's daily life), Urinary Tract Infection also known as UTI (is an infection of the urinary tract, which includes the kidneys, bladder, ureters, and urethra), and anxiety (a feeling of fear, dread, and uneasiness). Record review of Resident 2's quarterly MDS assessment, dated 01/30/25, indicated Resident #2 usually understood and was usually understood by others. Resident #2's BIMS score was 15, indicating she was cognitively intact. The MDS indicated Resident #2 required set-up assistance with her dressing and hygiene, independent with toileting and eating. The MDS indicated she was continent of bladder. Record review of Resident #2's comprehensive care plan dated 03/29/23 indicated Resident #2 was occasionally incontinent of urine. The intervention was for staff to monitor for signs and symptoms of UTI. The care plan did not indicate a care plan for contact isolation or refusal to comply with contact isolation for MRSA. Record review of Resident #2's electronic medical records revealed a urinalysis dated 04/03/25, which detected MRSA. Record review of Resident #2's physician's order dated 04/06/25 indicated: Rifampin 300mg, give 1 capsule by mouth two times a day related to MRSA in urine until 04/20/25. Record review of Resident #2's Physician order dated 04/06/25 indicated contact isolation precautions in place related to the diagnosis of MRSA. Record review of Resident #2's comprehensive care plan after surveyor intervention was dated 04/06/25 but updated on 04/09/25, indicating Resident #1 required isolation. The intervention was to follow the facility's isolation policy and give medication as ordered. During an observation on 04/08/25 at 11:00 a.m., Resident #2 was in the dining room attending an activity with 8 other residents while positive for MRSA. Resident #2 had a contact isolation sign on her door and an isolation cart outside her room door. During an interview on 04/09/25 at 10:00 a.m., the ADON said the MDS nurses were responsible for the care plans. She said she and the DON were responsible for updating the acute care plans. She looked at Resident #1's and Resident #2's care plan and said she did not see their contact isolation care plan, nor Resident #2's refusal to stay in her room. She said she was aware they were on contact precautions but had not had a chance to update the care plan. She said she was aware of all new orders or changes a resident might have because they discussed the residents in the morning meeting, and she read the 24-hour reports. She said care plans were updated so staff would be aware of the care the residents needed. (continued on next page)

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 04/09/25 at 11:08 a.m., the Regional MDS nurse said the MDS nurse was responsible for the comprehensive care plan, and the management team was responsible for updating the acute care plans. She said any changes about new orders should be updated within 24-48 hours, depending on when the order was received. She said care plans were done to direct the care of the resident. During an interview on 04/09/25 at 11:22 a.m., the DON said the MDS nurses were responsible for the care plans. He said he and the ADON were responsible for the acute care plans. He said he was not aware that Resident #1 or Resident #2's care plan had not been updated related to contact isolation and the refusal of Resident #2 to stay in her room. He said care plans were done to ensure staff conducted the plan of care for each resident. During an interview on 04/09/25 at 12:16 p.m., the Administrator said care plans were a team effort with the interdisciplinary team, but the MDS nurses were the overseers. She said the MDS nurse last day at the facility was last week; therefore, the DON/ADON was responsible for updating Resident #1 and #2's care plan. She said care plans were generated to provide each resident with the best care. Record review of the facility's policy, Care Plan (Comprehensive), revised 10/24/22, indicated, To ensure that a comprehensive person-centered Care Plan is developed for each resident based on their individual assessed needs. V. The IDT will revise the Comprehensive Care Plan as needed at the following intervals: A. Per RAI schedules; B. As dictated by changes in the resident's condition, C. In preparation for discharge, D. To address changes in behavior and care, and E. Other times as appropriate or necessary.

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	04/09/2025

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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** 45879 Based on observations, interviews, and record review, the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment to help prevent the development and transmission of communicable diseases and infections for 2 of 6 residents (Resident #1 and Resident #2) reviewed for infection control. The facility failed to ensure LVN D wore the proper PPE (gown and gloves) while checking Resident #1's blood sugar or administering insulin on 04/08/25, who was positive for ESBL. The facility failed to ensure CNA E wore the proper PPE (gown and gloves) while providing care to Resident #1, who was positive for ESBL on 04/09/25. The facility failed to ensure Resident #2 understood contact isolation precautions when the resident was in activities with other residents and positive for MRSA on 04/08/25. These failures could place residents and staff at risk for cross-contamination and spread of infection and could potentially affect all others in the building. Findings included: 1. Record review of Resident #1's face sheet, dated 04/09/25 indicated she was a [AGE] year-old female admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included urinary tract infection also known as UTI (is an infection of the urinary tract, which includes the kidneys, bladder, ureters, and urethra), extended-spectrum beta-lactamase also known as ESBL (occurs when bacteria producing the enzyme ESBL, which renders them resistant to many common antibiotics, causes an infection), diabetes (a chronic condition where the body either doesn't produce enough insulin or can't effectively use the insulin it produces, leading to high blood sugar levels), and stroke. Record review of Resident 1's quarterly MDS assessment, dated 02/26/25, indicated Resident #1 understood and was understood by others. Resident #1's BIMS score was 03, indicating she was severely cognitively impaired. The MDS indicated Resident #1 required assistance with his transfers, toileting, dressing, hygiene, and supervision for eating. The MDS indicated she was always incontinent of urine and was on an antibiotic. Record review of Resident #1's electronic medical records revealed a urinalysis dated 04/05/25 which detected extended-spectrum beta-lactamase, also known as ESBL. Record review of Resident #1's comprehensive care plan dated 04/06/25 indicated Resident #1 had a UTI. The intervention was for staff to encourage adequate fluids and monitor side effects. The care plan did not indicate Resident #1 was on contact isolation. Record review of Resident #1's physician's order dated 04/07/25 indicated: Doxycycline 100mg, give 1 capsule by mouth two times a day related to Urinary tract infection for 5 days. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #1's Physician order dated 04/07/25 indicated contact isolation precautions in place related to the diagnosis of ESBL. During an observation on 04/08/25 at 12:09 p.m., a contact isolation sign was noted on Resident #1's door. LVN D walked into Resident #1's room to check her blood sugar without applying a gown. LVN D reached over Resident #1 to check her blood sugar on her left finger. LVN D then left Resident #1's room to gather her insulin, reentered the room without a gown, and administered her insulin. During an interview on 04/08/25 at 1:44 p.m., LVN A said she was the nurse who received Resident #1's diagnosis of ESBL related to her lab results and the order for Doxycycline. She said she gave the initial dose on 04/07/25 and posted an isolation sign on Resident #1's door. She said she reported it to the oncoming nurse about Resident #1's isolation and new order for Doxycycline. She said she also placed it on the 24-hour report sheet. During an interview on 04/09/25 at 9:15 a.m., LVN D said she was the charge nurse for Resident #1 and Resident #2. She said Resident #1 was on contact precautions for ESBL in her urine, and Resident #2 was on contact precautions for MRSA in her urine. LVN D said staff should have on a gown and gloves when entering Resident #1 and Resident #2's rooms. She said she did not wear a gown when she went into Resident #1's room to check her blood sugar or when she administered her insulin. She said she honestly forgot she was in contact isolation. She said Resident #2 had rights, and if she wished to come out of her room, then she could. She said she could not recall if she had personally asked Resident #2 to stay in her room related to her contact isolation orders. She said if staff were not wearing gowns or gloves, they could spread the infection to others. During an observation on 04/09/25 at 9:45 a.m., CNA E went into Resident #1's room to provide care. CNA E did not have on her gown or gloves when entering Resident #1's room. During an observation and interview on 04/09/25 at 10:09 a.m., CNA E came out of Resident #1's room and disposed of her linen in the laundry barrel without it being in a yellow bag. She said she was aware Resident #1 was on contact precautions for something in her urine. She said she did not see a cart next to her door and did not see any boxes in her room, so she assumed she did not have to wear anything while in the room. She said that in the past, if a resident was on isolation, they would have a cart with equipment next to the door and boxes in the room with red bags for the trash and yellow bags for the linen. She said she worked yesterday (04/08/25) and did not wear a gown while providing care for Resident #1. She said she could spread infection since she did not properly dispose of her linen or wear a gown while in the room. During an observation on 04/09/25 at 10:15 a.m., no linen or trash boxes were noted in Resident #1's room. The isolation cart was noted 1 door to the right of Resident#1's room. 2.Record review of Resident #2's face sheet, dated 04/09/25 indicated she was a [AGE] year-old female admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included dementia(a general term for a group of diseases that cause a decline in memory, thinking, and reasoning abilities, significantly affecting a person's daily life), Urinary Tract Infection also known as UTI (is an infection of the urinary tract, which includes the kidneys, bladder, ureters, and urethra), and anxiety (a feeling of fear, dread, and uneasiness). (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident 2's quarterly MDS assessment, dated 01/30/25, indicated Resident #2 usually understood and was usually understood by others. Resident #2's BIMS score was 15, indicating she was cognitively intact. The MDS indicated Resident #2 required set-up assistance with her dressing and hygiene, independent with toileting and eating. The MDS indicated she was continent of bladder. Record review of Resident #2's comprehensive care plan dated 03/29/23 indicated Resident #1 was occasionally incontinent of urine. The intervention was for staff to monitor for signs and symptoms of UTI. The care plan did not indicate a care plan for contact isolation or refusal to comply with contact isolation. Record review of Resident #2's electronic medical records revealed a urinalysis dated 04/03/25, which detected MRSA (an infection caused by a type of staph bacteria that's become resistant to many of the antibiotics used to treat ordinary staph infections). Record review of Resident #2's physician's order dated 04/06/25 indicated: Rifampin 300mg, give 1 capsule by mouth two times a day related to MRSA in urine until 04/20/25. Record review of Resident #2's Physician order dated 04/06/25 indicated Contact isolation precautions in place related to MRSA. Record review of Resident #2's comprehensive care plan after surveyor intervention was dated 04/06/25 but updated on 04/09/25, indicating Resident #1 required isolation. The intervention was to follow facility isolation policy and give medication as ordered. During an observation on 04/08/25 at 11:00 a.m., Resident #2 was in the dining room attending an activity with 8 other residents while positive for MRSA. During an interview on 04/08/25 at 3:30 p.m., Resident #2 said the staff told her she had something in her bladder and to make sure she washed her hands after using the bathroom. She said they did not tell her she had something that someone might catch or to stay in her room. During an observation on 04/09/25 at 9:28 a.m., Resident #2 was in the day room sitting on the couch talking to another resident. During an interview on 04/09/25 at 10:00 a.m., the ADON said if a resident were in contact isolation, staff would know because of the sign posted on the door. She said staff should wear gowns and gloves when they enter contact-isolated rooms. She said they encourage handwashing before and after care for all residents. She said she was not sure what the policy said on contact isolation for a resident. She said she thought the contact isolated residents could walk the facility. She said she knew they had educated Resident #2 on hand washing. During an interview on 04/09/25 at 11:22 a.m., the DON said he expected all staff to follow the guidelines on the sign posted on the door. He said they should be wearing the proper PPE (gown and gloves) to protect themselves and to keep the spread of infection from other residents. He said if the resident were on contact isolation, then staff should be educating the resident on why they need to stay in their room and encouraging them to stay in their rooms. If the resident refuses to stay in their room, then the staff should document the refusal and add it to the resident's care plan. (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 04/09/25 at 12:16 p.m., the Administrator said when a resident was on contact isolation, staff should wear gowns and gloves when entering the room. She said the DON oversaw infection control. The Administrator said staff should ensure they had on the proper PPE to protect themselves and the residents and to prevent the spread of infection. She said residents who were on contact isolation should be encouraged to stay in their rooms and practice good hygiene to prevent the spread of infection. Record review of the facility's policy titled, Infection Prevention and Control Program, revised 06/2020, indicated, Purpose: Ensure the facility established and maintained an infection control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection in accordance with federal and state requirements. Policy: The facility must establish an infection prevention and control program under which it: #1 identifies, investigates, controls, and prevents infections in the facility . Record review of the facility's policy titled, Isolation-Categories of Transmission-Based Precautions, revised 6/2020, indicated, To ensure that transmission-based precautions are used when caring for residents with communicable diseases or transmittable infections. III. Contact Precautions A. Contact precautions are implemented for residents known or suspected to be infected or colonized with microorganisms that are transmitted by direct contact with the resident or indirect contact with environmental surfaces or resident-care items in the resident's environment. I. Examples of infections requiring Contact Precautions include, but are not limited to: A. Gastrointestinal, respiratory, skin, or wound infections or colonization with multi-drug resistant organisms (e.g., MRSA). C. Gloves and Handwashing: I. As outlined under Standard Precautions, gloves (clean, non-sterile) are worn when entering the room. D. Gown: I. As outlined under Standard Precautions, a (clean, non-sterile) gown is worn for interactions that may involve contact with the resident or potentially contaminated items in the resident's environment. G. Notice: I. The Facility alerts staff to the type of precaution a resident requires. ii. The Facility also ensures that the resident's care plan indicates the type of precautions implemented for the resident. iii. The Facility may utilize a sign requesting visitors to check in at the nursing station before entering a resident's room.