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	08/22/2024

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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45879 Based on interview and record review, the facility failed to ensure residents had the right to be informed of and participate in his or her treatment which included, the right to be informed in advance, by the physician or other practitioner or other professional, of the risks and benefits of proposed care, treatment, and treatment alternatives or treatment options to choose the alternative or option he or she preferred for 1 of 4 residents (Resident #179) reviewed for resident rights. The facility failed to obtain informed consent based on the information of the benefits and risks for Resident #179 before administering Bupropion HCL ER (Wellbutrin - a medication used to treat depression). This failure could place residents at risk of receiving medications they had not consented to, experiencing potential adverse reactions, and a potential decline in physical and mental health status. Findings included: Record review of Resident #179's face sheet, dated 08/22/24, indicated a [AGE] year-old male who was admitted to the facility on [DATE] and readmitted on [DATE] with the diagnoses which included Spinal stenosis (pain in the lower back that can cause cramping in one or both legs), Schizophrenia (a chronic mental illness that affects how a person thinks, feels, and behaves), depression (sadness), and post-traumatic stress disorder also known as PTSD (a mental health condition that's caused by an extremely stressful or terrifying event). Record review of Resident #179's admission MDS assessment, dated 08/12/24, indicated Resident #179 understood and was understood by others. Resident #179's BIMS score was 15, which indicated he was cognitively intact. The MDS indicated Resident #179 required extensive help with toileting bed mobility, dressing, transfers, set up for personal hygiene, and being independent with eating. The MDS indicated he took antidepressant medication during the 7-day look-back period. Record review of Resident #179's care plan dated 08/07/24 indicated he required antidepressant medication. The intervention of the care plan indicated staff would give medication as ordered, staff would monitor for signs and symptoms of depression such as sadness, crying, or shame, etc., and educate the resident/family/caregivers about risks, benefits, and the side effects and/or toxic symptoms. Record review of Resident #179's physician order dated 08/05/24 for Bupropion HCL ER(Wellbutrin) 150mg, give 1 tablet by mouth daily for depression. (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #179's records revealed there was no consent for the use of psychotropic medication, Bupropion HCL ER(Wellbutrin) documented in his chart. During an interview on 08/21/24 at 4:00 p.m., Resident #179 said he took a lot of medicine and was unsure of all the names. During an interview on 08/21/24 at 4:21 p.m., LVN A said consent(s) should be obtained for all psychotropic medication before being given. LVN A said Resident #179 was given, Bupropion HCL ER (Wellbutrin) for depression but did not know his consent was not done until mentioned by the State Surveyor. LVN A said consents were usually obtained during the admission process by the charge nurse. LVN A said psychotropic medications could change a resident's demeanor and this was why the resident or their responsible party should be aware of all medications and the possible side effects or behaviors from the medications. During an interview on 08/21/24 at 4:44 p.m., the ADON said the consent for psychotropic medications should be completed before the resident received the medication. The ADON said they normally got consent for all psychotropic medication because those types of medications could alter the mind and could cause other risks. The ADON said the nurse who received the order was responsible for getting the consent. The ADON said she was the admitting nurse for Resident #179 and did not realize she did not get his consent for Bupropion HCL ER (Wellbutrin) until questioned by the state surveyor. The ADON said failure to get consent could lead to a side effect or behaviors and the family or resident would not know why. During an interview on 08/22/24 at 2:30 p.m., the DON said consent should be signed prior to medication being administered. The DON said one reason consents were obtain was to inform the family or resident about the risk and benefits prior to receiving medications. The DON said they had psychiatrist services who would usually obtain consent if they place the resident on psychotropic medication. He said if the charge nurse received the order, they were responsible for obtaining the consent. He said the IDT was the overseer for ensuring residents had consent in place. The DON said failure to obtain consent could cause the resident not to know what medications he was taken or if he wanted to take them. During an interview on 08/22/24 at 03:00 p.m., the Administrator said consent should be done to inform families or residents of risk and/or benefits of medication. The Administrator said the ADON and the DON oversaw that process. The Administrator said failure to get consent could lead to families or residents not having a voice in resident care. Record review of the facility's policy titled; Psychotherapeutic Drug Management revised date of 06/2020, Purpose: To implement the most desirable and effective interventions to change, modify, decrease, or eliminate behaviors that are distressing to the resident, and/or decreasing or negatively impacting the residents' quality of life .G. The Licensed Nurse will not administer the psychotherapeutic medication until an informed consent from has been obtained and document by the attending physician from the resident and/or surrogate decision maker unless it is an emergency.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46928 Based on interview and record review, the facility failed to consult with the resident's physician immediately when there was a need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment) for 1 of 24 residents (Resident #33) reviewed for resident rights. The facility failed to notify Resident #33's physician when he refused his ordered lab draws for 4 weeks. This failure placed residents' physician at risk of not being aware of any changes in their conditions and could result in a delay in treatment and decline in residents' health and well-being. Findings included: Record review of Resident #33's face sheet dated [DATE], indicated a [AGE] year-old male who admitted to the facility on [DATE] and readmitted on [DATE]. Resident #33 had diagnoses of end stage renal disease (when the kidneys no longer adequately filter waste products from the blood and function less than 15 percent of normal levels), diabetes mellitus type 2 (a group of diseases that affect how the body uses blood sugar), dependence on renal dialysis (process of removing excess water, solutes, and toxins from the blood when the kidneys can no longer perform those functions naturally), and chronic obstructive pulmonary disease (chronic lung disease that causes breathing difficulty, cough, mucus production, and wheezing). Record review of Resident #33's quarterly MDS assessment dated [DATE], indicated Resident #33 was understood and was able to understand others. The MDS assessment indicated Resident #33 had a BIMS score of 15, which indicated his cognition was intact. The MDS assessment did not indicate Resident #33 refused care. The MDS assessment indicated Resident #33 received dialysis. Record review of Resident #33's comprehensive care plan dated [DATE], indicated Resident #33 needed hemodialysis related to renal failure, went one time a week to hospital, shunt site to left extremity, and received dialysis on Tuesday at hospital. The care plan interventions indicated monitor labs and report to doctor as needed. Resident #33's care plan also indicated he was resistive to care related to adjustment to nursing home refused medications, blood sugar checks, diagnostic test labs and showers at times. The care plan interventions included to educate resident/family/caregivers of the possible outcomes of not complying with treatment or care. Record review of Resident #33's order summary report dated [DATE], indicated Resident #33 had and order for CBC weekly for 4 weeks with an order date of [DATE]. Record review of Resident #33's progress note dated [DATE], written by LVN A indicated . Received new orders from MD to do CBC once a week for 4 weeks D/T HGB being 7.2 and he refused transfusion in hospital. Resident refused blood draw this AM. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #33's lab result dated [DATE], indicated Resident #33 refused CBC lab draw and LVN A was notified. Record review of Resident #33's lab result dated [DATE], indicated Resident #33 refused CBC lab draw two times. Record review of Resident #33's lab result dated [DATE], indicated Resident #33 refused CBC lab draw and LVN A was notified. Record review of Resident #33's lab result dated [DATE], indicated Resident #33 refused CBC lab draw and LVN A was notified. Record review of Resident #33's progress notes dated [DATE]-[DATE], indicated Resident #33 refused lab draw on [DATE]. There were no other documented refusals in the progress notes or if the physician had been notified. During an interview on [DATE] at 2:37 PM, LVN A said Resident #33's order for CBC was to be obtained weekly for 4 weeks. LVN A said she had obtained the order when Resident hemoglobin was low, and he had refused a blood transfusion at the hospital. LVN A said Resident #33 refused his lab draws. LVN A said she notified the physician of Resident #33's refusals but did not chart them . LVN A said if it was not charted, it did not happen. LVN A said it was her responsibility to ensure the physician was notified and for it to be documented. LVN A said by not notifying the physician of Resident #33's lab refusals his hemoglobin could have dropped, and he could have died . During an interview on [DATE] at 1:55 PM, the DON said he expected the physician to have been notified of Resident #33's lab refusal as it occurred. The DON said Resident #33 refused lab draws all the time and the physician was already aware of his refusals. The DON said he expected the nurse to have documented when the physician was notified. The DON said failure to notify the physician of Resident #33's lab refusals could cause Resident #33's lab to be out of range. The DON said not obtaining Resident #33's lab the concern was dampened since Resident #33 went to the hospital for dialysis weekly and labs were obtained there. During an interview on [DATE] at 2:21 PM, the Administrator said she expected the nurses to have documented in the resident's medical record when the physician was notified of Resident #33's lab refusals. The Administrator said, if it was not documented, it was not done. The Administrator said since Resident #33 refused his lab draws and physician was not notified, Resident #33 could have had critical labs that they would not have been aware of. The Administrator said the charge nurse was responsible for notifying the physician and documenting in the resident's electronic medical record. During an attempted phone interview on [DATE] at 2:38 PM, Resident #33's physician did not answer the phone. Record review of the facility's policy Laboratory, Diagnostic and Radiology Services revised on ,d+[DATE] indicated . To ensure that laboratory, diagnostic and laboratory services are provided to meet the resident's needs. Laboratory, diagnostic and radiology services will be coordinated pursuant to an order by a physician, physician assistant, nurse practitioner or clinical nurse specialist in accordance with the scope and practice under state law . (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the facility's policy Change of Condition Notification revised on ,d+[DATE] indicated . To ensure residents, family, legal representatives, and physicians are informed of changes in the resident's condition in a timely manner . The licensed nurse will notify the residents Attending Physician when there is an . D. a need to alter treatment significantly .

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45879 Based on observation, interview, and record review, the facility failed to ensure residents had a right to personal privacy and confidentiality of medical records for 1 (Resident #57) of 4 residents reviewed for resident rights The facility failed to ensure the ADON logged out of her computer and protected the privacy of Resident #57's Medication Administration Record. This failure could place residents at risk for low self-esteem, loss of dignity and decreased quality of life due to medication administration record being accessible to others. Findings included: Record review of Resident #57's face sheet, dated 08/22/24, indicated a [AGE] year-old female who was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included stroke, diabetes, and high blood pressure. Record review of Resident #57's quarterly MDS assessment, dated 06/13/24, indicated Resident #57 understood and was understood by others. Resident #57's BIMS score was 10, which meant she was moderately cognitively impaired. The MDS indicated Resident #57 required extensive help with toileting bed mobility, dressing, transfers, and set up for personal hygiene and eating. The MDS indicated she took insulin medication during the 7-day look-back period. During an observation and interview on 08/20/24 at 12:00 PM, the ADON stepped away from the medication cart, and entered Resident #57's room to check her blood sugar The ADON left the computer screen (on top of the medication cart) unlocked where the medication administration record of Resident #57 was clearly displayed. While the ADON was in the room staff, residents, and visitors were observed walking by the unlocked computer screen. The ADON said she left the computer screen open for Resident #57 because she was in a hurry and had other things on her mind. She said she should have closed the MAR before entering Resident #57's room. She said it was a HIPPA violation to keep the MAR open where others could see Resident #57's personal information. During an interview on 08/22/24 at 2:20 p.m., the DON stated he expected the nurses and med aides to provide full visual privacy and confidentiality of information for all residents. The DON said staff had been educated on HIPPA violations. The DON said failure not to protect the resident's information could cause poor self-esteem and embarrassment for the resident. During an interview on 08/22/24 at 3:00 p.m., the Administrator said she expected the MAR to be always closed when unattended because of resident information and privacy. (continued on next page)

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the facility's policy titled Notice of Privacy Practices, revised August 2020 revealed Purpose: the facility adopts this policy requiring that the facility provide notice of the facilities privacy practices to facility residents and the public. Policy: the facility has adopted a notice of privacy practice that describes the facility's private practice, the use and disclosure of protected health information at the facility, and the resident's rights regarding protected health information. The policy did not indicate anything about protecting the residents' health information.

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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** 45810 Based on interview and record review, the facility failed to implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents, for 1 of 24 residents (Resident #10) reviewed for abuse. The facility failed to follow their policy to report neglect to HHSC when Resident #10's Family Member alleged that CNA C left Resident #10 in bed beyond soiled, and shaking and CNA C stated, I don't fool with her because she hits me. This failure could place residents at risk of abuse, neglect, physical harm, mental anguish, and emotional distress. Findings included: Record review of the facility's policy titled, Abuse Prevention and Prohibition Program revised October 24, 2022, indicated: Policy Each resident has the right to be free from mistreatment, neglect, abuse, involuntary seclusion, and misappropriation of property .IX. Reporting/Response .D. The facility will report allegations of abusee, neglect, injuries of unknown source, misappropriation of resident property .i. Immediately or no later than 2 hours after forming the suspicion . Record review of Resident #10's face sheet dated 08/22/24 indicated she was a [AGE] year-old female who admitted to the facility on [DATE] with the diagnoses of dementia (a symptom associated with neurogenerative diseases, characterized by a decline in cognitive abilities), diabetes mellitus (a group of diseases that result in too much sugar in the blood), major depression (mental disorder characterized by a low mood and sadness), and chronic kidney disease (kidney disease leading to renal failure). Record review of Resident #10's quarterly MDS assessment dated [DATE] indicated the resident was usually understood and usually understood others. The MDS also indicated Resident #10 had severely impaired cognition. The MDS did not indicate Resident #10 had any behaviors. The MDS also indicated she required total assistance from staff for toileting, maximal-moderate assistance from staff for dressing, bathing, and personal hygiene, touch assistance with bed mobility, and supervision with eating. Record review of Resident #10's care plan revised on 05/13/24 indicated she has occasional bladder incontinence related to dementia. The care plan initiated 08/22/24 after survey intervention indicated Resident #10 had an ADL self-care performance deficit related to dementia and required substantial/ maximal assistance staff participation for toileting. The care plan did not indicate Resident #10 had behaviors. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #10's family member's grievance report dated 05/15/24 indicated the family member said Two weeks ago (beg(beginning) of May 2024) Resident was in bed shaking due to being beyond soiled. (Named CNA C) was the aide; aound 5-6pm on Saturday; Aide states I don't fool with her (Resident #10) because she hits me During a phone interview on 08/20/24 at 3:37 PM Resident #10's Family member said he was concerned with the way the facility handled problems. He said he reported an incident to the facility back in May 2024 and he did not see any changes. He said at that time his family member had been left wet and the CNA C said, she does not fool with his relative. During an attempted phone interview on 08/21/24 at 3:04 PM, CNA C's phone indicated it was disconnected. During an interview on 08/22/24 at 02:28 PM, the Social Worker said she received the grievance report from Resident #10's family member and when she received the grievance, she transcribed the grievance, and she notified the administrator immediately. The Social Worker said she did not determine what was reportable, but the Administrator had 2 hours to report to the state per policy, suspend the employee, and talk to all the staff. The failure of not reporting incidents when they needed to be reported placed the resident at risk for abuse or more neglect or bed sores. During an interview on 08/22/24 at 03:24 PM, the DON was advised that Resident #10 shaking, beyond soiled, and CNA C stating she did not fool with the resident should have been reported. The DON stated the incident did not seem to be an allegation of neglect. He said he was aware of the grievance and was not sure of what he would have reported. He said he felt it was simply a grievance. The DON said he expected ADLs to be provided as needed and he could not prove that Resident #10 had been left. During an interview on 08/22/24 at 03:43 PM, the Administrator was presented with the grievance from Resident #10's family member on 5/15/24 and she said she thought it was truly a grievance and the incident should not have been reported to HHSC.

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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** 45810 Based on interviews 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 not later than 2 hours after the allegation was made, if the events that caused the allegation involved abuse or resulted in serious bodily injury, or not later than 24 hours if the events that caused the allegation did not involve abuse and did not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with state law through established procedures for 1 of 24 residents (Residents # 10) reviewed for abuse and neglect. The facility failed to report the allegation of neglect for Resident #10 to the State Agency within required reporting timeframes, within 24 hours of incident. This failure placed residents at risk for ongoing neglect. Findings included: Record review of Resident #10's face sheet dated 08/22/24 indicated she was a [AGE] year-old female who admitted to the facility on [DATE] with the diagnoses of dementia (a symptom associated with neurogenerative diseases, characterized by a decline in cognitive abilities), diabetes mellitus (a group of diseases that result in too much sugar in the blood), major depression (mental disorder characterized by a low mood and sadness), and chronic kidney disease (kidney disease leading to renal failure). Record review of Resident #10's quarterly MDS assessment dated [DATE] indicated the resident was usually understood and usually understood others. The MDS also indicated Resident #10 had severely impaired cognition. The MDS did not indicate Resident #10 had any behaviors. The MDS also indicated she required total assistance from staff for toileting, maximal-moderate assistance from staff for dressing, bathing, and personal hygiene, touch assistance with bed mobility, and supervision with eating. Record review of Resident #10's care plan revised on 05/13/24 indicated she has occasional bladder incontinence related to dementia. The care plan initiated 08/22/24 after survey intervention indicated Resident #10 had an ADL self-care performance deficit related to dementia and required substantial/ maximal assistance staff participation for toileting. The care plan did not indicate Resident #10 had behaviors. Record review of Resident #10's family member's grievance report dated 05/15/24 indicated the family member said Two weeks ago (beg(beginning) of May 2024) Resident was in bed shaking due to being beyond soiled. (Named CNA C) was the aide; aound 5-6pm on Saturday; Aide states I don't fool with her (Resident #10) because she hits me (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a phone interview on 08/20/24 at 3:37 PM Resident #10's Family member said he was concerned with the way the facility handled problems. He said he reported an incident to the facility back in May 2024 and he did not see any changes. He said at that time his family member had been left wet and the CNA C said, she does not fool with his relative. During an attempted phone interview on 08/21/24 at 3:04 PM, CNA C's phone indicated it was disconnected. During an interview on 08/22/24 at 02:28 PM, the Social Worker said she received the grievance report from Resident #10's family member and when she received the grievance, she transcribed the grievance, and she notified the administrator immediately. The Social Worker said she did not determine what was reportable, but the Administrator had 2 hours to report to the state per policy, suspend the employee, and talk to all the staff. The failure of not reporting incidents when they needed to be reported placed the resident at risk for abuse or more neglect or bed sores. During an interview on 08/22/24 at 03:24 PM, the DON was advised that Resident #10 shaking, beyond soiled, and CNA C stating she did not fool with the resident should have been reported. The DON stated the incident did not seem to be an allegation of neglect. He said he was aware of the grievance and was not sure of what he would have reported. He said he felt it was simply a grievance. The DON said he expected ADLs to be provided as needed and he could not prove that Resident #10 had been left. During an interview on 08/22/24 at 03:43 PM, the Administrator was presented with the grievance from Resident #10's family member on 5/15/24 and she said she thought it was truly a grievance and the incident should not have been reported to HHSC. Record review of the facility's policy titled, Abuse Prevention and Prohibition Program revised October 24, 2022, indicated: Policy Each resident has the right to be free from mistreatment, neglect, abuse, involuntary seclusion, and misappropriation of property .IX. Reporting/Response .D. The facility will report allegations of abusee, neglect, injuries of unknown source, misappropriation of resident property .i. Immediately or no later than 2 hours after forming the suspicion .

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45810 Based on interviews and record reviews, the facility failed to ensure the assessment accurately reflected the resident's status for 2 (Resident #64, and Resident #78) of 24 residents reviewed for accuracy of MDS assessments. 1) The facility failed to ensure that Resident #64's MDS accurately reflected the resident had received antibiotics during the 7-day look back period. 2) The facility failed to ensure that Resident's #64's MDS accurately reflected the resident had a MRSA infection to his right hip. 3) The facility failed to ensure Resident #78's MDS accurately reflected his discharge from the facility. These failures could put residents at risk of not receiving the necessary care and services related to inaccurate MDS assessment. Findings included: 1) Record review of Resident #64's face sheet dated 08/20/24 indicated he was a [AGE] year-old male who admitted to the facility on [DATE] with the diagnoses of depression (common but serious mood disorder causing sadness), centrilobular emphysema (a form of lung disease in people who smoke that affects the upper lungs), anxiety (a feeling of nervous, restless, or tense), and heart failure (a chronic condition in which the heart does not pump blood as well as it should). Record review of Resident #64's quarterly MDS assessment dated [DATE] indicated he made himself understood, he understood others, and he had a BIMS score of 3 which meant he had severely impaired cognition. The MDS also indicated he required maximal assistance from the staff for toileting and dressing and moderate assistance from staff for bed mobility and transfers. The MDS did not indicate Resident #64 had a MRSA diagnosis nor did it indicate he received antibiotics for the 7-day look back period. Record review of Resident #64's care plan (that included the resolved plans) revised on 07/29/24 did not include a care plan for the diagnosis of MRSA with interventions to care for the infection to his wound. Record review of Resident #64's Order summary reported dated 07/01/24-07/31/24 indicated he had an order for: 1) Doxycycline Hyclate oral capsule 100mg Give 1 capsule by mouth two times a day for MRSA positive to wound bed for 14 days that had a start date of 07/31/2024 and end date of 08/14/2024. Record review of Resident #64's lab report dated 07/26/24 indicated the MRSA infection resulted on 07/28/24. (continued on next page)

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	675664	A. Building B. Wing	08/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 08/22/24 at 02:56 PM, the MDS Nurse said that Resident #64 was taking the antibiotics as of 08/22/24 but he was unaware at the time he completed the MDS, dated [DATE]. He said 7 days of antibiotics and the MRSA infection should have been coded on the MDS for accuracy and to ensure the facility was providing the correct care. The MDS Nurse said he was responsible for all the facility MDS's, and the information submitted. During an interview on 08/22/24 at 03:23 PM, the DON said he expected the MRSA and the antibiotics to be on the MDS assessment dated [DATE]. He said the failure placed a risk for improper care for Resident #64. The DON said the MDS Nurse was responsible for ensuring accurate information was submitted in the MDS assessments. During an interview on 08/22/24 at 03:35 PM, the Administrator said her expectation was for the antibiotics and the MRSA infection to have been included in the MDS assessment dated [DATE]. She said the MDS Nurse was responsible for all the MDS assessments. The Administrator said information about antibiotics and MRSA infection being included in the MDS was important to ensure the resident received proper treatment and to ensure accuracy of the information that was being sent to CMS. 45879 2.Record review of Resident #78's face sheet, dated 08/22/24 indicated Resident #78 was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses which included Metabolic encephalopathy (ME - a group of neurological disorders that affect the brain due to chemical imbalances in the blood), Hepatitis C (a viral infection that causes liver inflammation and can lead to serious liver damage), and high blood pressure. Record review of Resident #78's quarterly MDS assessment, dated 07/07/24, indicated Resident #78 was discharged from the facility to the hospital. Record review of Resident #78's nurse's note dated 07/16/24 written by the Social Worker indicated Resident #78 was discharged on [DATE] with meds. The discharge was initiated per the resident. Resident #78 was transported per medical transport to his residence. During an interview on 08/22/24 at 1:42 p.m., the MDS nurse said he was responsible for the completion of the MDS assessments. He looked at section A on Resident # 78 and said he coded his discharge incorrectly. He said he got his information from hearsay instead of the chart. He said it was important to code the MDS assessment correctly because it reflected their care and reimbursement. He said he would update their assessments and resend them to the state. During an interview on 08/22/24 at 1:51 p.m., the ADON said the MDS Coordinator was responsible for completing the MDS assessments. The ADON stated she did not know why the MDS indicated Resident # 78 was discharged to the hospital. The ADON stated it was important for the MDS assessments to be accurately coded to make sure they provide the residents with the care they needed. During an interview on 08/22/24 at 2:20 p.m., the DON said the MDS Coordinator was responsible for completing the MDS assessments. The DON said it was a mistake in the MDS coding for Resident #78 being discharged to the hospital from the facility. The DON stated the MDS assessment was important to ensure the care was going right, and the bill was correct as well. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 08/22/24 at 3:00 p.m. the Administrator said the MDS Coordinator was responsible for completing the MDS assessments. She said she was his overseer The Administrator said she expected the coding on the MDS assessments to be accurate. Record review of the facility policy titled, Minimum Data Set Policy, unknown date, indicated The purpose: to utilize the most current version of the resident assessment instrument manual to guide all IDT members on the proper procedure for coding items on the MSDS assessment, completion of care area assessment, and other instructions related to MSDS procedure.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45810 Based on interviews and record reviews, 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 that are identified in the comprehensive assessment for 1 of 24 residents (Residents #64) reviewed for care plans. The facility failed to develop a care plan for Resident #64's diagnosis of MRSA (methicillin-resistant staphylococcus aureus) infection to the wound on his right hip. This failure could have placed resident at risk for not having their needs met. The findings included: Record review of Resident #64's face sheet dated 08/20/24 indicated he was a [AGE] year-old male who admitted to the facility on [DATE] with the diagnoses of depression (common but serious mood disorder causing sadness), centrilobular emphysema (a form of lung disease in people who smoke that affects the upper lungs), anxiety (a feeling of nervous, restless, or tense), and heart failure (a chronic condition in which the heart does not pump blood as well as it should). Record review of Resident #64's quarterly MDS assessment dated [DATE] indicated he made himself understood, he understood others, and he had a BIMS score of 3 which meant he had severely impaired cognition. The MDS also indicated he required maximal assistance from the staff for toileting and dressing and moderate assistance from staff for bed mobility and transfers. Record review of Resident #64's care plans (that included the resolved plans) revised on 07/29/24 indicated there was no care plan addressing the diagnosis of MRSA with interventions to care for the infection to his wound. Record review of Resident #64's lab report dated 07/26/24 indicated the MRSA infection resulted on 07/28/24. During an interview on 08/22/24 at 02:21 PM, the ADON said Resident #64's care plan should have included the MRSA infection. She said the MDS Nurse was responsible for placing the diagnosis on the residents' care plans. The ADON said the failure placed the risk for spreading of infection and placing a risk for staff not knowing Resident #64 had the infection. During an interview on 08/22/24 at 03:04 PM, the MDS Nurse said he was unaware that Resident #64 had the diagnosis of MRSA until 08/22/24 but he was responsible for completing the care plans and ensuring they were updated. The MDS Nurse said the importance of the care plan to include the diagnosis was for everyone who cared for Resident #64 to know how to care for him and his diagnosis of MRSA. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 08/22/24 at 03:20 PM, the DON said he would have expected the MRSA infection for Resident #64 to be included in his care plan. The DON said the MDS was responsible for the care plan and ensuring that information was on the care plan. The DON said the risk for the MRSA infection not being on the care plan was miscommunication and the proper care not being received. During an interview on 08/22/24 at 03:38 PM, the Administrator said she expected the diagnosis for MRSA and interventions to be included in Resident #64's care plan. She said the risk for the failure was the staff were not properly caring for Resident #64 and he could have been at risk for greater infection. Record review of the facility policy Care Planning revised October 2022 indicated: Purpose To ensure a comprehensive person-centered Care Plan is developed for each resident based on their individual assessed needs . Procedure .X The Comprehensive Care Plan must be completed within 7 days after completion of Comprehensive Admission Assessment, and must be periodically reviewed and revised by a team of qualified persons after each assessment, including the comprehensive and quarterly review assessments .

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide activities to meet all resident's needs. 30527 Based on observation, interview, and record review, the facility failed to provide an ongoing program of activities based on the comprehensive assessment to meet the interests of and support the physical, mental, and psychosocial well-being of each resident for 2 (08/21/24 and 08/22/24) of 2 days reviewed for quality of life. The facility failed to ensure 4 of 8 scheduled activities were provided according to the August 2024 activity schedule on 08/21/2024 and 08/22/2024. This failure could place residents at risk for not having activities to meet their interests or needs and a decline in their physical, mental, and psychosocial well-being. Findings included: Record review of the Activity Calendar dated August 2024 indicated the following: Wednesday 08/21/2024: 09:30 AM balloon tennis; 10:30 AM Left-Right-Center game; 2:30 PM bean bag toss; 03:30 PM Help Your Neighbor Thursday 08/22/2024: 09:30 AM ball toss; 10:30 AM Left-Right-Center game; 02:30 PM Dominoes; 03:30 PM Skip Bo. During an observation on 08/21/2024 at 02:35 PM, the bean bag toss activity was not happening in the dining room. During an observation and interview on 08/21/2024 at 03:30 PM, an anonymous resident was sitting in the wheelchair looking at the activity calendar and stated there was not much activity in the facility mainly popcorn and bingo on some Fridays even though the calendar had an activity scheduled. During an observation on 08/21/2024 at 03:35 PM, the Help your Neighbor activity was not happening in the dining room. During an observation on 08/22/2024 at 09:35 AM PM the ball toss activity was not happening in the dining room. During an observation on 08/22/2024 at 3:30 PM the Skip Bo activity was not happening in the dining room. During an interview on 08/22/2024 at 03:40 PM., the Business Office Manager said the facility activities usually occurred in the dining room. The Business office Manager said the Activity Director was not in the facility at that time. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 08/22/2024 at 4:10 PM, the Activity Director said she had been the Activity Director since 2017. The AD said she left the facility to pick up her grandchildren from school. The Activity Director said she usually picked them up from the school daily during the week. The Activity Director said she probably needed to adjust the scheduled activities because she picked up her grandchildren from school during the scheduled 3:30 PM activity and was not in the facility. The Activity Directory said the residents that were bedridden received one on one activities. The Activity Director said some residents did better in small groups and the larger groups were for the more outgoing residents. The Activity Director said she had done the ball toss activity with a resident in the front lobby area in the morning, but she did not have a lot of time because she had to watch the residents smoke. The Activity Director said she had not done the bean bag toss or the ball toss in the dining hall yesterday (08/21/2024) or today (08/22/2024). The Activity Director said the residents liked for her to take them out to smoke because they trusted her. The Activity Director said she did not mind taking the residents out to smoke because she smoked also. The Activity Director said she was unable to recall any other times when an activity was cancelled or not done. She stated a possible negative outcome for not having new games that were stimulating for the residents could be depression and memory loss. The Activity Director stated a possible negative outcome for not conducting activities that were scheduled could be boredom and depression. During an interview on 08/22/2024 at 4:17 PM, the DON said the activities were expected and should be conducted per the scheduled times listed on the activity calendar. The DON said without meaningful activities held per the calendar the residents could become depressed. During an interview on 08/22/2024 at 4:22 PM, the Administrator said the activities should be scheduled and conducted per the resident's activity calendar. The Administrator said when activities were not held as scheduled, the residents could become bored, lose interest, and potentially become depressed. The Administrator said she had oversight of the Activity Director. The Administrator said she was aware of the Activity Director being out of the facility but had not realized the activities were scheduled and missed during this time. Record review of facility policy titled Activities Program with a revised date of 006/2020 did not address conducting scheduled activities.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. 45879 Based on observations, interviews, and record review the facility failed to ensure that residents requiring respiratory care were provided such care, consistent with professional standards of practice for 1 of 1 oxygen cylinders reviewed for respiratory care. The facility failed to ensure an oxygen cylinder was stored properly. This failure could place residents and staff at risk for accidents, leaks, and damage to the cylinder. The findings included: During an observation on 08/21/24 at 4:00 p.m. revealed an unsecured oxygen cylinder at the nurse's station. During an observation and interview on 08/21/24 at 4:21 p.m., revealed LVN B looked at the oxygen cylinder unsecured at the nurses' station. LVN B said she was unaware that the oxygen cylinder was at the nurse's station. She said it was one of the residents who went out to smoke. She said the oxygen cylinders should always be secured. During an interview on 08/21/24 at 5:25 p.m., the Activity Director said she was the person who set the oxygen cylinder at the nurses' station. She said she was aware that the oxygen cylinder needed to be secured but got distracted and forgot. She said it was dangerous to leave the oxygen cylinder unsecure because it could fall and explode. During an interview on 08/22/24 at 1:51 p.m., the ADON said oxygen cylinders should be kept in the storage closet and always secured. She said if an oxygen cylinder were left unsecured it could fall over, cause a fire, or explode. The ADON said all staff was responsible for ensuring oxygen cylinders were secured. During an interview on 08/22/24 at 2:20 p.m., the DON said oxygen cylinders should not be left unsecured at the nurses' station or anywhere. He said they had a closet where they stored the oxygen cylinders and they should be secured and standing up. He said if an oxygen cylinder was left unattended, it could accidentally fall over, projectile, or cause property damage. During an interview on 08/22/24 at 3:00 p.m., the Administrator said oxygen cylinders should be placed in a secured rack. She said it was everyone's responsibility to ensure oxygen cylinders were always secure. She said if oxygen cylinders were left unattended, they could fall and be a danger to the residents or staff. Record review of the facility policy titled, Oxygen Administration dated 06/20 indicated, The purpose of this procedure was to prevent or reverse hypoxemia and provide oxygen to the tissues. The policy for IV. Safe Handling of Oxygen/Equipment: #D. Oxygen cylinders are to be secured in a cylinder cart of bracket at all times.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46928 Based on interview and record review, the facility failed to ensure dialysis services were provided consistently with professional standards of practice for 1 of 1 resident (Resident #33) reviewed for quality of care. The facility failed to ensure Resident #33 had a physician's order for dialysis treatment. The facility failed to monitor Resident #33's dialysis catheter. These failures could place the residents, who received dialysis, at risk for complications and not receiving proper care and treatment to meet their needs. Findings included: Record review of Resident #33's face sheet dated 08/21/24, indicated a [AGE] year-old male who admitted to the facility on [DATE] and readmitted on [DATE]. Resident #33 had diagnoses of end stage renal disease (when the kidneys no longer adequately filter waste products from the blood, function less than 15 percent of normal levels), diabetes mellitus type 2 (a group of diseases that affect how the body uses blood sugar), dependence on renal dialysis (process of removing excess water, solutes, and toxins from the blood when the kidneys can no longer perform those functions naturally), and chronic obstructive pulmonary disease (chronic lung disease that causes breathing difficulty, cough, mucus production, and wheezing). Record review of Resident #33's quarterly MDS assessment dated [DATE], indicated Resident #33 was understood and was able to understand others. The MDS assessment indicated Resident #33 had a BIMS score of 15, which indicated his cognition was intact. The MDS assessment indicated Resident #33 received dialysis. Record review of Resident #33's comprehensive care plan dated 04/03/2024, indicated Resident #33 needed hemodialysis (treatment for advanced kidney failure that filter wastes, salts, and fluids from the body) related to renal failure, went to the hospital one time a week to hospital, shunt (vascular access that connects a hemodialysis access point to a major artery) site to left extremity, and received dialysis on Tuesday at a hospital. The care plan interventions indicated to encourage Resident #33 to go for scheduled dialysis appointments. Record review of Resident #33's progress note dated 05/31/24, indicated . Resident arrived via facility van, via w/c resident alert and oriented makes needs known skin intact with dressing to left arm graft, cdi (clean, dry and intact) double lumen picc line to right thigh for dialysis use . Record review of Resident #33's order summary report dated 08/21/24, indicated Resident #33 had the following orders: *Assess dialysis device graft/fistula: location left AV. Monitor for bruit/thrill every shift with a start date of 02/06/24. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	*Assess dialysis shunt site every shift for signs and symptoms of infection, bleeding, pulsation, or aneurysm every shift with a start date of 02/07/24. *Change dialysis access catheter dressing as needed with a start date of 06/03/24. Resident #33's order summary report did not reveal orders for dialysis treatment weekly at the hospital or to monitor Resident #33's dialysis catheter for complications. Record review of Resident #33's electronic medical records on 08/21/24 indicated under special instructions . seen in ER by hospitalist for dialysis on Tuesdays. During an interview on 08/21/24 at 9:02 AM, Resident #33 said he did not want to speak to surveyor. During an interview on 08/21/24 at 2:37 PM, LVN A said Resident #33 did not require a physician's order for dialysis treatment since it was in their policy to place under special instructions. LVN A said under special instructions it indicated Resident #33 went to the hospital on Tuesdays for dialysis. LVN A said Resident #33 had a dialysis catheter to his right groin because his dialysis access to his arm was clotted and they were unable to access it. LVN A said Resident #33 did not have orders to monitor his dialysis catheter, but he should have had one. LVN A said she had been monitoring Resident #33's dialysis catheter. LVN A said it was important for the catheter to be monitored every shift for complications or infection. LVN A said the nursing staff was responsible for ensuring Resident #33 had an order for monitoring his dialysis catheter. During an interview on 08/21/24 at 3:53 PM, the DON said Resident #33 did not require a physician's order for dialysis since under special instructions in Resident #33 electronic medical record it indicated Resident #33 went to the hospital on Tuesdays for dialysis. The DON said special instructions was not an order but a guideline they had to follow. The DON said they sent Resident #33 to the emergency roiagnom on Tuesdays where he was evaluated for dialysis. The DON said there was not an order needed to send the resident to the emergency room since it what was a standing order from the physician. During an interview on 08/22/24 at 1:55 PM, the DON said he expected Resident #33 to have an order to monitor his dialysis catheter. The DON said the nurse was responsible for ensuring the order was placed in the medical record. The DON said by not monitoring the dialysis catheter, Resident #33 was at risk for infection. The DON said Resident #33 had not had any complications with his dialysis catheter. During an interview on 08/22/24 at 2:21 PM, the Administrator said she expected Resident #33 to have an order for his dialysis catheter because without an order Resident #33 should not have had it. The Administrator said Resident #33 should have had an order for dialysis treatment because one does not get dialysis without a doctor's order. The Administrator said the DON and the charge nurses were responsible for ensuring those orders were placed in the resident's electronic medical record. The Administrator said failure to have an order to monitor for dialysis catheter and for dialysis treatment placed Resident #33 at risk for becoming septic (a life-threatening complication of an infection), toxic, confused or cause all types of issues with his health. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the facility's policy Dialysis Care revised 06/2020, indicated . The facility will be responsible for the overall care delivered to the resident, monitoring of the resident prior to and after the completion of each dialysis treatment, and providing for all non-dialysis needs of the resident including during the time period when the resident is receiving dialysis . The facility will arrange dialysis care for residents as ordered by the Attending Physician .E. The Licensed Nurse will monitor the integrity of the catheter dressing every shift and reinforce the dressing with tape as needed. The License Nurse will inspect the catheter every shift for cracks, breaking or leakage and notify the physician immediately if signs are present. In case of accidental separation or dislodging of the cannula, transfer the resident to the hospital immediately. Catheter dressings will be maintained by the dialysis center. Catheters will not be opened, flushed, or used by the facility staff. Blood draws will not be obtained from the catheter.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45879 Based on interviews and record review, the facility failed to ensure each resident's drug regimen was free from unnecessary psychotropic drugs (without adequate behavior monitoring or side effects) for 1 (Resident #179) of 5 residents reviewed for unnecessary meds. 1. The facility failed to ensure Resident #179 had behavior monitoring for Bupropion HCL ER(Wellbutrin) and Sertraline (Zoloft) used for depression. 2. The facility failed to ensure Resident #179 had side effect monitoring for Clonazepam (Klonopin) used for anxiety. These failures could place residents at risk of possible medication side effects, adverse consequences, decreased quality of life, and dependence on unnecessary medications. Findings included: Record review of Resident #179's face sheet, dated 08/22/24, indicated a [AGE] year-old male who was admitted to the facility on [DATE] and readmitted on [DATE] with the diagnoses which included Spinal stenosis (pain in the lower back, that can cause cramping in one or both legs), Schizophrenia (a chronic mental illness that affects how a person thinks, feels, and behaves), depression (sadness), and post-traumatic stress disorder also known as PTSD (a mental health condition that's caused by an extremely stressful or terrifying event). Record review of Resident #179's admission MDS assessment, dated 08/12/24, indicated Resident #179 understood and was understood by others. Resident #179's BIMS score was 15, which indicated he was cognitively intact. The MDS indicated Resident #179 required extensive help with toileting bed mobility, dressing, transfer, setup for personal hygiene, and being independent with eating. The MDS indicated he took antianxiety and antidepressant medication during the 7-day look-back period. Record review of Resident #179's physician's order dated 08/05/24 for Bupropion HCL ER(Wellbutrin) 150mg, give 1 tablet by mouth daily for depression. Record review of Resident #179's physician's order dated 08/05/24 for Sertraline (Zoloft) 50mg, give 1 tablet by mouth daily for depression. Record review of Resident #179's physician's order dated 08/05/24 for Clonazepam (Klonopin) 1 mg, give 1 tablet by mouth at bedtime for anxiety. Review of Resident #179's medication administration record dated 08/05/24 through 08/22/24 revealed Resident #179 took Bupropion HCL ER(Wellbutrin) 1 tab daily for depression, Sertraline (Zoloft) 1 tab daily for depression, and Clonazepam (Klonopin) 1 tab at bedtime for anxiety. (continued on next page)

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	675664	A. Building B. Wing	08/22/2024

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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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #179's medication administration record dated 08/05/24 through 08/22/24 did not reveal any behavioral monitoring for Bupropion HCL ER(Wellbutrin) or Sertraline (Zoloft) 1 tab daily for depression. Review of Resident #179's medication administration record dated 08/05/24 through 08/22/24 did not reveal any side effect monitoring for Clonazepam (Klonopin) 1 tab at bedtime for anxiety. During an interview on 08/21/24 at 4:05 p.m., LVN A said she was Resident #179's nurse. LVN B said she was not aware Resident #179 did not have his monitoring in place for his psychoactive medications. LVN B said the nurses should put monitoring and side effects in place once they received the order for psychotropic meds. She said if the nurse failed to put monitoring in place the resident might not have the proper monitoring to see if the medication was effective or not and may not know which side effects to look for. During an interview on 08/22/24 at 1:51 p.m., the ADON said the nurses were responsible for adding the behavior monitoring and the side effects when the resident received an order for psychotropic medication. She said she and the DON were responsible for checking behind the nurses to ensure they added the behavior monitoring and or side effects for psychotropic medications. She said behavior monitoring should be in place to see if the medication was effective. The ADON said side effects monitoring should be in place to see if the resident could be experiencing any side effects from the medication. She said if they did not monitor behavior they would not know if the medication was effective or if they needed to increase or decrease the medication. During an interview on 08/22/24 at 2:20 p.m., the DON said the admission nurse or nurse receiving the order was responsible for putting orders in for behavior and side effects monitoring. He said they put a blank statement such as monitor for any side effects or behavior until they got to know the resident better and then they would make it more specific as they learned the resident. He said the IDT was responsible for ensuring side effects or behavior monitoring was in place. He said not documenting could cause a delay in notification to the doctor. He said it was important to document behaviors and side effects of medication to observe for adverse reactions and to know if it was effective. During an interview on 08/22/24 at 3:00 PM, the Administrator said behavior and side effect monitoring should be done for psychotropic medications. She said she expected the nurses to document behavior and intervention when the medication was given. She said the ADON/DON were responsible for ensuring side effects and behavior monitoring were done. She said it was important to track to see if the medication was needed and if it worked. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the facility policy, Guidelines for Psychotherapeutic Medication unknown date, indicated Antipsychotic medication: residents with a mental health diagnosis may be admitted on psychotropic medications that that the diagnosis shall be noted on the physician order and the physician shall be responsible for obtaining informed consent. II. Antidepressant medication: residents receiving antidepressant drugs shall have behaviors and side effects monitored on the medication administration record. Dose reductions are not required however, monitoring to ensure that residents are improving on the medication is required. III. Anti-anxiety medication: non-drug intervention shall be tried to decrease the resident's anxiety . When a resident displays behavioral symptoms (i.e., crying, hollering, hitting, resisting care, etc.) The facility staff shall assess the behavioral symptoms to determine possible causal factors and implement non-drug interventions to alleviate the behavioral symptoms prior to initiating psychotherapy agents. All assessments, interventions, and outcomes shall be documented in the resident's medical record.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 45879 Based on observation and interview the facility failed to ensure all drugs were only accessible by authorized personnel for 1 of 4 medication carts (hall 100). The facility did not ensure the 100 hall medication cart was secured and unable to be accessed by unauthorized personnel. This failure could place residents at risk of not receiving drugs and biologicals as needed and a drug diversion. Findings included: During an observation and interview on 08/20/24 at 12:10 p.m., the 100-hall medication cart was left unlocked, and staff, residents, and visitors were observed walking by the unlocked medication cart. The ADON exited a resident's room and said she was responsible for leaving the cart unlocked. She said she was in a hurry and forgot to lock her cart. The ADON said it was her responsibility to lock the cart when unattended. The ADON said by leaving the cart unlocked and unattended, anyone could open the cart and take medications. During an interview on 08/22/24 at 12:15 p.m., LVN B said the medication cart should never be left open when unattended. She said the medication cart should be locked to prevent anyone except who was authorized to be in the cart. She said if the medication cart were left open it could lead to someone stealing medication or a resident opening the cart and taking the wrong medication. During an interview on 08/22/24 at 2:20 p.m., the DON said he expected the medication cart to be locked when unattended. He said the nurse or med aide who was working on the medication cart should have ensured it was closed when unattended. He said if the medication cart were left open a staff member or a confused resident could take medication out of the cart. During an interview on 08/22/24 at 3:00 p.m., the Administrator said nurse management was the overseer of the nursing staff for ensuring the medication carts were locked. She said if carts were left open anyone could obtain anything off the carts without authorization. The Administrator said she expects the medication carts to be locked to ensure the safety of others. Record review of the facility's policy titled, Storage of Medications, revision date of 08/20 indicated: The policy: Medications and biologicals are stored safely, securely, and properly, following manufacturer's recommendations or those of the supplier. The medication supply is accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications. General Guidelines: #2. Only licensed nurses, pharmacy personnel, and those lawfully authorized to administer medications (such as medication aides) are permitted to access medications. Medication rooms, carts, and medication supplies are locked when they are not attended by persons with authorized access.

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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** 46928 Based on 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 3 of 4 residents (Residents #38, #31 and #8) reviewed for hospice services. The facility failed to obtain Resident #38's most recent plan of care, hospice election form, physician certification, and hospice medication list. The facility failed to obtain Resident #31's most recent updated hospice plan of care and hospice medication list. The facility failed to ensure Resident #8's hospice medication orders reflected what Resident #8 was currently receiving at the facility. These deficient practices could place residents who receive hospice services at-risk of receiving inadequate end-of-life care due to a lack of documentation, coordination of care and communication of resident needs. Findings included: 1. Record review of Resident #38's face sheet dated 08/21/24, indicated a [AGE] year-old male who admitted to the facility on [DATE] with diagnoses of neurocognitive disorder with Lewy bodies (a progressive dementia characterized by the presence of Lewy bodies (protein deposits) in the nerve cells in the brain), cerebral infarction (stroke), seizures and hypertension (high blood pressure). Record review of Resident #38's admission MDS assessment dated [DATE], indicated he was usually understood and usually understood others. The MDS assessment indicated Resident #38 had a BIMS score of 11, which indicated his cognition was moderately impaired. The MDS assessment did not indicate Resident #38 received hospice care since the MDS assessment was completed prior to Resident #38 being admitted to hospice services. Record review of Resident #38's comprehensive care plan dated 07/10/24, indicated Resident #38 had a terminal prognosis and placed on hospice care [hospice company] on 07/09/24. The care plan interventions indicated to adjust provisions of ADLS to compensate for Resident #38's changing abilities. Record review of Resident #38's order summary report dated 08/21/24, indicated he had an order to admit to [hospice company] with diagnosis of Lewy body dementia, continue all current orders and treatments with a start date of 07/09/24. Record review of Resident #38's electronic medical record on 08/21/24, did not include a hospice plan of care, hospice election form, physician certification, or hospice medication list. (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 interview on 08/21/23 at 10:01 AM, the Administrator said all hospice documents that were at the facility had been uploaded to each resident's medical record. During an interview on 08/21/24 at 10:05 AM, the Hospice DON said Resident #38 was on their hospice services since 07/09/24. The Hospice DON said she personally updated Resident #38's hospice binder on Monday, 08/19/24, when she became aware the surveyors had entered the facility. The DON said she placed the binder at the facility under the nurse's station. During an interview on 08/21/24 at 10:16 AM, LVN A looked for Resident #38's hospice binder and it could not be located. LVN A said they did not keep hospice binders as the facility had requested all documents be uploaded in the resident's electronic medical record. 2. Record review of Resident #31's face sheet dated 08/21/24, indicated a [AGE] year-old male who admitted to the facility on [DATE] with diagnoses of malignant neoplasm of prostate (prostate cancer), hyperlipidemia (high levels of any or all lipids or lipoproteins in the blood), macular degeneration (condition that causes blurred or no vision in the center of the visual field), and depression. Record review of Resident #31's quarterly MDS assessment dated [DATE], indicated he was usually understood and usually understood others. The MDS assessment indicated Resident #31 had a BIMS score of 14, which indicated his cognition was intact. The MDS assessment indicated Resident #31 received hospice care. Record review of Resident #31's comprehensive care plan dated 03/04/24, indicated he had a terminal prognosis related to malignant neoplasm of prostate and was on hospice. The care plan indicated to work cooperatively with hospice team to ensure the resident's spiritual, emotional, intellectual, physical and social needs were met. Record review of Resident #31's order summary report dated 08/21/24, indicated he had an order to admit to [hospice company] with an order date of 03/01/24. Record review of Resident #31's hospice medication list dated 03/19/24, indicated Resident #31 had the following orders on his hospice medication list that were not on his facility's order summary report: *Minocin 100mg capsule give one capsule twice a day for septic arthritis (infection in the joint) with a start date of 02/27/24. *Melatonin 3mg tablet give 2 tablets to equal 6mg at bedtime for sleep with a start date of 02/27/24. *xyzal 5mg tablet by mouth at bedtime for allergies with a start of 02/27/24. *Gas-X 80mg tablet give one tablet every 6 hours as needed for gas with a start of 02/27/24. *Lidoderm 5 percent patch apply 1 patch topically to painful area on for 12 hours an off for 12 hours for pain. (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #31's electronic medical record on 08/21/24, indicated the last hospice interdisciplinary plan care revision physician order was dated 03/28/24; the last hospice medication list was dated 03/19/24; and the last hospice plan of care review was dated 03/06/24. There was not a most recent plan of care update, or a most recent hospice mediation list noted in Resident #31's electronic medical record. During an interview on 08/21/24 at 10:07 AM, the Hospice Team Manger said Resident #31 had been on their hospice services since 02/27/24. The Hospice Team Manager said they completed a team meeting every 14 days and a copy of the meeting, which includes the plan of care and medication list, was taken by the case manager on the next scheduled hospice visit. The Hospice Team Manager said Resident #31 should have had a most recent plan of care dated 08/15/24. The Hospice Team Manager said the most recent hospice documents should have been at the facility for coordination of care. During an interview on 08/22/24 at 10:30 AM, Resident #31's Hospice Case Manager said she brought the most recent hospice documents to the facility weekly. The Hospice Case Manager said she usually gave the documents to the facility staff that was available. The Hospice Case Manager said the facility did not allow them to keep a hospice binder, so all documents were given to the facility staff to be uploaded in the resident's medical record. The Hospice Case Manager said it was important for the most recent hospice documents to be at the facility and uploaded in the resident's chart for coordination of care. 30527 3. Record review of a face sheet dated 02/07/2024, indicated Resident #8 was a [AGE] year old male initially admitted to the facility on [DATE], with diagnoses which included atherosclerotic heart disease (condition that develops when plaque builds up in the arteries that supply blood to the heart), dysphagia (difficulty swallowing), intestinal obstruction (bowel), non ST elevation myocardial infarction (type of heart attack that occurs when a coronary artery is partially blocked), muscle wasting and atrophy. Record review of the Quarterly MDS assessment dated [DATE], indicated Resident #8was usually understood and usually understood others. The MDS assessment indicated Resident #8 had a BIMS score of 15, which indicated her cognition was intact. The MDS assessment indicated Resident #8 received hospice services while a resident at the facility. Record review of the care plan with date initiated 12/12/2023, indicated Resident #8 had a terminal prognosis related to atherosclerotic heart disease with a goal of dignity and the Resident #8 will remain comfortable and pain free through the review date. Interventions included to assist with ADL's and provide comfort measures as needed, monitor for decreased appetite, weight loss, skin break down, and nausea and vomiting and report to hospice. Record review of the order summary report dated 02/07/2023 indicated Resident #8 had orders for: admit to hospice on 12/28/2023. Duloxetine HCL Oral Capsule Delayed Release Particles 30 MG - give 30 MG by mouth in the morning for neuropathy. (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	*Morphine Sulfate Oral Solution 100 MG/5ML - give 0/25ML by mouth every 15 minutes as needed for pain and/or shortness of breath; *Budesonide Inhalation Suspension 0.5 MG/2ML - 1 vial inhale orally two times a day for shortness of breath; and *MiraLAX oral powder 17 GM/Scoop - give 1 scoop by mouth one time a day for constipation. Record review of Resident #8's hospice orders dated 08/12/2024, indicated he did not have the following orders: *Duloxetine HCL Oral Capsule Delayed Release Particles 30 MG - give 30 MG by mouth in the morning for neuropathy *Morphine Sulfate Oral Solution 100 MG/5ML - give 0/25ML by mouth every 15 minutes as needed for pain and/or shortness of breath; *Budesonide Inhalation Suspension 0.5 MG/2ML - 1 vial inhale orally two times a day for shortness of breath; and *MiraLAX oral powder 17 GM/Scoop - give 1 scoop by mouth one time a day for constipation. During an interview on 08/22/202 at 11:36 AM., the hospice nurse said Resident #8's most recent hospice records were delivered to the nurse's station last week by her. The hospice nurse said Resident #8's pages 3, 5 and 7 were missing from the plan of care. The hospice nurse said the missing medications would be noted on the missing pages from the plan of care. The hospice nurse said the orders for the following medications had been updated Duloxetine HCL Oral Capsule Delayed Release Particles 30 MG - give 30 MG by mouth in the morning for neuropathy, Morphine Sulfate Oral Solution 100 MG/5ML - give 0/25ML by mouth every 15 minutes as needed for pain and/or shortness of breath, Budesonide Inhalation Suspension 0.5 MG/2ML - 1 vial inhale orally two times a day for shortness of breath and MiraLAX oral powder 17 GM/Scoop - give 1 scoop by mouth one time a day for constipation. During an interview on 08/22/24 at 01:55 PM, the DON said he expected when hospice brought the updated documents to be given to the nurse that was available at the time. The DON said he expected the nurse to place the documents in the medical records folder located behind the nurse's desk. The DON said he expected the hospice documents to be updated in the resident's medical record. The DON said they had staff that completed chart reviews to ensure the hospice documents were uploaded. The DON said not having the most updated hospice documents in the facility was not detrimental to the residents. The DON said if they needed the required documents, they could call the hospice company and obtain them. During an interview on 08/22/24 at 2:21 PM, the Administrator said she expected the hospice company to either bring, email or fax the required documents to the facility. The Administrator said the facility then uploaded the hospice documents to the resident's electronic medical record. The Administrator said failure to have the most updated hospice documents could result in the resident receiving the wrong medication, and not receiving treatments as required. The Administrator said she was ultimately responsible for ensuring the most recent hospice documents were at the facility and uploaded in the resident's medical records. (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 interview on 08/22/2024 at 04:15 PM, Medical Records said the residents' hospice records were brought to her by either the floor nurses or the hospice nurses. Medical Records said she was responsible to scan and upload the hospice documents to the hospice resident's electronic records each day. Medical Records said she had contacted the hospice nurse regarding Resident #8s' updated plan of care including pages 1 - 8. Medical Records stated she had failed to scan both sides when uploading the documents to Resident #2 electronic records. Medical Records said she had not received any recent documents to upload for Residents # 38 and #31 therefore, she could not be responsible to upload something she did not have on hand. Medical Records stated it was imperative to have up to date records uploaded and readily available for the staff to coordinate care of the hospice staff and facility staff to ensure the residents were taken care of appropriately. Record review of the facility's policy End of Life Care revised on 08/2020, indicated . to provide a process to assist the resident in fulfilling their spiritual, physical, and emotional needs, and to provide emotional support to families of residents with a terminal illness . IV. Coordination with Hospice A. If Hospice care is involved, the residents care plan will reflect hospice interventions .

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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 interviews, and record reviews 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 (Resident #64) of 24 residents reviewed for infection control practices and transmission-based precautions. 1) The facility failed to ensure Resident #64 was placed on (TBP) transmission-based isolation for MRSA infection to his right hip wound. 2) The facility failed to ensure CNAs received proper notification about the infection. These failures could place residents at increased risk for serious complications from a communicable disease that could diminish the resident's quality of life. Findings included: 1) Record review of Resident #64's face sheet dated 08/20/24 indicated he was a [AGE] year-old male who admitted to the facility on [DATE] with the diagnoses of depression (common but serious mood disorder causing sadness), centrilobular emphysema (a form of lung disease in people who smoke that affects the upper lungs), anxiety (a feeling of nervous, restless, or tense), and heart failure (a chronic condition in which the heart does not pump blood as well as it should). Record review of Resident #64's Order summary reported dated 07/01/24-07/31/24 indicated he had an order for: 1) Doxycycline Hyclate oral capsule 100mg Give 1 capsule by mouth two times a day for MRSA positive to wound bed for 14 days that had a start date of 07/31/2024 and end date of 08/14/2024. The order summary did not have an order for isolation for MRSA infection. Record review of Resident #64's lab dated 07/26/24 indicated the MRSA infection resulted on 07/28/24. Record review of Resident #64's quarterly MDS date 08/03/24 indicated he made himself understood, he understood others, and he had a BIMS score of 3 which meant he have severely impaired cognition. The MDS also indicated he required maximal assistance from the staff for toileting and dressing and moderate assistance from staff for bed mobility and transfers. The MDS did not indicate Resident #64 had a MRSA diagnosis nor did it indicate he received antibiotics for the 7-day look back period. Record review of Resident #64's care plan (that included the resolved plans) revised on 07/29/24 indicated that he never had a care plan for the diagnosis of MRSA with interventions to care for the infection to his wound. Record review of Resident #64's roommate's census line indicated the facility moved Resident #64's roommate on 07/30/24 and placed him back in his room on 08/02/24. (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 08/22/24 at 07:37 AM Resident #64 said the staff did not always wear PPE when they came to care for him, but they did most of the time. He said he had always had a roommate but when he had COVID the roommate was removed. Resident #64 said he then he had a blood infection after COVID, and the roommate returned to the room. During an interview on 08/22/24 at 07:55 AM the Treatment Nurse said Resident #64 was on EBP so that if he had something (infection) in the wound or if the staff had something (infectious) they were protected. She said he had always been on enhanced-barrier precautions since the wound was infected. The Treatment Nurse said Resident #64 was placed on transmission-based precautions when he had COVID 7/17/24-07/27/24 but when he had MRSA infection to his right hip he was placed on enhanced-barrier precautions. She said his roommate was never removed because he had COVID as well. The Treatment Nurse said the facility placed the signage for EBP but did not notify the staff of the infection the resident had because the staff knew to use PPE when they provided care. The concern was to ensure the staff used the PPE when caring Resident #64 at all times. The Treatment Nurse said the risk to the resident and staff was infection control. During an interview on 08/22/24 at 02:21 PM the ADON said she did nothing with infection control except the infection sheet they used for tracking and trending when a resident began an antibiotic. She said the DON was responsible for infection control. The ADON said Resident #64's MRSA of his right hip wound resulted on 07/28/24. The ADON said he was on isolation for COVID 07/17/24-07/27/24 and the team decided that if Resident #64's wound was covered, he did not have to be in isolation. She said she thought the dressing the facility was using would not allow drainage out of it but did not think about if the resident touched the area or if it leaked. The ADON said the facility should have notified the staff of the infection, placed a transmission-based precaution signage on Resident #64's door, placed the PPE outside the room, and placed the isolation disposal boxes in the room. She said there should have been an order for isolation placed. She said Resident #64 never had the order because he was in EBP (enhanced barrier precautions) instead of transmission-based precautions. She said the failure placed the staff at risk for not knowing Resident #64 had an infection and where it was located and how to properly care for him to prevent infection because with transmission-based precautions the PPE is used at all times. During an interview on 08/22/24 at 03:12 PM the DON said Resident #64 should have been on the transmission-based precautions, but enhanced barrier precautions was the same. He said the CNAs only needed to know what personal protective equipment to use while they cared for the resident. The DON said CNAs did not have to know that the resident had an infection. He said it was nurse practice to determine the difference between EBP and TBP. The DON said the only difference in EBP and TBP was when the nurse was providing wound care because he did not feel anyone else needed to use PPE other than during wound care. The DON said it was not their policy to notify the staff and the visitors when a resident had an infection that required transmission-based precautions. He said when the staff were aware that a resident had any precautions, he expected the staff to use barriers with care to prevent infection. The DON said he was responsible for tracking and trending of infections and no one else has had the diagnosis of MRSA infection in the facility. During an interview on 08/22/24 at 03:39 PM the Administrator said she would have expected Resident #64 to be on transmission-based precautions for the MRSA infection. She said the failure placed a risk for everyone to be infected with the MRSA and a risk for it to be carried throughout the facility. (continued on next page)

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	08/22/2024

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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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the facility policy Resident Isolation-Categories of Transmission-Based Precautions dated October 24, 2022reflected: Purpose To ensure that transmission-based precautions are used when caring for residents with communicable diseases or transmittable infections. Policy I. Standard precautions are used when caring for residents at all times regardless of their suspected or confirmed infection status. Transmission-based precautions are used accordingly when caring for residents who are documented or suspected of having communicable diseases or infections that can be transmitted to others . Procedure I. Transmission-based precautions are used when measures more stringent than standard precautions are needed to prevent or control the spread of infection .III. A. Contact precautions are implemented for residents known or suspected to be infected or colonized with microorganisms that are transmitted by direct 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 .B. Resident Placement i. The resident placed in a private room .

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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 0926 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have policies on smoking. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45879 Based on observation, interview, and record review, the facility failed to follow their own established smoking policy for 1 of 4 residents (Resident #9) reviewed for smoking. The facility failed to follow the policy on smoking by not completing a smoking screen assessment quarterly on Resident #9. This failure could place residents at risk of unsafe smoking and injury. Findings included: Record review of Resident #9's face sheet, dated 8/22/24 indicated Resident #9 was a [AGE] year-old male admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included stroke and high blood pressure. Record review of Resident #9's quarterly MDS assessment, dated 07/04/24, indicated Resident #9 was usually understood and usually understood by others. Resident #9's BIMs score was 15, which indicated he was cognitively intact. Resident #9 required limited assistance with bathing and set-up assistance with toileting, personal hygiene, transfer, eating, and bed mobility. Record review of Resident #9's comprehensive care plan, dated 10/31/22 indicated Resident #9 was a smoker. The interventions of the care plan were for staff to provide Resident #9 with a smoking assessment according to facility policy. Record review of Resident #9's last completed Smoking Screen Assessment, dated 07/12/23, revealed he required supervision for smoking. During an observation on 08/21/24 at 10:12 p.m., revealed Resident #9 was outside smoking with staff. During an observation and interview on 08/22/24 at 1:51 p.m., the ADON said the nurses were responsible for completing the smoking assessments. She said the smoking assessment was supposed to be done on admission and quarterly. She said the smoking assessment should have been generated in the resident's electronic medical records. when they were due to be done. The ADON looked in Resident #9's electronic medical records and said his last smoking assessment was done on 07/12/23. She said since the smoking assessments were not being done, residents were at risk of being burned. During an interview on 08/22/24 at 2:20 p.m., the DON said the nurses were responsible for doing the smoking assessments. He said they had a system in place for checking on smoking assessments but since some of the smoking assessments did not trigger, they were not aware they were not being done. He said since the smoking assessment was not being done it could place the residents at risk for burns. (continued on next page)

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F 0926 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 08/22/24 at 3:00 p.m., the Administrator said the nurses should be completing the smoking assessment. She said she had only been at the facility for 4 weeks and was not sure about the time frame of the smoking assessments. She said the DON was the overseer of the smoking process. She said if the smoking assessment were not being done then it could potentially place a resident at risk for injury. Record review of the facility Policy titled Smoking by Residents, revised date of November 2023, indicated, The purpose: To respect residents' choice to smoke and to maintain a safe healthy environment for both smokers and non-smokers. Procedure: I. Smokers shall be identified at the time of admission. 2. Residents will be provided with a copy of this policy during the admission process A. All smokers shall be assessed related to smoking safety at the time of admission and then at least quarterly as outlined by the OBRA (Omnibus Budget Reconciliation Act of 1987) assessment timeframe.