STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675695	A. Building B. Wing	07/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
College Street Health Care Center	4150 College St Beaumont, TX 77707

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41057 Based on interview and record review, the facility failed to complete a significant change MDS assessment within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition a significant change of condition for 1 of 14 residents reviewed for assessments. (Resident #25) The facility failed to complete a Significant Change MDS for Resident #25 within 14 days after the resident was admitted to hospice services. This failure could place residents who experienced a significant change in their condition requiring an MDS assessment at risk of not receiving needed services. Findings Included: Record review of a face sheet dated 07/15/24 indicated Resident #25 was a [AGE] year-old-male with a readmitted [DATE] and an admitted [DATE]. Resident #25 was admitted with diagnoses including atherosclerosis (a buildup of fats and other substances in and on the artery walls) and heart failure (a chronic condition in which the heart does not pump blood as well as it should). Record review of a Quarterly MDS assessment dated [DATE] indicated Resident #25's BIMS was 12 out of 15 indicating cognition was moderately impaired. The assessment indicated Resident #25 had a diagnosis of heart failure. Record review of a care plan initiated on 06/28/24 indicated Resident #25 had chosen to have hospice care for heart failure. Record review of physician orders indicated an order on 06/28/24 indicated Resident #25 was admitted to hospice services with a diagnosis of heart failure. Record review of the electronic medical record on 07/16/24 indicated Resident #25's MDS section had a significant change MDS with an ARD of 7/5/24 in progress but not completed. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675695	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/17/2024
NAME OF PROVIDER OR SUPPLIER College Street Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 4150 College St Beaumont, TX 77707	

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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 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 07/16/24 at 1:50 p.m., the MDS Nurse said she was responsible for all MDS in the facility. She said the Corporate MDS Coordinator was her back-up. She said she was educated on MDS completion and timing of significant change MDS. The MDS Nurse said Resident #25 was admitted to hospice services on 06/28/24 and she should have completed the significant change MDS by 07/11/24. She said she opened the MDS in the computer system but was unable to complete the MDS timely due to being part time and only working 3 days a week at the facility. She said at times she was unable to stay caught up, especially during the middle of the month when there were a lot of admissions. The MDS nurse said the possible negative outcome was an incorrect care plan. She said she completed the comprehensive triggered care plans. During an interview on 07/16/24 at 2:10 p.m., the DON said the MDS Nurse was responsible for all MDS at the facility. She said the MDS nurse was educated on completion and timeliness of MDS. The DON said Resident #25's significant change MDS was not completed timely due to being possibly overlooked. She said there was no negative outcome, the care plan was updated but policy was not followed. The DON said her expectation was all MDS completed accurately and timely. During an interview on 07/16/24 at 2:15 p.m., the Regional Nurse said the facility follows the RAI (Resident Assessment Instrument) for a MDS policy. During an interview on 07/16/24 at 2:20 p.m., the Administrator said the MDS nurse was responsible for all MDS in the facility. She said the Corporate MDS nurse was a double check and audited some MDS assessments. The Administrator said the possible negative outcome was not following facility policy. The administrator said her expectation was all MDS completed accurately and timely. Attempted phone interview on 07/16/24 at 3:00 p.m., with the Corporate MDS Coordinator was not successful. Record review of the, Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual, dated, October 2023, indicated, . Chapter 2 . An SCSA {significant change in status assessment} is required to be performed when a terminally ill resident enrolls in a hospice program (Medicare-certified or State-licensed hospice provider) or changes hospice providers and remains a resident at the nursing home. The ARD {assessment reference date} must be within 14 days from the effective date of the hospice election (which can be the same or later than the date of the hospice election statement, but not earlier than). An SCSA must be performed regardless of whether an assessment was recently conducted on the resident. This is to ensure a coordinated plan of care between the hospice and nursing home is in place. The MDS completion date (item Z0500B) must be no later than 14 days from the ARD (ARD + 14 calendar days) and no later than 14 days after the determination that the criteria for an SCSA were met.

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 25779

Based on observation, interview and record review, the facility failed to ensure that residents received treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices for 1 of 14 residents reviewed for quality of care. (Resident #85)

The facility did not assess or obtain orders for a post-surgical incision to Resident #85's left hip.

This failure could place the residents at risk of not receiving the care and services to maintain their highest practicable physical, mental, and psychosocial well-being.

Findings included:

Record review of physician orders dated July 2024 indicated Resident #85, admitted [DATE], was a [AGE] year-old female with a diagnosis of displaced intertrochanteric closed fracture of the left femur (fracture of the hip that is made up of the thigh bone and the pelvis [socket]. The orders did not indicate the resident had orders to treat the left hip incision.

Record review of the clinical record dated 07/14/24 indicated the admission MDS was in progress and had not been completed.

Record review of the baseline care plan dated 07/14/24 indicated Resident #85 had potential/actual impairment to skin integrity. Focus: The resident has potential/actual impairment to skin integrity. Observe and identify any new affected skin area, intervene with treatment as necessary and notify MD. Does the resident have a surgical site? . Yes . Goal: The resident's surgical site will show signs of healing and/or remain free from infection by/through review date. Intervention: Documentation to include measurement of each area of skin impairment: width, length, depth, type of tissue, exudate, and any other notable changes upon observations. Intervention: Follow-up with surgeon per physician order. Treatment of surgical site to be provided per physician order. Monitor for s/s of infection, change in appearance, or increased pain/discomfort, intervene and notify surgeon/MD upon significant change.

Record review of a hospital emergency room record dated 07/03/24 indicated Resident #85 had a fall from the bed at home, was in pain to the left hip area and had a CT scan (a computer imaging test which can diagnose life threatening conditions) performed. The CT scan dated 07/10/24 indicated the resident had an acute impact fracture of the left intertrochanteric femur with minimal displacement. The discharge summary dated 07/14/24 indicated Resident #85 had an open reduction and internal fixation repair (a surgical procedure that treats severe fractures and dislocations) of the left hip. The instructions indicated to contact your health care provider if: . you have more redness, swelling or pain at the incision area, if you have more fluid or blood coming from your incision or leaking through the dressing, you notice your incision feels warm to the touch, you have pus or a bad odor coming from the incision. There were no wound care instructions noted.

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of an admission assessment dated [DATE] at 2:46 p.m., indicated Resident #85 had a surgical dressing to the left trochanter. There was no documentation of the incision site. During an interview on 07/16/24 at 10:16 a.m., the ADON/treatment nurse said she was responsible for making sure Resident #85's wound was assessed. She said she should have assessed the wound and obtained an order for the wound care yesterday on 07/15/24 and she did not. She said she did not have orders for the left hip dressing to be changed. She said the possible negative outcome of not assessing the incision site is that it could be infected, or the edges could possibly not be approximated. During interview and record review on 07/16/24 at 1:36 p.m., the ADON/treatment nurse said the wound specialist NP came in today 07/16/24 and looked at Resident #85's incision and gave orders for treatment. She provided an order for Resident #85 dated 07/16/24 that read: cleanse surgical incision with dermal wound cleanser, pat dry, apply cut to fit adaptic gauze (a gauze designed to protect regenerating tissue), apply a non-adherent dressing and cover with tegaderm dressing (a transparent self-adhesive dressing), change today and then on 7/22/24. The ADON/treatment nurse said she was unable to get the surgeon to return her call. She said the wound specialist NP who was in the same group as the orthopedic surgeon, was familiar with the post orthopedic surgery protocol. During an interview on 07/16/24 at 12:53 p.m., the DON said her expectation was for newly admitted residents to have orders from the hospital where they were coming from and if not, the physician should be notified to receive orders. She said Resident #85's incision should have been assessed and the physician called for orders. She said the possible negative outcome would be the site could possibly get infected or the resident would not receive treatment in a timely manner. During observations on 07/16/24 at 1:46 p.m., Resident #85's surgical dressing to the left hip was not dated or initialed. The ADON/treatment nurse removed the dressing to the incision. The incision was clean, dry, without signs of infection and the edges were approximated. She performed wound care without concerns noted. During an interview on 07/17/24 at 12:14 p.m., LVN A said she was working Sunday 07/14/24, when Resident #85 was admitted . She said it was her responsibility to assess the newly admitted residents from head to toe and make sure she had orders for Resident #85's incision. She said she did not take Resident #85's dressing off and she did not call the doctor for orders related to care of the incision. She said she should have assessed the incision and called the doctor. She said when the resident was admitted she was resisting care, and she did not take the dressing off. She said the possible negative outcome would be the incision could be infected or the sutures might not have been intact. Record review of a Provision of Quality of Care policy with a copyright date of 2023 indicated: Based on comprehensive assessments, the facility will ensure that residents receive treatment and care by qualified persons in accordance with professional standards of practice, the comprehensive person-centered care plans, and the residents' choices. 1. Each resident will be provided care and services to attain or maintain his/her highest practicable physical, mental, and psychosocial well-being. 4. Qualified persons will provide the care and treatment in accordance with professional standards of practice, the resident's care plan, and the resident's choices.

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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 0755

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 32217

Based on observation, interview, and record review, the facility failed to provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) for 4 of 14 residents (Residents #10, #20, #21, and #24) and failed to establish a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation and drug records were in order and that an account of all controlled drugs was maintained for 1 of 14 residents (Resident #10) to meet the needs of each resident for reviewed for pharmacy services.

LVN A did not prepare medications for Resident #21 per the facility policy.

RN D did not flush Resident #10's gastric tube (tube surgically inserted through the wall of the abdomen directly into the stomach) per gravity and did not destroy the used fentanyl (scheduled II controlled medication used for severe pain) patches in a sharps container per policy and with a witness for destruction.

LVN A did not prepare medications for Resident #20 and Resident #24 per the facility policy.

These failures could place residents at risk of not receiving the therapeutic effects of their prescribed medications and at risk of drug diversion.

Findings included:

1. Record review of Resident #21's face sheet, dated 06/10/24, indicated the resident was admitted to the facility on [DATE] with diagnoses including high blood pressure, diabetes, and post-surgical repair of fractured hip.

Record review of Resident #21's admission MDS indicated it was in process and had not been completed due to required timeframe.

Record review of Resident #21's care plan, dated 06/13/24, indicated the resident had impaired cognitive function related to short term memory loss.

During an observation and interview on 07/15/24 at 8:25 a.m., Resident #21 was eating breakfast in her room. A plastic medicine cup was observed next to the resident's breakfast tray containing 8 unidentifiable pills. Resident #21 said the staff gave her the medication daily before breakfast and she took them after she ate her meal. She said staff did not return to ensure the medications were consumed.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation and interview on 07/15/24 at 8:35 a.m., LVN A said she only left Resident #21's morning medications with the resident during medication pass. She said Resident #21 preferred to have morning medications available to take after the morning meal. LVN A said she had been trained in safe medication administration and knew medication was not left at bedside. She said she had been trained to prepare medications and to observe residents consuming medications to ensure all were taken. She said potential negative outcomes of leaving the medications at a resident's bedside unsupervised, would be not knowing if the resident swallowed the medication or not, medications could be dropped, lost, or not taken. She said she always came back to check to see if the medications were taken. During an interview on 07/17/24 at 10:45 a.m., the DON said her expectations were for nursing staff to never leave resident medications at their bedside. She said nurses should always stay with residents to ensure medications were taken. The DON said potential negative outcomes included resident not taking medications, not swallowing all medications, or even a resident with wandering behaviors could go into room and take medications that did not belong to them. During an interview on 07/17/24 at 11:00 a.m., the Administrator said her expectations of staff included medications should not be left at any resident's bedside and should always be administered by licensed personnel while in attendance with the resident. She expected licensed nursing staff to abide by facility policies. She said staff were trained in medication administration policy and procedures. 2. Record review of the admission record dated 07/16/24 indicated Resident #10 was female [AGE] years old and was admitted on [DATE] with diagnoses of dementia, and pain. Record review of the physician's orders dated 07/16/24 indicated Resident #10 was to receive a fentanyl transdermal patch 72 Hour (75 MCG/HR) Apply 1 patch transdermal every 72 HRS related to pain, unspecified and remove per schedule with start a date of 12/15/2023. The orders included dilute each medication with 5-10 cc of water and flush with 30 cc of water before and after medications with start date of 04/03/24. Record review quarterly MDS assessment dated [DATE] indicated Resident #10 was severely impaired with cognition with BIMS of 00. A nutritional approach indicated feeding tube during last 7 days while she was a resident. The pain management section indicated she received routine pain medication. Record review of the care plan revision dated 10/20/23 indicated Resident #10 had chronic pain and received fentanyl 75MCG/HR patch Q 72 HRS. Record review of the MAR dated July 2024 indicated Resident #10's fentanyl patch was applied 07/07/24 and removed on 07/10/24 and the patch was applied on 07/10/24 and removed on 07/13/24. Record review of the count sheet for Resident #10 dated 06/26/24 indicated no witnesses on 07/07/24, 07/10/24, and 07/13/24 for the disposal of the fentanyl patch. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation and interview on 7/16/24 at 9:23 a.m., RN D went to apply Resident #10's fentanyl patch and RN D removed an old patch dated 7/13/24 on left arm. She reached over to apply a new patch on the r arm and there were 2 more fentanyl patches dated 7/7/24 and 7/10/24 on the resident right arm. RN D removed both patches and placed all 3 used fentanyl patches in the sharp's container without a witness. She looked on the residents back for any more patches, reviewed her v/s and applied the new patch dated 7/16/24. She said if the used patches were not removed the resident could receive too much fentanyl and could be over medicated. She said the resident should have only had one patch on as ordered. During an observation and interview on 07/16/24 at 9:30 a.m., RN D checked placement with aspiration and auscultation and said the tube was in place, then flushed the gastric tube for Resident #10 with 30 cc of water per syringe not to gravity. RN D gave each medication mixed with 5-10 cc water per gravity then flushed with 30 cc of water per syringe not by gravity. During an interview on 07/16/24 at 9:35 a.m., RN D said she thought the water flushes were to be pushed like an IV flush and had not been trained any differently here and works as needed here. During an interview on 07/16/24 at 9:45 a.m., the DON said the fentanyl patch should be removed every 3 days before the new patch was applied and if a resident had multiple patches could receive more than what was ordered. She said the medications and water flush was to be given by gravity for all residents with gastric tubes per our policy. During an interview on 7/16/24 2:30 p.m., LVN E said she had forgotten to remove Resident #10's fentanyl patch on 07/10/24 and 07/13/24. She said she initialed she had removed the patch, but she got busy and forgot to remove it and she was responsible. She said if the resident had multiple patches the resident might receive the wrong dose of medications. Record review of the undated policy titled flushing a feeding Tube indicated it is the policy of this facility to ensure that staff providing care and services to the resident via a feeding tube are aware of, competent in and utilize facility protocol regarding feeding nutrition and care. Record review of the Narcotic Pain Patch policy dated February 2023 indicated It is the policy of this facility to maintain records of all narcotic patches at the time of receiving in the facility until destruction.10. Upon placement of the new patch, the used patch will be disposed by folding the patch in half with sticky sides together and flush down the sink or toilet or disposed of via a DEA-compliant drug disposal system and verified by the nurse removing and the nurse verifying discard of the patch. 3. Record review of the admission record dated 07/16/24 indicated Resident #20 was male [AGE] years old and was admitted on [DATE] with diagnoses of Parkison's disease (disorder which affects movement) and high blood pressure. Record review of the physician orders dated 07/16/24 indicate Resident #20's orders included buspirone (used for anxiety) 5 mg three times a day, and Carbidopa-Levodopa (used for Parkinson's disease) 25-100 MG give 2 tablets twice daily, and colace (used for constipation) 100 MG daily, Lasix (used for edema) 20 MG daily. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the admission record dated 07/16/24 indicated Resident #24 was male [AGE] years old and was admitted on [DATE] with diagnoses of high blood pressure and heart disease. Record review of the physician orders dated 07/16/24 indicate Resident #24's orders included amlodipine tablet (used for high blood pressure 10 MG, Coreg Oral Tablet 12.5 MG (used for high blood pressure, Gabapentin (used for nerve pain)100 MG three times a day, and Sertraline (used for depression) 100 MG daily. During an observation and interview on 07/15/24 at 8:46 a.m., LVN A was administering medications to residents who resided on the 200 hall. She was standing in front of room [ROOM NUMBER] and said, I still have both of these residents to give medications but cannot give with you because I prepared them earlier. She said she knew the policy was not to set up medications ahead of time. She said she was to assess the resident vital signs then prepare medications and then give medications to prevent medication errors or having to dispose of medications. During an interview on 07/15/24 at 11:00 a.m., the DON said medications should not be set up ahead of time because the assessment and vital signs should be done before medications were prepared. She said medications were to be prepared at the door of the resident's room or by the resident. She said this was to prevent medication errors or prevent medications from having to be wasted if not needed. Record review of the undated Medication Administration indicated Policy: Medications are administered by licensed nurse, or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice . 8. Obtain and record vital signs . 10. Ensure that the six rights of medication are followed .11.Review MAR to identify medication to administered. 16. Observe resident consumption of medication.18 Sign MAR after administered. For those medications requiring vital signs, record the vital signs onto the MAR. 33460