STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675708	A. Building B. Wing	12/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Keeneland Nursing and Rehabilitation	700 S Bowie Dr Weatherford, TX 76086

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 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45411 Based on observation, interview, and record review, the facility failed to ensure residents fed by enteral means received the appropriate treatment and services for 2 of 2 residents (Residents #8 and #23) reviewed for tube feeding management. 1. The facility failed to ensure that Resident #8 and Resident #23 had properly labeled formula and water for their tube feedings on 12/17/24 and 12/18/24. 2. The facility failed to ensure that Resident #8's head of bed was elevated while her tube feeding was infusing on 12/18/24. These failures could place residents at risk of aspiration and not receiving adequate nutrition by way of enteral feeding. The findings included: Review of Resident #8's face sheet revealed she was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses including dementia, dysphagia (difficulty swallowing) following stroke, and protein-calorie malnutrition. Review of Resident #8's Annual MDS Assessment, dated 11/21/24, revealed: she scored a 5 on her mental status exam, indicating severe cognitive impairment. She was dependent on staff for all ADLs. She had loss of liquids/solids from mouth when eating or drinking, holding food in mouth/cheeks or residual in food in mouth after meals, coughing or choking during meals or when swallowing medications, and complaints of difficulty or pain with swallowing. She had a feeding tube and received 51% or more of her total calories from tube feeding and 501 cc/day or more of her fluid intake from tube feeding. (continued on next page)

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

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

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #8's Care Plan, most recent edit date 12/18/24, revealed the following: Problem - Resident was at nutritional risk and fluid alteration as she requires enteral tube feeding, Isosource 1.5 continuous feeding with water flushes. (Resident is NPO related to stroke associated dysphagia. Goal - Resident will not exhibit signs of complications from feeding tube or enteral feeding solution. Approach (interventions) - Administer medications via tube; evaluate/record/report effectiveness/adverse side effects. Check placement and patency of feeding tube before each feeding or medication administration. Monitor for signs of malnutrition (pale skin, dull eyes, swollen lips, swollen gums, swollen and/or dry tongue with [NAME] or magenta hue, poor skin turgor, cachexia (a general state of ill health involving weight loss and muscle loss), bilateral edema, muscle wasting). NPO (nothing by mouth) status. Provide flushes/additional fluids as ordered. Provide frequent oral care, lubricate lips. Review of Resident #8's Physician Order Report on 12/18/24 revealed the following orders: Change irrigation set every day (Start Date: 12/28/23) Diet - NPO (nothing by mouth) every shift (Start Date: 8/6/24) Elevate head of bed 30 degrees every shift (Start Date: 8/14/23) Monitor feeding tube site and change dressing daily, cleanse site with normal saline and gauze, place a new dressing over the site daily and as needed for soiled dressing (Start Date: 9/4/24) Isosource 1.5 at 85 ml/hour for 20 hours - flush to be 350 ml of water every 4 hours while pump is running, every day at 2:00 pm (Start Date: 9/5/24) Check feeding tube placement by auscultating (listening with stethoscope) air passage before medication administration and every shift (Start Date: 11/26/24) Observation on 12/17/24 at 12:51 pm revealed Resident #8 in bed with tube feeding disconnected. The resident's tube feeding formula and water were hanging on a pole at bedside. The prefilled bag of formula had no label on the bag indicating resident information or date the feeding was prepared. The bag of water hanging with formula had a label with only the date (12/16/24) and resident's name legible. Observation on 12/18/24 at 5:10 pm revealed Resident #8 in bed, the head of the bed was elevated approximately 15-20 degrees with tube feeding connected and infusing at 85 ml/hr. Review of Resident #23's Face Sheet revealed he was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses including stroke, dysphagia (difficulty swallowing), gastrostomy (feeding tube) status, and protein-calorie malnutrition. Review of Resident #23's Quarterly MDS Assessment, dated 11/5/14, revealed: he scored a 15 on his mental status exam, indicating he was cognitively intact. He was dependent on staff for all ADLs. He had loss of liquids/solids when eating or drinking, and coughing or choking during meals or when swallowing medications. He had a feeding tube. He had a mechanically altered diet. He received 51% or more of his total calories from tube feeding and 501cc/day or more of his fluid intake from tube feeding. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #23's Physician Order Report revealed the following orders: Check feeding tube placement by aspirating stomach contents prior to feedings and flushes every shift - if residual is greater than 100 cc, hold feeding for 1 hour and recheck, if still greater than 100 cc notify physician (Start Date: 9/24/20) Elevate head of bed 30 degrees every shift (Start Date: 3/1/21) Cleanse feeding tube site every day with normal saline and gauze (Start Date: 3/9/23) Change irrigation set and feeding bad every day, 6 pm - 6 am (Start Date: 8/27/24) Flush feeding tube with 5-10 ml of water between each medication when administering medications, every shift (Start Date: 10/5/23) Start tube feeding with Isosource 1.5 at 90 cc/hour for 12 continuous hours, 225 cc water every 4 hours, every day at 5:00 pm (Start Date: 10/7/24) Stop tube feeding at 5:00 am every day (Start Date: 10/7/24) Pleasure feedings, regular diet, mechanical soft texture, thin liquids, must be sitting up in wheelchair for pleasure feedings (Start Date: 12/17/24) A record review of Resident #23's care plan was completed on 12/19/24. The care plan contained proper documentation of the resident's tube feeding, goals, and interventions. The saved copy of the resident's care plan was erased and unable to be referenced at the time the citation was written. Observation on 12/18/24 at 5:05 pm revealed Resident #23's tube feeding hanging on pole with bag of water. The resident was not in the room at the time, and the tube feeding set up was hanging but not connected to the resident. Neither bag (formula or water) had a label indicating date prepared or resident information. In an interview on 12/19/24 at 5:26 pm with the ADON and DON, the DON stated that Resident #8 and Resident #23 were the only tube residents in the facility with feeding tubes. The DON stated that the nurses should ensure that the HOB was elevated to 30 to 45 degrees during a tube feeding, the resident should remain with HOB elevated throughout the feeding and then for at least 30 minutes after the feeding is disconnected. The DON and ADON both stated that the formula and water bags should have a label including the date, nurse initials, flow rate for feeding, resident name, resident room number, and the time the bag was hung. The DON stated that annual competencies were done for feeding tubes for all nursing staff. The ADON stated there were newly hired nurses in the facility that might need refreshing on the training and policy/procedure. The DON stated there was no excuse for the failures. The ADON stated the failures were an educational issue with the nursing staff. In an interview on 12/19/24 at 6:17 pm, the Administrator stated that she had nothing further to add regarding the failures and that she agreed with everything the ADON and DON had stated. She stated that the formula and water bags not being labeled occurred on 2 different staff rotations and that indicated it was an educational issue across the board that needed to be addressed. She stated that the head of the bed not being elevated was also an educational issue. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of facility policy titled Enteral Formula Via: Feeding Tube, Bolus, Gravity, Pump (Closed/Open) Administration effective date 10/2020 revealed, in part: The syringe and bag (if used) should be changed every 24 hours. The ready-to-hang bottles should be changed according to the manufacturer recommendation or when total amount infused is less than the manufacturer recommendation . The syringe, bag, and/or bottle should be labeled with the resident name, room number, date changed, and the nurse's signature/initials. The bag or bottle should also specify the physician order for formula, rate, route, and means of administration. Elevate the head of the bed at least 30 degrees or more before starting the feeding and for at least 30-40 minutes after the feeding. It is policy that the head of the bed is elevated at least 30 degrees or more during the administration of the tube feeding and 1 hour after the feeding is completed.

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F 0801 Level of Harm - Potential for minimal harm Residents Affected - Many	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. 46641 Based on interview and record review, the facility failed to employ sufficient staff with the appropriate competencies, and skills set to conduct the functions of the food and nutrition service for 1 of 1 (DM) reviewed for qualified dietary staff. The facility failed to ensure the facility's DM met the requirements for a certified dietary manager. This failure could place residents at risk of not having their nutritional needs met and place them at risk for food born illnesses. Findings included: Record review of the DM's employee file revealed a hire date on 1/20/21. There was no documented evidence of a Dietary Manager Certificate found in the file. In an interview on 12/17/24 at 10:30AM, the DM stated she did not have her dietary manager certification. The DM stated she stated her employment at the facility was in Housekeeping then as the Dietary Manager at the facility for the past 2 years. The DM stated she was planning on starting online classes after the New Year. She stated she did have a current food handlers' certificate. In an interview on 12/19/24 at 2:00 PM, the Administrator stated her expectation was that the Dietary Manager would have completed a food service manager's course and have a current certification as a Dietary manager. She stated the failure could result in the resident's not having their nutritional needs met and place them at risk for foodborne illness. Review of the Job description of the Dietary Manager not dated, revealed in part: Job summary - Manage the operations of the dietary department to include staffing, food ordering and preparation, food delivering and clean up, in accordance with facility policies, physician orders, care plans, and appropriate regulations. Successful completion of Certified Dietary Manager exam.

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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** 45411 48593 Based on observations, interviews, and record reviews, the facility failed to establish and 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 2 of 5 residents (Resident #26, Resident #32) reviewed for infection control. The facility failed to ensure staff followed infection control policies and procedures while providing Resident #26 and Resident #32 with wound care. This failure could place residents at risk for cross contamination and infection. The findings include: Record review of Resident #26's admission record dated 12/19/24 revealed Resident #26 was a [AGE] year-old female with an admitted to the facility of 01/03/2023. Admission record revealed Resident #26 had diagnoses that included muscle weakness, type 2 diabetes, transient cerebral ischemic attack (stroke), and anxiety. Record review of Resident #26 's MDS (minimum data set) assessment dated [DATE] revealed the resident had a BIMS (Brief Interview for Mental Status) of 6 indicating the resident had severe cognitive impairment. Under section M1200 the skin and ulcer/injury treatment, revealed the resident to had a pressure injury and needed applications of ointments/medication. Record review of Resident #26 's Care plan dated 11/12/2024 revealed Problem: Resident has a stage 3 right medial shin pressure ulcer related to immobility. Goal: Resident's ulcer will heal without complications. Approach: keep clean and dry as possible. Minimize skin exposure to moisture. Record review of Resident #26 's order summary revealed an order of pressure wound of the left medial shin: cleanse with normal saline and gauze. Apply alginate calcium and santyl to wound bed. Cover with a bordered island dressing. And pressure wound of the right medial shin: cleanse with normal saline and gauze. Apply alginate calcium and santyl to wound bed. Cover with a bordered island dressing During an observation of wound care on 12/19/24 at 09:54 AM with the DON for Resident #26, the DON used shears that were not cleaned prior to use, to cut the dressing that was placed on Resident #26's wounds on her left shin and right shin. Record review of Resident #32's admission record dated 12/19/24 revealed Resident #32 was a [AGE] year-old female with an admitted to the facility of 06/04/2024. Admission record revealed Resident #32 had diagnoses that included Cerebral infarction due to thrombosis of right middle cerebral artery (stroke), hearing loss, contracture (A permanent tightening of the muscles, tendons, skin, and surrounding tissues that causes the joints to shorten and stiffen) of muscle right upper arm, contracture of muscle left upper arm, and contracture right hand. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #32 's MDS dated [DATE] revealed the resident was unable to obtain a BIMS score due to being rarely or never understood. Section M1200 the skin and ulcer/injury treatment, revealed the resident to have a have a pressure injury and needing of applications of ointments/medication. Under section M1040 other ulcers, wounds and skin problems, D. open lesion(s) other than ulcers, rashes, cuts. Record review of Resident #32 's order summary revealed orders of Right hand: Apply alginate calcium once daily wrap with island gauze with border for 30 days ordered on 10/18/24 and pressure wound of the right ring finger: cleanse w/ NS and gauze. Apply alginate calcium and santyl. Cover with bordered island dressing ordered on 12/06/24. During an observation of wound care on 12/19/24 at 09:54 AM with the DON for Resident #32, the DON cleansed the resident's wound to the inside of her right hand, then set the resident's hand down on the resident's gown with no barrier in place. During an interview on 12/19/24 at 01:53 PM, the DON stated that he normally had someone holding Resident #32's hand during wound care due to pain, but since she was not in pain, he did not think to have someone hold the hand to prevent contaminating the wound. The DON stated he recognized how that was cross contamination. The DON stated the shears he used were cleaned after the last wound care was performed and was placed in his office. The DON acknowledges that he could not guarantee the shears were clean by the time he used them since they had been out of his sight. The DON stated he recognized how that could be a chance for cross contamination. Record review of facility policy titled infection control - cleaning and disinfecting resident care items and equipment stated in part reusable items are to be cleaned and disinfected or sterilized between residents.