STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675810	A. Building B. Wing	02/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lancaster Ltc Partners Inc	1515 N Elm St Lancaster, TX 75134

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34399 Based on observation, interview and record review the facility failed to ensure the comprehensive care plan described the services that were to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being for one (Resident #1) of four residents reviewed for comprehensive care plans. The facility failed to ensure Resident #1's care plan addressed Resident #1's family member measuring Resident #1's food using her own measuring cups. The facility failed to ensure Resident #1's care plan included Resident #1 received assistance by a family member without using the call button for staff assistance. This deficit practice could place residents at risk of not receiving the services they need, not having interventions in place, and a delay in response for assistance. Findings included: Review of Resident #1's quarterly MDS assessment dated [DATE] reflected Resident #1 was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses of Huntington's disease , cognitive communication deficit, muscle wasting and atrophy disorder, generalized muscle weakness and dysphagia . Resident #1 had a BIMS of 4 indicating he was severely cognitively intact. Resident #1 was dependent with ADLs of eating, showering, personal hygiene, dressing and transferring with two or more staff assistance. Review of Resident #1's comprehensive care plan last updated 01/20/24 reflected the following: - [Resident #1] is (High) risk for falls r/t unsteady Gait/balance, Psychotropic medication use and progression of Huntington's Disease. Intervention included educated the resident on the importance of call-light use and the risk of serious injury when ambulating without staff assistance. - Resident #1 has an ADL Self Care Performance Deficit r/t Disease Process Huntington's Disease. Interventions included TOILET USE: The resident requires 1 staff participation to use toilet. and TRANSFER: The resident has requires x1 staff participation with transfers. (continued on next page)

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

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- [Resident #1] has a diet order of Regular Mech Soft (Double Portions) with thin liquids (snacks in between meals) and is at risk for unplanned weight loss or gain. Review of Resident #1's Care Plan Conference dated 01/09/24 reflected Meeting help with Hospice nurse and family member in regards to resident having a two meal trays for double portions. Hospice sent order for resident to have double portions on separate trays. Residents current diet is double protein portions from October from 10/2022. resident has gained 16 pounds per weight over the last 6 months. resident [family member] brings her own measuring tools to measure food. and was informed our dietician monitors food portions for all residents. The care plan did not reflect Resident #1's family measuring Resident #1's food portions using her own measuring cups. Observation on 02/03/24 at 11:13 AM revealed Resident #1's family member asked Resident #1 if he needed to go the bathroom and he said yes. Resident #1's family member did not use call button and assisted Resident #1 to the bathroom on her own. Resident #1's family member stated He was heavy . Review of Resident #1's comprehensive care plan last updated 01/20/24 reflected the care plan did not reflect Resident #1's family not using the call button for staff assistance and assisting Resident #1 by herself. Interview on 02/03/24 at 11:18 AM with RN Weekend Supervisor revealed Resident #1's family member did weigh Resident #1's food prior to feeding Resident #1. She stated Resident #1's family member did assist Resident #1 with ADLs without asking for assistance from the facility staff. Observation on 02/03/24 at 12:08 PM revealed Resident #1 sitting in chair in his room. His lunch tray was sitting on the bedside table while his family member was measuring the spinach in a plastic measuring cup. Interview with the family member revealed she measured the food portions because he was not getting the correct food portions. His family member stated it was good so far and meat was 8 ounces as it was supposed to be. She had his meat on a coffee filter. She stated she would feed him once she was done with measuring his food portions. Interview on 02/03/24 at 2:22 PM with LVN A revealed Resident #1's family member did assist Resident #1 by herself without asking for facility staff for assistance or use the call button for assistance. She stated Resident #1's family member had been weighing Resident #1's food with her own measuring cups since September 2023. Interview on 02/03/24 at 2:32 PM with CNA B revealed Resident #1's family member assisted Resident #1 with feeding when at the facility and did not want the facility staff to feed Resident #1. CNA B stated Resident #1's family member did weigh Resident #1's food when she was at facility. She stated Resident #1's family member disagreed about the food portions being the right size. She stated Resident #1's family member would not use the call button to ask for assistance with ADLs. Interview on 02/03/24 at 2:58 PM with the Dietary Manager revealed Resident #1 had been receiving double portions at meals as ordered and if Resident #1 wanted more food he could ask for more food. She stated she became aware of Resident #1's family member weighing the food when Resident #1 received his meal tray using her own measuring cups about a month ago when she met with Resident #1's family member and hospice for a care plan meeting in January 2024. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 02/03/24 at 3:10 PM with the MDS Coordinator revealed the facility had a care plan meeting with hospice and Resident #1's family member about her complaint of Resident #1 not receiving double portion meals as ordered. She stated at the care plan meeting the family member reported she was measuring the food portions with her own measuring cups. She stated this should be care planned to include interventions. She stated she was not aware of Resident #1's family member assisting Resident #1 on own without calling for assistance. She stated she would update Resident #1's care plan to address these issues. Interview on 02/03/24 at 3:56 PM with the DON revealed she was aware of Resident #1's family member was measuring Resident #1's food items with her own measuring cups this past week when Resident #1's family member talked to her in the facility parking lot. She stated her first day as the DON at the facility was 01/29/24. The DON stated she was unaware of Resident #1's family member assisting Resident #1 with ADLs without using the call button. She stated the MDS Coordinator should have care planned about Resident #1's family member measuring food portions if they were aware of it. She stated if facility staff were aware of Resident #1's family member providing care to Resident #1 without calling for assistance they should notify her or the MDS Coordinator so it could be added to resident's care plan. Review of facility's policy revised September 2013 Care Planning - Interdisciplinary Team reflected Our facility's Care Planning/Interdisciplinary Team is responsible for the development of an individualized comprehensive care plan for each resident.

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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** 34399 Based on observation, interview and record review, the facility failed to maintain an infection prevention and control program designated to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable disease and infection for 1 (Resident #2) of 3 residents reviewed for infection control. The facility failed to ensure Resident #2's sheets and privacy curtain were free of blood stains. These failures could place residents at-risk of cross contamination which could result in infections or illness. Findings included: Review of Resident #2's face sheet dated 02/03/24 reflected Resident #2 was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses of cerebrovascular disease, Lupus (disease that occurs when your body's immune system attacks your own tissues and organs), End Stage Renal Disease and Heart Failure. Review of Resident #2's quarterly MDS assessment dated [DATE] reflected Resident #2 had a diagnosis of a contusion of the right middle finger with damage to nail. Resident #2 had a BIMS of 5 indicating she was severely cognitively impaired. Resident #1 required substantial/maximal assistance with hygiene, bathing, dressing and mobility in the bed. Resident #2 was on dialysis services. Observation on 02/03/24 at 11:16 AM revealed Resident #2's privacy curtain was pulled close to the door. The privacy curtain had a light tan with reddish stain on right side bottom of it measuring about 10 inches long and 7 inches wide. Resident #2 was lying in her bed with a pink/reddish stain of about 3 x 3 inches on the right bottom of fitted sheet. Interview on 02/03/24 at 11:18 AM with RN Weekend Supervisor revealed Resident #2 required her bed sheets to be changed daily due to Resident #2 biting on right middle finger and being on dialysis. She stated Resident #2 received dialysis at the facility and dialysis nurse from contract company came to the facility to provide dialysis treatment in her room. She stated the stain on the privacy curtain was a blood stain and when she had dialysis the blood may have gotten on the privacy curtain and the bed. She stated the sheets and privacy curtain needed to be changed. She stated the contract dialysis nurse did not communicate to them about Resident #2's bed and privacy curtain needing to be changed due to blood. Observation on 02/03/24 at 2:28 PM revealed Resident #2's privacy curtain had a blood stain on right side bottom of it measuring about 10 inches long and 7 inches wide. Interview with the RN Weekend Supervisor revealed the privacy curtain had not been changed and should have been changed. She stated Resident #2's bed sheet and the privacy curtain having blood on it was an infection control issue which should be addressed. RN Weekend Supervisor stated it should be changed when noticed by facility staff. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 02/03/24 at 2:30 PM with LVN A revealed Resident #2 had received dialysis treatment this morning in her room by dialysis contract nurse. She stated Resident #2 did bite her middle finger and would have to bandage it. Interview on 02/03/24 at 3:35 PM and 3:59 PM with DON revealed Resident #2's privacy curtain looked like the blood stain was fresher. She stated the bed sheet and privacy curtain having blood stains on them was an infection control and cross contamination issue. She stated would follow up with the dialysis nurse to ensure communication with facility staff about the blood stains in the resident room when the dialysis treatment was completed for the resident. Review of facility's policy Infection Control revised October 2018 reflected facility's infection control policies and practices are intended to facilitate maintaining a safe, sanitary and comfortable environment and to help prevent and manage transmission of diseases and infections.