| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 675810 | A. Building<br>B. Wing | 03/05/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Lancaster Ltc Partners, Inc. | 1515 N Elm St<br>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 0622<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the transfer or discharge is documented in the medical record for one (Resident #1) of four residents reviewed for clinical records.<br><br>The facility (RN A) failed to complete a Transfer/Discharge Form on 03/03/25 when he sent Resident #1 for evaluation to the Emergency Room.<br><br>This failure could put residents at risk of arriving at the emergency room without information regarding their medical conditions or needs.<br><br>Findings included:<br><br>Record review of an undated Face Sheet revealed Resident #1 was a [AGE] year-old man admitted to the facility on [DATE]. Resident #1 diagnoses included Anemia (not enough healthy red blood cells to carry oxygen throughout the body), Hypotension (blood pressure is significantly lower than normal), End Stage Renal Disease (the kidneys have permanently lost most of their ability to function), Malignant Neoplasm of the Kidney (cancerous tumor that develops in the kidney), Ulcerative colitis (chronic inflammatory bowel disease that affects the large intestine), Cerebral Infarction (blood flow to the brain is interrupted), Type 2 Diabetes (does not produce enough insulin, resulting in high blood sugar levels), and Shortness of Breath.<br><br>Record review of Resident #1's MDS assessment dated [DATE] revealed a BIMS (Brief Interview for Mental Status) of 15 meaning he was cognitively intact. Under Section G, Function Status revealed Resident #1 required extensive assistance with all ADL's, except eating where he only required setup. Under Section O, Special Treatments, Procedures, and Programs revealed Resident #1 required oxygen therapy.<br><br>Record review of Resident #1's care plan revised on 1/06/2025 revealed he suffered from shortness of breath. Under goal revealed [Resident #1] will maintain normal breathing pattern as evidenced by eupnea (normal, good, healthy and unlabored breathing), normal skin color, and regular respiratory rate/pattern through the review date. Under interventions included monitor/document changes in orientation, increased restlessness, anxiety, and air hunger and notify the nurse if the resident is having trouble breathing.<br><br>Record review of Resident #1's care plan revised on 7/17/2024 revealed [Resident #1] has hypotension r/t Medication use (Midodrine 15mg). Some of the interventions included:<br><br>(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 0622<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Give medications as ordered. Monitor for side effects and effectiveness. Monitor vital signs as ordered and record. Report significant abnormalities to MD. Monitor/document/report to MD PRN any s/sx of hypotension: dizziness, fainting, syncope (temporary loss of consciousness that occurs when the brain does not receive enough blood flow), blurred vision, lack of concentration, nausea, fatigue, cold clammy pale skin.<br><br>Record review of Resident #1's Nursing Note by RN A dated 3/3/2025 at 10:45 pm revealed [Resident #1] sent to hospital on FM's request [Family Name]. [Resident #1] was at baseline that is consistent with steady decline and low blood pressure managed with Midodrine 15 mg.<br><br>In an interview on 3/5/2025 FM A stated she was not sure if Resident #1 was supposed to be on oxygen all the time. FM A stated she lived in [City] and had not seen Resident #1 in almost one year. Resident #1 stated she communicated with Resident #1 over the phone. FM A stated she did not know if Resident #1's vitals had been taken, but when the staff member entered the room, he said he had just started his shift and had not taken Resident #1's vitals yet.<br><br>In an interview on 3/5/2025 at 02:00 pm with the MD, he stated the facility notified him that FM A wanted Resident #1 sent out to the hospital. The MD stated Resident #1 was mostly bed-bound with many diagnoses including, hypotension, ESRD, shortness of breath, cardiac diagnosis, etc. The MD stated Resident #1 had a guarded prognosis because there are so many medical problems. The MD stated Resident #1 was high risk for rehospitalizations and high risk for complications just due to his frequent blood transfusions and frequent infections. The MD stated Resident #1 was a colonizer of resistant organisms as well. The MD stated Resident #1 was a very high risk individual for decompensation. The MD stated Resident #1 had anemia which they are trying to figure out because he had a history of gastrointestinal leaks, but he refused colonoscopies a couple of times while in the hospital. The MD stated the only concern with Resident #1's dialysis was due to his low BP. The MD stated sometimes they were not able to dialyze him due to his BP not holding, and he was on Midodrine 15 gms to help regulate it. The MD stated Resident #1's blood pressure was a big issue because he ran low blood pressure and was on medication to keep it up.<br><br>In an interview on 3/5/2025 at 2:25 pm with the DON, she stated RN A called and informed her that FM A wanted Resident #1 sent out. The DON stated when RN A assessed Resident #1, his blood pressure was low and FM A insisted he be sent to the hospital. The DON stated RN A informed her that Resident #1 was alert and oriented x 1 at the time and he was normally alert and oriented x 4. The DON stated Resident #1's blood pressure was last checked at 12:53 PM with a reading of (83/53 mmHg). The DON stated Resident #1's oxygen was PRN and his O2 must remain above 92%. The DON stated Resident #1's O2 had never been less than 95%. The DON stated Resident #1's blood pressure ranged between 83/53 mmHg and 98/56 mmHg, and sometimes 101/52 mmHg depending on the days he went to dialysis. The DON stated if the top number were over 120 mmHg and the bottom number was over 80 mmHg, they would hold the medication. The DON stated anything under those numbers, Resident #1 was administered his Midodrine 15 mg medication. The DON stated anytime a resident was sent out to the hospital, the Nurse was required to complete an eTransfer form. The DON stated if the nurse failed to do so, they would not know the exact time, reason, nor who transported the Resident if it was not documented in the nurse's notes. The DON stated her expectation was for the nursing staff to adhere to policy and complete the eTransfer Form every time a resident was sent out to the hospital. The DON stated staff was supposed to complete and print the eTransfer Form and give it to the EMTs along with the resident's face sheet, the DNR form and a list of their diagnoses and orders. The DON stated starting today (3/5/2025), they were going to make sure the eTransfer Forms were completed entirely and properly.<br><br>(continued on next page) |

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| F 0622<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | In an interview and record review on 3/5/2025 at 3:10 pm with RN A, he stated Resident #1's blood pressure reading was 97/57 mmHg. RN A stated whenever Resident #1's blood pressure decreased, he was administered 15mg of Midodrine which in turn elevated Resident #1's blood pressure within 30 minutes. RN A stated he called 911 due to the instruction of FM A. RN A stated he called the doctor and the DON. RN A stated the facility policy says, You are supposed to send an eTransfer and the SBAR forms to the hospital. RN A stated the only thing different he would have done was adhered to policy and completed the eTransfer form.<br><br>In an interview and record review on 3/5/2025 at 5:05 pm with the ADM, he stated RN A was required to complete the eTransfer Form, the SBAR Form, print Resident #1's face sheet, a list of medications and diagnosis, so the hospital could determine quickly what needed to be done. The ADM stated RN A should have completed the eTransfer Form, especially if he were sending a resident to the hospital. The ADM stated if any resident needed to be sent out, the nursing staff should have all the correct paperwork available to hand over to EMS to take with the resident.<br><br>Record Review of the facility's policy, Notifying the Physician of Change in Status with a revised date of 3/11/2013 revealed, .<br><br>10. If a resident is transferred to the hospital, complete a transfer form.<br><br>Record Review of the facility's policy, Documentation with a revised date of May 2013 revealed, Documentation is the recording of all information, both objective and subjective, in the clinical record of an individual resident.<br><br>Goal .<br><br>1. The facility will maintain complete and accurate documentation for each resident on all appropriate clinical record sheets.<br><br>2. The facility will ensure that information is comprehensive and timely and properly signed.<br><br>Procedure .<br><br>6. Document completed assessments in a timely manner and per policy. |