STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675821	A. Building B. Wing	02/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Madisonville Care Center	411 E Collard Madisonville, TX 77864

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44700 Based on interviews and records review, the facility failed to ensure that medical records were accurately documented for three (3) of eight (8) residents (Resident #1, Resident #2, Resident #3) reviewed for accurate clinical records, in that: The facility failed to ensure Resident #1, Resident #2, and Resident #3's EMRs contained orders upon admission with corresponding clinical criteria to admit them to the secure unit. This deficient practice could result in errors in care and treatment and violate resident rights. Findings included: Resident #1 Review of Resident #1's face sheet dated 2/17/2025, reflected an [AGE] year-old male admitted to the facility on [DATE] with diagnoses that included: Alzheimer's Disease (a progressive disease that destroys memory), Dementia (a group of conditions characterized by impairment of at least two brain functions), Hypertension (high blood pressure), Benign Prostatic Hyperplasia (enlargement of the prostate gland) and history of Colorectal cancer (cancer of the colon and rectum.) Review of Resident #1's admission MDS dated [DATE], reflected a BIMS of 0 (zero) suggesting severe cognitive impairment. Review of MDS Section E on behaviors reflected resident had rejected care and had wandering behaviors in the last 1 to 3 days. Further, behaviors reflected Resident #1's wandering placed him at risk of potential harm and intruded on the privacy of others, *Review of Resident #'1s undated care plan reflected the problem: Resident resides in the Secure Care Unit, related to diagnosis of dementia and Alzheimer's Disease and risk for elopement. Intervention included Admit to SecureCare unit per MD orders. Review of Resident #1's orders dated 2/16/2025 reflected the following order: May admit to the secure unit. Review of Resident #1's EMR orders from 1/31/2025 to 2/15/2025 revealed there were no clinical criteria/problems referenced for the resident's admission to the secured unit. (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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #2 Review of Resident #2's face sheet dated 2/17/2025, reflected a [AGE] year-old male admitted [DATE] with diagnoses that included: Major Depressive Disorder, Anemia (low iron in the blood), Vascular Dementia (Cognitive decline related to decreased blood flow in the brain), Hypertension (high blood pressure), Atrial Fibrillation (irregular heart rhythm) and personal history of Cerebral Infarction (stroke.) Review of Resident #2's admission MDS dated [DATE] reflected a BIMS of 3 suggesting severe cognitive impairment. Review of MDS Section E on behaviors reflected resident had daily wandering behaviors. *Review of Resident #2's undated care plan reflected the problem: Resident resides in the Secure Care Unit, related to diagnosis of dementia and risk for elopement. Intervention included Admit to SecureCare unit per MD orders. Review of Resident #2's orders dated 2/16/2025 reflected the following order: May admit to the secure unit. Review of Resident #2's EMR orders from 1/24/2025 to 2/16/2025 revealed There were no clinical criteria/problems referenced for the resident's admission to the secured unit. Resident #3 Review of Resident #3's face sheet dated 2/17/2025, reflected an [AGE] year-old female admitted on [DATE] with diagnoses that included: Alzheimer's Disease (a progressive disease that destroys memory), Major Depressive Disorder, Bipolar Disorder, (disorder associated with episodes of mood swings), generalized anxiety disorder and insomnia due to other mental disorder (inability to fall asleep.) Review of Resident #3's admission MDS dated [DATE] reflected a BIMs of 9 suggesting moderate cognitive impairment. Review of MDS Section E on behaviors, reflected resident had wandering behaviors in the last 1 to 3 days. **Review of Resident #3's undated care plan reflected the problem: Resident resides in the Secure Care Unit, related to diagnosis of dementia delirium. Intervention included Admit to SecureCare unit per MD orders. Review of Resident #3's orders dated 2/16/2025 reflected the following order: May admit to the secure unit. Review of Resident #3's EMR orders from 1/9/2025 to 2/15/2025 revealed there were no clinical criteria/problems referenced for this the resident admission to the secured unit. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 2/17/2025 with LVN A, she stated she had done the admission for Resident #2 but did not remember putting in orders for him to be admitted to the secure unit. She stated she had just started at the facility and had not been familiar with the EMR and had not known how to do batch orders for admissions. She stated she was not sure who was responsible for putting in orders for a resident to be admitted to the secure unit, but she thought it was the corporate nurse or ADON. She stated not having orders in the system for admission to the secure unit could be a concern because we could be holding them against their will. During an interview on 2/24/2025 with LVN B, she stated she had done the admission for Resident #3 but did not recall if she had put in an order in for her because someone from admissions had come up and told her Resident #3 was being admitted to the secure unit. She stated she had only been responsible for the admission assessment and the skin assessment on Resident #3 and was not sure who was supposed to complete the orders. She stated she thought the orders were being completed by one of the corporate nurses. LVN B stated it could be against a resident's right to be confined to a secure unit without an order saying why they needed to be there. She stated orders were important because all staff needed to know what they were dealing with for residents. During an interview on interview on 2/17/2025 at 1:15 pm the ADO stated the charge nurse that does the admission was responsible for putting in the orders. She stated orders should have been put in the EMR timely and accurately. She further stated the DON should have reviewed documentation including orders upon admission. She stated her concerns with orders not being put in were that there could have been inaccurate documentation including inaccurate orders on a resident's chart. During an interview on 2/17/2025 at 3:32 pm, the IDON stated she had put the admission orders for the secure unit for Resident #'s 1, 2 and 3 on 2/16/2025. She stated she had been auditing the system [EMR] and noticed the orders were missing, so she put them in. She stated she had been aware that the orders to admit Residents #1, 2 and 3 were put in well after the residents had been admitted . She stated the admitting nurse was supposed to put in the orders and the nurses had the ability to do batch orders for admissions. She stated a problem with not having orders in for residents to be on the secure unit could be considered involuntary seclusion for those residents. She stated she had been covering as the interim DON and when she went to a facility, she would start auditing charts and if she found things missing, she would correct them and that was what happened with Resident #'s 1, 2 and 3 for their orders to be admitted to the secure unit. During an interview on 2/17/2025 at 3:39 pm, the Medical Director stated his expectations upon admission to the secure unit was that orders would be put in for those residents. He further stated he had been aware that Resident #'s 1, 2 and 3 were admitted to the secure unit and he had seen them/assessed them on the unit. He stated he expected orders to be completed timely and should be reviewed by either a physician or a midlevel provider [NP or PA]. He stated he will have to go through this process with the nursing facility to be sure the policies are being followed. Review of facility policy SecureCare Environment Admission Criteria and Process dated Revised February1, 2007 revealed: 1. Residents eligible for admission to the SecureCare Environment will have a diagnosis of a dementia related illness. 2. The need for admission to the SecureCare Environment must have a physician[s] order.