STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675832	A. Building B. Wing	08/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rising Star Nursing Center	411 S Miller Rising Star, TX 76471

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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44722 Based on observation, interview and record review, the facility failed to develop a baseline care plan within 48 hours of a resident's admission that included the instructions needed to provide effective and person-centered care of 1 of 13 (Resident #133) residents reviewed for care plan completion. The facility failed to include Resident #133's oxygen use, smoking status, and discharge goals in the baseline care plan within the required 48-hour timeframe. This failure could place residents who were newly admitted at risk for not receiving necessary care and services or having important care needs identified. Findings included: Record review of Resident # 133's face sheet dated 08/09/2024 revealed a [AGE] year-old female who was admitted to the facility on [DATE] with diagnoses which included Chronic Obstructive Pulmonary Disease, Asthma, and hypertension (high blood pressure). Record review of Resident #133's Admission MDS assessment dated [DATE] revealed: Section C (Cognitive Patterns) BIMS score had not been completed. Record review of Resident #133's Physician Orders dated 08/09/2024 revealed, Start date of 08/01/2024 Oxygen at 2 l/m to 5 l/m per nasal cannula prn SOB/respiratory compromise as needed for shortness of breath. Record review of Resident #133's baseline care plan was completed on 08/01/2024 revealed Resident #133's oxygen use, smoking status, and discharge goals were not incorporated in the base-line care plan. During an observation and interview on 08/08/2024 at 10:53 AM PM, Resident #133's door to her room did not have Oxygen in Use sign posted outside the entrance of her door. Resident #133 stated she was a smoker and did not wear her oxygen when she went outside to smoke. (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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 08/09/24 at 3:24 PM, the ADON stated it was her responsibility to complete the base line care plan. The ADON stated her expectation was baseline care plans should have included all of a resident's care areas and there should not have been any blanks. The ADON stated Resident #133's oxygen use, smoking status and discharge goals should have been included in the baseline care plan. The ADON stated the DON and herself are responsible to monitor the accuracy of base line care plans. The ADON stated she did not feel there was an affect to Resident #133 because Resident #133 was cognitive, and staff knew she smoked, and the oxygen use was in her orders. The ADON stated what led to failure was she could have gotten into hurry and did not incorporate all areas into the baseline care plan. During an interview on 08/09/24 at 3:46 PM, the DON stated her expectation was the baseline care plan should have been completed within 48 hours of admission and all blanks should have been completed on the baseline care plan. The DON stated the ADON and herself were responsible to completed baseline care plans and to ensure they were completed. The DON stated the effect on Resident #133 was there could have been a potential for a gap of comprehensive care and/or failure to meet a resident's need. The DON stated she did not feel there was a failure because care plans were an evolving process and if it was in the orders, they would follow the orders. Record review of facility policy titled, Baseline Care Plan undated revealed: Nursing home staff will develop a baseline care plan for the residents care within 48 hours of admission to the facility . The baseline care plan will include, at a minimum, the following: a. Initial goals based on admission orders b. Physician orders c. Dietary orders d. Therapy services e. Social Services

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44722 Based on interviews and record reviews, the facility failed to ensure the comprehensive care plan was developed within 7 days after completion of the comprehensive assessment for 1 of 13 (Resident #28) residents reviewed for comprehensive person-centered care plans. The facility failed to develop Resident #28 comprehensive care plan within 7 days of the completion of the comprehensive assessment. This failure could affect the residents by placing them at risk for not receiving care and services to attain or maintain the residents highest practicable physical, mental, and psychosocial well-being. Findings include: Record review of Resident #28 dated 08/09/2024 revealed a [AGE] year-old female admitted on [DATE] with the diagnosis of Acute Transverse Myelitis in Demyelinating Disease of Central Nervous System (Inflammation of spinal cord that causes neurological affects) Rheumatoid Arthritis, Bartter's Syndrome (an inherited disease that results in low potassium and increased blood acidity and low blood pressure), Chronic Kidney Disease and high blood pressure. Record review of Resident #28's Admission MDS revealed a completion date of 02/16/2024. Record review of Resident #28's Quarterly MDS dated [DATE] revealed: Section C- Cognitive Patterns revealed a BIMS score of 15 which means cognitively intact. Record review of Resident #28's comprehensive care plan revealed an initiation date of 04/16/2024. During an interview on 08/09/24 at 3:25 PM, the ADON stated her expectation was that comprehensive care plans should have been completed within 7 days of the completion of the comprehensive assessment. The ADON stated she was responsible to complete and monitor the comprehensive care plan. The ADON stated the effect on residents could have been care area could have been missed. The ADON stated Resident #28's comprehensive care plan should have been initiated by February 23, 2024, The ADON stated what led to failure of the care plan not being initiated until 4/16/2024 was oversight on her part, she had returned from medical leave about that time and had a lot of things to catch up on. During an interview on 08/09/2024 at 3:46 PM, the DON stated her expectation was that compressive care plans be completed within 21 days of admission. The DON stated the ADON and herself were responsible to complete care plans. The DON stated the effect on residents could have been a lapse in compressive care. The DON stated what led to failure was oversight by the DON and ADON. Record review of facility policy titled, Comprehensive Care Plans not dated, revealed: The comprehensive care plan will be developed within 7 days after completion of the comprehensive assessment.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48883 Based on observation, interviews and record reviews the facility failed to ensure that residents receive care, consistent with professional standards of practice, to prevent pressure ulcers and do not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and residents with pressure ulcers receive necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing for 1 of 12 (Resident #27) residents reviewed for pressure ulcers. The facility failed to assess Resident #27's pressure ulcer weekly. The facility failed to assess Resident #27's skin weekly. These failures could place residents at risk of infections and worsening of wounds. Findings include: Record review of Resident #27's electronic face sheet dated 08/09/2024 revealed a [AGE] year-old male who was admitted to the facility on [DATE] with diagnoses that included: pressure ulcer of left heel, unstageable (left heel pressure ulcer that is not able to show how deep or how many layers of tissue was damaged), unspecified protein-calorie malnutrition (low protein levels and calorie intake), cognitive communication deficit (inability to communicate effectively related to mental deficit), and muscle weakness. Record review of Resident #27's quarterly MDS assessment dated [DATE] revealed Resident #27 had a BIMS score of 12, meaning moderate cognitive impairment. Further review of MDS section M - Skin Conditions revealed Resident #27 had 1 unhealed pressure ulcer and resident was at risk of developing pressure ulcers. Record review of Resident #27's physician orders dated 08/06/2024 revealed: Cleanse left heel with soap and water, apply silver alginate to wound cand cover with heel border foam. Change on Tuesday and Fridays. every day shift every Tue, Fri for Left heel D.U. Record review of Resident #27's care plan date initiated 03/06/2024 revealed Focus: Resident is at risk for skin breakdown r/t decreased mobility, incontinence, equipment, nutritional status Goal: Resident will have no reports of skin breakdown trough next review date Interventions: Encourage and assist resident to suspend heels when in bed with pillows. Further review of care plan date initiated 03/06/2024 revealed Focus: Resident entered facility with unstageable ulcer to L heel Goal: Area will have no S/S of complications and will show S/S of improving/healing through next review date .resident will have no S/S or reports of unrelieved pain to wound area through next review date Interventions: Assess wound condition weekly and with dressing change, Notify MD if noted with change in wound condition, (increased drainage, odor, eschar, warmth, decline/improvement in wound condition .keep dressing clean dry intact, replace as needed .Keep pressure off area. Use positioning devices as needed. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #27's assessment record on 08/09/2024 revealed last weekly skin assessment documented was on 03/12/2024 and no evidence that any documented wound care sheets found. During on observation and interview on 08/08/2024 at 9:57 a.m., Resident #27 was lying in bed watching television. He stated he had wound on his foot and went to wound clinic once a week. He did not voice concerns with how facility staff cared for wound but he was concerned the wound had not healed. During an interview on 08/09/2024 at 2:21 p.m., the DON stated Resident #27 was admitted into nursing home with skilled nursing services. She stated during the time Resident #27 received skilled nursing services, which ended May 2024, the nurse documented daily in skilled services nursing note which included a skin assessment. The DON stated the skilled note showed that his skin was assessed during that time frame. was included in the skilled nurses note which showed that skin was assessed. She stated the electronic system that facility used did not trigger for weekly skin assessments when Resident #27 was removed from skilled nursing, and she did not know why system did not start triggering for weekly skin assessments. She stated she expected for skin assessments to be performed weekly by nurses and CNAs will look at resident's skin in between nurses' assessment. The DON stated CNAs are not allowed to perform assessments. She stated no proof was available that nurses performed skin assessments after May of 2024. She stated nurses should perform head to toe assessments and not just look at resident's wounds that the nurses provided treatment to. She stated she was who monitored weekly skin assessments were performed and did not know system had not been triggering. She stated no negative outcome occurred to the resident from weekly skin assessments not being performed. Review of facility policy titled Skin Assessment with no date revealed Assess the resident head to toe to identify all skin concerns to include but not limited to: bruises, skin tears, rashes, burns, implanted ports, devices, stomas, pressure injuries of any type, or any other skin concerns. All NON-PRESSURE findings: complete weekly skin assessment in electronic medical chart. All PRESSURE findings: completed wound care sheet. If a resident has a pressure ulcer(s) or complicated wound(s) then the wound care sheet should be completed. This form may be utilized to address all skin concerns (in lieu of using the weekly skin assessment form in conjunction with the wound care sheet. A RN is to accompany the nurse providing wound care for the scheduled assessment where possible. The skin assessment schedule is to be implemented and followed weekly .Nursing management will periodically perform random checks on completed Skin Assessment for accuracy. The Director of Nursing or designee is to follow-up weekly in Standards of Care (SOC/IDT) to ensure completion and accuracy of assessments.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44722 Based on observations, interviews, and record reviews, the facility failed to ensure residents who needed respiratory care were provided respiratory care consistent with professional standards of practice for 1 of 13 residents (Resident #133) reviewed for oxygen administration. The facility failed to ensure an Oxygen in Use sign was posted on the outside of Resident #133's door. These deficient practices could place residents who received oxygen and treatments at risk of respiratory infection. The findings include: Record review of Resident # 133's face sheet dated 08/09/2024 revealed a [AGE] year-old female who was admitted to the facility on [DATE] with diagnoses which included Chronic Obstructive Pulmonary Disease, Asthma, and hypertension (high blood pressure). Record review of Resident #133's Admission MDS assessment dated [DATE] revealed: Section C (Cognitive Patterns) BIMS score had not been completed. Record review of Resident #133's Physician Orders dated 08/09/2024 revealed, Start date of 08/01/2024 Oxygen at 2 l/m to 5 l/m per nasal cannula prn SOB/respiratory compromise as needed for shortness of breath. During an observation on 08/07/2024 at 3:35 PM, Resident #133's door to her room did not have Oxygen in Use sign posted outside the entrance of her door. During an observation and interview on 08/08/2024 at 10:53 AM PM, Resident #133's door to her room did not have Oxygen in Use sign posted outside the entrance of her door. Resident #133 stated she was a smoker and did not wear her oxygen when she went outside to smoke. During an interview on 08/09/24 at 03:25 PM, the ADON stated her expectation was that a Oxygen in Use sign should have been placed on the outside of door of residents who smoked. The ADON stated no one specific was responsible for ensuring the sign was posted on the door, the person who set up the concentrator should have posted the sign. The ADON stated all staff should have monitored the doors to ensure the signs were on the doors. The ADON stated the DON and herself make random rounds daily throughout the facility. The ADON stated what led to failure was staff were in a rush. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 08/09/2024 at 3:46 PM, the DON stated her expectation was that each room where a resident was using an oxygen concentrator should have had an Oxygen in Use sign on the door. The DON stated the maintenance supervisor was responsible to ensure a sign was placed on the door and all staff should have monitored to ensure each room had an Oxygen in Use Sign on the door. The DON stated the effect on the residents could have been a safety issue if they were not aware that oxygen was in use in a room. The DON stated what led to failure was Resident #133 was admitted on [DATE] late in the day, and staff were focused on the admission, care, and assessment of Resident #133. The DON stated ultimately it was an oversight of staff. Record review of facility policy titled Oxygen Administration dated March 2004, revealed: Place an Oxygen in Use sign on the outside of the room entrance door.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 44722 Based on interview and record review, the facility failed to maintain medical records on each resident, in accordance with accepted professional standards and practice, that were complete and accurate for 1 of 12 (Resident #11) residents reviewed for resident records. The facility failed to ensure physician order parameters were accurate on Resident #11's cardiac medications (carvedilol. hydralazine and losartan potassium) This failure could place residents at risk of having errors with their care and treatment. Findings included: Record review of Resident #11's face sheet dated 08/08/2024 revealed a [AGE] year-old female admitted on [DATE] with the following diagnosis heart failure (heart disease interfering with how much blood is pumped through heart with each beat), dementia, history of falling, weakness, unspecified atrial fibrillation (irregular heartbeat), edema (swelling), essential hypertension (high blood pressure), and long term use of anticoagulants (chronic blood thinner use). Record review of Resident #11's annual MDS dated [DATE] revealed Section-C Cognitive Patterns Resident #11 had a BIMS score of 7 meaning severe cognitive impairment; Section N- Medications revealed Resident #1 had taken anticoagulant (medication to help prevent blood clots) and diuretic (medication to decrease fluid retention). Record review of Resident #11's physician order dated 06/19/2024 revealed carvedilol tablet 6.25mg give 1 tablet by mouth two times a day for HTN hold is systolic is < 100 and diastolic < 60 and HR < 60. Record review of Resident #11's physician order dated 03/28/2022 revealed hydralazine tablet 25mg give 1 tablet by mouth two times a day for HTN hold is systolic is < 100 and diastolic < 60. Record review of Resident #11's physician order dated 06/19/2024 revealed losartan potassium tablet 25mg give 12/5mg by mouth one time a day for HTN hold is systolic is < 100 and diastolic < 60 and HR < 60. During an observation on 08/08/2024 at 7:14 a.m., LVN A took Resident #11's vital signs. Blood pressure reading was 107 / 57 (systolic 107 and diastolic 57) and pulse reading was 64 beats per minute. LVN A held carvedilol, hydralazine, and losartan potassium medication. During an interview on 08/08/2024 at 10:23 a.m., LVN A stated she did not give carvedilol, hydralazine, and losartan potassium medication due to parameters not being met in physician order. She stated in the past she had asked physician about parameters and had been instructed to give medication if one of the parameters were not met. She was unsure if order needed to be changed so that only one parameter needed to be met to hold medication but stated she would ask physician. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 08/09/2024 at 9:26 a.m., the DON stated she expected parameters to be followed when administering medication but clarified that order had been entered into electronic medical system wrong. She stated that there should have been an or instead of and meaning that only one parameter needed to be out of range to hold the medications. She stated this occurred due to transcription error. She stated no negative affect occurred to the resident due to nurse had administered medication correctly. She stated she was responsible for ensuring orders in system were correct and had missed these orders due to when she scanned over the orders, she would look at numbers and not and instead of or. She stated order will be corrected in electronic medical record to prevent any medication error from occurring. During an interview on 08/09/2024 at 2:28 p.m., the ADMN was not able to provide policy about accuracy of records. He stated the medication policy was all he could provide regarding physician orders accuracy. Review or facility policy titled Receiving and Recording Medication Orders with no date revealed Telephone orders may be accepted by a licensed nurse only (i.e., RN, LPN, LVN). Telephone or verbal orders must be recorded on the Physicians' Order Sheet when received and must be recorded by the nurse receiving the order. Telephone or verbal orders for drugs must include: a. Name and strength of the drug b. Quantity or specific duration of the drug c. Dosage and frequency of administration d. Route of administration; and e. Date and time received. Telephone or verbal orders must be countersigned by the physician within forty-eight (48) hours of receiving the order.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48883 Based on observations, interviews and record reviews, the facility failed to 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 (LVN A and CNA B) staff observed for infection control. 1. The facility failed to ensure LVN A sanitized insulin flex pen rubber stopper prior to applying pen needle. 2. The facility failed to ensure CNA B sanitized catheter bag drain after emptying bag. 3. The facility failed to ensure Resident #183's catheter bag was stored off the floor. These failures could place residents of the facility at risk of infections due to not sanitizing equipment and not storing catheter bag off the floor. Findings included: Record review of Resident #183's electronic face sheet dated 08/09/2024 revealed a [AGE] year-old male admitted to facility on 08/06/2024 with diagnosis of benign prostatic hyperplasia with lower urinary tract symptoms (enlargement of prostate that could cause difficulty urinating). Record review of Resident #183's electronic medical record revealed admission MDS had not been completed. Record review of Resident #183's baseline care plan dated 08/06/2024 revealed section Bladder: catheter with goal to discontinue catheter. Record review of Resident #183's physician orders dated 08/06/2024 revealed foley catheter to BSDB every shift for urinary retention/urinary obstruction. During an observation on 08/07/2024 at 9:34 a.m. Resident #183 was lying in bed and catheter bag was lying on the right side of bed on the floor between bed and wall. During an observation on 08/07/2024 at 10:32 a.m., Resident #183 was lying in bed, catheter bag was hanging from right bed railing and bottom of catheter bag was touching the floor. CNA B and NA C performed catheter care. NA C cleansed perineal area front to back using wet wipes. She held catheter tip closest to resident with her fingers and cleansed tube using wet wipe pulling away from resident. NA C attempted to empty catheter bag but was unable to work the clamp. CNA B emptied catheter bag into urinal and secured drain back into catheter bag. CNA B did not sanitize drain on bag after emptying prior to securing drain back into bag. NA C moved catheter bag and secured it to the bed frame to the right side of the bed after catheter care. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 08/08/2024 at 11:23 a.m., CNA B stated the drain to catheter bag should have been sanitized with alcohol swab after catheter bag had been emptied. She stated she was unsure why Resident #183's catheter bag had been on the floor the beginning of her shift. She stated she did not have alcohol swab on her during catheter care which led to her not sanitizing the drain after she emptied catheter bag. She stated not sanitizing the drain and catheter bag being on the floor could cause resident to have an infection. During an observation on 08/08/2024 at 7:03 a.m., LVN A administered insulin using flex pen. She did not sanitize rubber stopper on multi dose flex pen that had been opened prior to this dose with alcohol swab prior to securing pen needle. During an interview on 08/08/2024 at 10:23 a.m., LVN A stated she had been trained on using flex pens in nursing school but not from the facility. She stated she should have sanitized flex pen rubber stopper prior to securing needle with alcohol swab but forgot. She stated she was nervous from being watched which led to her missing the sanitizing step and she was trying to do everything right. LVN A stated not sanitizing rubber stopper could cause resident to get an infection from bacteria. During an interview on 08/09/2024 at 8:38 a.m., the DON stated she was the infection preventionist of the facility. She stated it was her expectation that catheter bags did not touch the floor. She stated she felt Resident #183 may have pulled on the tubing and caused the catheter bag to land on the floor. She stated Resident #183 had been educated since his admission to call staff to assist with moving around in the bed to prevent catheter bag from touching the floor. The DON stated the drain on the catheter bag should be sanitized with alcohol when the bag was emptied. She stated she monitored staff providing catheter care randomly, but facility did not have many residents with catheters and that could be the reason CNA B did not sanitize drain. She stated that any external or internal contamination of catheter bag could lead to resident getting an infection. The DON stated she expected for insulin flex pen rubber stopper be sanitized with alcohol prior to securing pen needle. She stated she monitored insulin were administered appropriately randomly. She felt nerves of nurse administering insulin led to her failing to sanitize rubber stopper. She stated the affect not sanitizing rubber stopper could have on a resident would be causing an infection. Review of facility policy titled Insulin Pen Administration Procedure undated revealed Wipe the rubber stopper with an alcohol wipe. Attach a new pen needle to the insulin pen. Review of facility policy titled Emptying a Urinary Drainage Bag dated September 2005 revealed Always attach the drainage bag to the bedframe - never to the side rails .Keep the drainage bag and tubing off the floor at all times to prevent contamination and damage .Remove the drain tube from its holder. Open the drainage bag and let the urine flow into the measuring container. After the drainage bag has emptied, close the drain. Wipe the drain with an alcohol sponge or swab. Discard the sponge or swab into the designated container. Replace the drain tub back into its holder.