STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675884	A. Building B. Wing	08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Teague Nursing and Rehabilitation	884 Hwy 84 W Teague, TX 75860

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 - 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** 45957 Based on observatations, interviews, and record review, the facility failed to ensure the medical record contain an accurate representation of the actual experiences of the resident and include enough information to provide a picture of the resident's progress, including his/her response to treatments and/or services, and changes in his/her condition for 1of 7 residents (Resident #1) review for resident assessments. The facility failed to ensure Resident #1's Weekly Nursing Summary dated 08/14/24, 08/21/24 & 08/28/2024 reflected that Resident #1 had an indwelling catheter. This deficient practice could place residents at-risk for inadequate care due to an inaccurate assessment. Findings included: A record review of Resident #1's face sheet dated 08/29/24 reflected a [AGE] year-old male who was readmitted to the facility on [DATE]. Resident #1's diagnoses included retention of urine (a condition that make it difficult or impossible to empty the bladder), muscle wasting and atrophy (loss of muscle tissue), chronic kidney disease stage 4 (when the kidneys are severely damaged and can't filter waste from the blood as well as they should), and muscle weakness (loss of muscle strength). A record review of Resident #1's Quarterly MDS assessment, dated 07/31/24, reflected Resident #1 had a BIMS score of 14, which indicated cognitively intact. Resident #1's Quarterly MDS Section H Bladder and Bowel reflected that Resident #1 had an indwelling catheter. A record review of Resident #1's care plan, dated 06/11/24, reflected Resident #1 was care planned for history of urinary tract infection, chronic kidney disease, and an indwelling catheter. A record review of Resident #1's Weekly Nursing Summary , dated 08/14/24, 08/21/24 & 08/28/2024 reflected Resident #1 did not have a catheter. During an observation and interview on 08/29/24 at 10:15 a.m., Resident #1 appeared to have a catheter with a navy-blue privacy bag cover. Resident #1 stated he has had a catheter since he was admitted to the facility. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(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 - Few	In an interview on 08/29/24 at 1:15pm, LVN A stated that Resident #1 has had a catheter since his admission. LVN A stated if a resident had a catheter, but an assessment did not reflect the catheter the resident would not receive proper care. In an interview on 08/29/24 at 3:45 p.m., the DON stated that Resident #1 was admitted to the facility with a catheter. The DON stated that the Weekly Nursing Summary should have reflected Resident #1's catheter. The DON stated that if the Weekly Nursing Summary was inaccurate that could cause the resident to receive inadequate care. In an interview on 08/29/24 at 3:55 p.m., the ADM stated Resident #1 had catheter. The ADM stated Resident #1's Weekly Nursing Summary should have reflected Resident #1's catheter. The ADM stated it was the nurse's responsibility to ensure the Weekly Nursing Summary was completed accurately. The ADM stated if resident's assessment was inaccurate that could cause the resident to receive improper care. A record review of the facility's Charting and Documentation policy, dated July 2017, reflected, Policy Statement All services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional or psychosocial condition, shall be documented in the resident's medical record. The medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care. Policy Interpretation and Implementation 2. The following information is to be documented in the resident medical record: a. Objective observations; b. Medication administered; c. Treatment or services performed; d. Changes in the resident's condition e. Events, incidents or accidents involving the resident; and f. Progress toward or changes in the care plan goals and objectives; 3. Documentation in the medical record will be objective (not opinionated or speculative), complete and accurate .