STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675931	A. Building B. Wing	05/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cedar Hills Geriatric Center	710 Hwy 55 Camp Wood, TX 78833

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 0775 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep complete, dated laboratory records in the resident's record. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44906 Based on interview and record review, the facility failed to file in the resident's clinical record laboratory reports that were dated and contained the name and address of the testing laboratory for 5 of 8 residents (Residents #49, #1, #48, #66, and #15) whose labs were reviewed in that: 1. Resident #49 had lab results sent to the facility on [DATE] not uploaded as of 5/28/2024 [98 days after receipt], resulting in an auxiliary provider not having the information for dietary consultation. 2. Resident #1 had lab results sent to the facility on [DATE] not uploaded as of 5/28/2024 [243 days after receipt]. 3. Resident #48 had lab results sent to the facility on [DATE] not uploaded as of 5/28/2024 [98 days after receipt]. 4. Resident #66 had lab results sent to the facility on [DATE] not uploaded as of 5/28/2024 [98 days after receipt]. 5. Resident #15 had lab results sent to the facility on [DATE] not uploaded as of 5/28/2024 [98 days after receipt]. This failure could place residents at risk of not receiving timely diagnosis and treatment, and not receiving appropriate monitoring for health and well-being. The findings were: 1.Record review of the admission record revealed Resident #49 was a [AGE] year-old female originally admitted on [DATE]. Record review of the quarterly MDS, dated [DATE], revealed Resident #49 had a BIMS summary score of three, indicative of severe cognitive impairment. Resident #49's primary medical condition that best described the primary reason for admission was non traumatic brain dysfunction related to Alzheimer's disease [brain disorder that gets worse over time, most common cause of dementia which is a decline in memory, thinking, behavior and social skills]. Other active diagnoses included cancer. (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 0775 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review the care plan revealed Resident #49 had interventions to monitor labs as per MD orders, and report results to the MD under the following problem areas: at risk for complications related to hypercholesterolemia [high cholesterol] and hyperlipidemia [high fats in the blood] with a revision date of 2/06/2024; impaired cognitive function/dementia or impaired thought processes with a revision date of 2/06/2024; potential nutritional problem with a revision date of 2/06/2024. Record review of the orders details revealed Resident #49 had active orders for labs that included complete blood count with differential, comprehensive metabolic panel, fast lipid profile, and liver function tests, annually in February with a start date of 8/16/2022. Record review of Nurses Note dated 2/20/2024 at 5:35 AM authored by Charge Nurse A reflected venipuncture to right antecubital space successful pending labs to be taken to [closest hospital lab]. Record review of [closest hospital lab] sheet with a fax confirmation time of 2/20/2024 at 3:15 PM revealed Resident #49's lab blood draw was collected 2/20/2024 at 6:00 AM. Included hand drawn initials for the physician, undated, on each of the 3 pages towards the middle or bottom of the page. [Lab results not uploaded in medical records as of 5/28/2024, 98 days after receipt.] Record review of Physicians Nursing Home Progress Note for Resident #49, dated 3/08/2024 revealed no new problems. [Did not indicate if labs were reviewed.] Record review of Nutrition Quarterly Progress Note for Resident #49, dated 5/29/2024 at 8:09 PM, authored by RD B, reflected, Reviewed [Abnormal Labs]. In an interview on 5/31/2024 at 3:01 PM, the RD stated she would expect to find all recent labs in the EHR scanned under the miscellaneous tab. The RD stated she had reviewed, but there were no recent labs for Resident #49 when she made her quarterly progress notes on 5/29/2024. Upon reading the abnormal lab values from the 2/20/2024 lab blood draw, the RD stated none of the levels, as read, would have changed her course of treatment or recommendations. The RD stated she would have preferred to see the labs herself at the time of her visit, rather than verbally hearing the results over the phone. 2. Record review of the admission record revealed Resident #1 was a [AGE] year-old female originally admitted on [DATE]. Record review of the quarterly MDS, dated [DATE], revealed Resident #1 had a BIMS summary score of 14, indicative of intact cognition. Resident #1's primary medical condition that best described the primary reason for admission was medically complex conditions related to urinary tract infection. Other active diagnoses included non-Alzheimer's dementia. Record review the care plan revealed Resident #1 had interventions to monitor labs as per MD orders, and report results to MD under the following problem areas: at risk for complications related to hyperlipidemia with a revision date of 1/30/2024; delirium or acute episodes of confusion with a revision date of 1/30/2024; fluid overload or potential fluid volume overload with a revision date of 1/30/2024; GERD [gastro-esophageal reflux disease, which is a digestive disorder that affects the ring of muscle between esophagus and stomach] with a revision date of 1/30/2024; cerebral infarction [stroke] with a revision date of 1/30/2024; dementia with a revision date of 1/30/2024; high risk for pressure injury development with a revision date of 1/30/2024; (continued on next page)

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F 0775 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Nurses Note dated 9/28/2023 at 2:44 PM authored by Nurse C reflected, notified [MD] of UA [urinalysis] results for Resident #1; new orders to start antibiotic for 7 days. [UA results not uploaded in medical records as of 5/28/2024, 243 days after notifying the MD of results.] Record review of [closest hospital lab] sheet with a fax confirmation time of 10/02/2023 at 10:20 AM revealed Resident #1's UA was collected 9/25/2024 at 4:15 PM. Included hand drawn initials for the physician, undated, on the mid- to bottom of the page. 3. Record review of the admission record revealed Resident #48 was a [AGE] year-old male originally admitted on [DATE]. Resident #48's primary diagnosis was pneumonia and secondary diagnosis was sepsis, with acute respiratory failure. Other diagnoses included down syndrome, anemia, and GERD. Record review of Nurses Note dated 2/20/2024 at 5:38 AM authored by Charge Nurse A reflected Resident #48 had venipuncture to left forearm, pending labs to be taken to [closest hospital lab]. Record review of [closest hospital lab] sheet with a fax confirmation time of 2/20/2024 at 9:07 AM revealed Resident #48's blood draw was collected 9/25/2024 at 4:15 PM. Includes hand drawn initials for the physician, undated, on the mid- to bottom of the page. [Lab results not uploaded in medical records as of 5/28/2024; 98 days from receipt.] 4. Record review of the admission record revealed Resident #66 was a [AGE] year-old female originally admitted on [DATE]. Resident #66's primary diagnosis was dementia. Other diagnoses included psychotic disorder with delusions and high blood pressure. Record review of [closest hospital lab] sheet with a fax confirmation time of 2/20/2024 at 3:14 PM revealed Resident #66's blood draw was collected 2/20/2024 at 6:00 AM. Includes hand drawn initials for the physician, undated, on the mid- to bottom of the page. [Lab results not uploaded in medical records as of 5/28/2024, 98 days from receipt] 5.Record review of the care plan revealed Resident #15 was a [AGE] year-old male, admitted [DATE]. Diagnoses included chronic heart failure, repeated falls, and high cholesterol. Record review the care plan revealed Resident #15 had interventions to monitor labs as per MD orders, and report results to MD under the following problem areas: at risk for complications related to hypercholesterolemia and hyperlipidemia with a revision date of 1/29/2024; heart failure with a revision date of 10/30/2023; dehydration or potential fluid deficit with a revision date of 10/30/2023; fluid volume overload related to heart failure with a revision date of 10/30/2023; GERD with a revision date of 10/30/2023. Record review of [closest hospital lab] sheet with a fax confirmation time of 2/20/2024 at 11:37 AM revealed Resident #15's blood draw was collected 2/20/2024 at 6:00 AM. Includes hand drawn initials for the physician, undated, on the mid- to bottom of the page. [Lab results not uploaded in medical records as of 5/28/2024, 98 days from receipt.] (continued on next page)

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F 0775 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview and record review on 5/30/2024 at 3:26 PM, the DON stated, lab work results were scanned in to the EHR by a Medical Records clerk. The DON brought a stack of papers, stating this is everything (lab work) that has not yet been scanned in so far. Review of this stack of papers revealed the earliest date in the stack of papers went back to as far as September 2023, but mostly held February 2024 lab results. The DON stated where she found the stack of lab work results was not considered a part of the medical records. The DON stated the Medical Records clerk was admitted ly behind in scanning all manner of records. The DON stated providers would expect to find the most recent labs in the EHR in scanned in under the miscellaneous tab, and the file to be named appropriately. The DON stated no one would reasonably be expected to search elsewhere for lab work results. In an interview on 5/31/2024 at 4:51 PM, the DON stated the MD was on site every Friday to round and sign paperwork. The DON stated she expected lab results to be scanned in to EHR no later than the following Monday. The DON stated, the nurses call the MD as soon as labs came in via the fax machine. The DON stated, the MDS Nurse had access to [closest hospital lab] network to pull labs and other pertinent data, for the residents. The DON stated this was why the nurses note was before the official fax came in for Resident #1. The DON stated she believed that whenever a fax came in, which ever nurse was on duty was very aware and conscientious to contact the MD immediately of any abnormal results. The DON stated the risk for not having the paperwork in the EHR was that providers need complete and accurate up to date data to make informed decisions for treatment plans for the residents. Record review of the Laboratory Policy, undated, indicated, Once the physician has indicated that the lab results have been reviewed, the original lab result will be forwarded to the director of nursing for review, then scanned into the resident's clinical record.