STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675960	A. Building B. Wing	03/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Castle Pines Health and Rehabilitation	2414 W Frank Ave Lufkin, TX 75904

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46273 Based on observation, interviews and record review, the facility failed to develop and implement a comprehensive person-centered care plan for each resident, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs, for 1 of 6 residents (Resident #41) reviewed for comprehensive care plans. The facility failed to care plan Resident #41's refusals to allow staff to perform tracheostomy (a hole that surgeons make through the front of the neck and into the windpipe (trachea)) care. The facility failed to care plan Resident #41's desire to perform her own tracheostomy care. These failures could affect residents by placing them at risk of not receiving appropriate interventions to meet their current needs. Findings include: Record review of a facility face sheet dated 3/26/24 for Resident #41 indicated that she was a [AGE] year-old female admitted to the facility on [DATE] with diagnosis of acute respiratory failure with hypoxia (a serious condition that causes fluid to build up in your lungs; it results in low oxygen in the blood). Record review of a Comprehensive MDS assessment dated [DATE] for Resident #41 indicated that she had a BIMS score of 12, which indicated that she had a moderate cognitive impairment. Section O indicated that Resident #41 received tracheostomy care. Record review of a Comprehensive Care Plan dated 3/24/24 for Resident #41 did not address that resident was safe to perform own tracheostomy care, that she often refused staff to perform tracheostomy care, or that she was performing it on her own. Review of a physician order report dated 3/24/24 for Resident #41 indicated that she had the following physician orders: Tracheostomy care every day and evening shift; and Tracheostomy care every 6 hours as needed. Record review of Resident #41's electronic medical record indicated there was no safe assessment for her to safely perform her own tracheostomy care. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of a physician order dated 2/29/24 for Resident #41 indicated that she had the following order: Augmentin Oral tablet 500-125 mg. Give 1 tablet by mouth two times a day for infection until 3/10/24. Record review of a Skin/Soft-Tissue Infection or Cellulitis Note dated 3/4/24 for Resident #41 indicated that the location of infection was stoma/trach (a hole in the windpipe). During an observation and interview on 3/24/24 at 3:41 pm Resident #41 was observed lying in bed, head of bed elevated, with overbed table in front of her. An opened tracheostomy care kit was on table, and she was cleaning her inner cannula without wearing gloves. Resident #41 said that she always performed her own tracheostomy care. Hand sanitizer was observed on the table next to the tracheostomy care supplies. During an interview on 3/14/24 at 3:50 pm LVN B said that Resident #41 was very particular and would not allow nurses to perform her tracheostomy care. She said that she had educated her multiple times on the risks, but that Resident #41 continued to insist on performing it herself. She said that Resident #41 never wore gloves because she claimed that her hands were sterile. During an interview on 3/25/24 at 3:45 pm LVN C said Resident #41 preferred to perform her own tracheostomy care and normally would not allow the nurses to do it. She said she had educated her multiple times on the risks, but Resident #41 was very adamant that she knew what she was doing. During an interview on 3/25/24 at 4:00 pm Resident #41 said that staff would bring her the kits to perform her own tracheostomy care and that she has had the tracheostomy care for about 8 years. She said, I know what I am doing. She said she was aware of the risks and that staff would tell her all the time about the risk of infection. She said she had not had any issues with infections. During an interview on 3/25/24 at 4:30 pm DON said that the staff were educating Resident #41 often on risks but that she preferred to do her own tracheostomy care despite the risks, and she was very noncompliant. During an interview on 3/26/24 at 8:45 am DON said that Resident #41's physician was aware of her performing her own tracheostomy care. She said that Resident #41 could be at increased risk of infections by performing her own tracheostomy care. During an interview on 3/26/24 at 12:07 pm DON said that if resident care plans were not comprehensive or did not include all needed care, then residents could be at risk of not getting the needed care or interventions and could lead to possible decline. She said going forward, they now have a Performance Improvement Plan in place, and she would be ensuring that care plans were completed appropriately and timely. She said she thought that Resident #41's tracheostomy care refusals and performing her own tracheostomy care had been care planned prior to surveyor entrance, but it must have just gotten missed. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a joint interview on 3/26/24 at 12:20 pm MDS G and MDS H both said they normally take just one day a week, print off a roster and check the names off as they go while doing care plans so they can keep up with who they have done. MDS G said she reviewed admitted s and would set target dates from there. MDS H said they may be able to make a calendar to help them keep up and add residents to the calendar as soon as they come in. MDS H said that floor staff may not know how to care for residents if the care plans were not completed and contain needed information. During an interview on 3/26/24 at 12:30 pm CNA F said that she cared for Resident #41 often. She said Resident #41 was very independent and liked to do her own tracheostomy care. She said she had never watched her do it as she was not a nurse but that she knew she did wash her hands frequently when she was out of bed, and she kept hand sanitizer nearby to use when she was in the bed. Record review of a facility policy titled Comprehensive Care Planning undated read .In situations where a resident's choice to decline care or treatment (e.g., due to preferences, maintain autonomy, etc.) poses a risk to the resident's health or safety, the comprehensive care plan will identify the care or service being declined, the risk the declination poses to the resident, and efforts by the interdisciplinary team to educate the resident and the representative, as appropriate. The facility's attempts to find alternative means to address the identified risk/need should be documented in the care plan .

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47339 Based on observation, interview and record review, the facility failed to ensure the resident environment remained as free of accident hazards as was possible and each resident received adequate supervision to prevent accidents for 1 of 1 resident (Resident #13) reviewed for accidents and hazards. The facility failed to ensure Resident #13 was provided with adequate supervision to prevent her from falling off the mechanical lift of the facility van on 02/28/24. The non-compliance was identified as past non-compliance. The Immediate Jeopardy (IJ) began 02/28/24 and ended on 03/05/24. The facility corrected the non-compliance before survey began. This failure could place residents at risk of harm and serious injuries due to lack of supervision and failure to follow protocols. Findings included: Record review of Resident #13's Face sheet undated revealed she was admitted to the facility on [DATE]. Resident #13 was a [AGE] year-old female admitted with diagnosis of anemia (low red blood cells), end stage renal disease (kidneys cease to function), dependence on renal dialysis (procedure to remove waste products and excess fluid from the blood when the kidneys stop working). Record review of Resident #13's significant change in status MDS assessment dated [DATE] revealed she had a BIMS score of 13 indicating no cognitive impairment. The MDS Assessment indicated Resident #13 was dependent with chair/bed-to-chair transfers. The MDS Assessment indicated Resident #13's car transfer was not attempted. Record review of Resident #13's care plan dated 12/22/2023 and revised on 02/12/2024 revealed: Resident #13 was at risk for falls related to impaired mobility, incontinent status with interventions that included Mechanical lift x2 to assist with transfers. Resident #13 has limited physical mobility related to generalized weakness with interventions that included The resident requires x1 staff participation for mobility and the resident uses wheelchair for locomotion. Record review of incident report dated 02/28/2024 revealed: nurse was called outside to the facility van resident was lying on right side on ground just behind van. Head to toe assessment done resident was assisted back in the w/c and brought into building. 14. Initial treatment/New orders revealed: assessment done sent to hospital for further evaluation. 15. Resident Statement revealed: I tipped over backwards and fell . Record review of the facility's Provider Investigation report dated 02/28/2024 revealed the following: (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	[Resident#13] was being unloaded in the van using the lift. The seatbelt came unfastened and [Resident #13's] wheelchair tipted backwards causing [Resident #13 to fall backward hitting her head on the pavement. No bruising cuts, abrasions were noted. [Resident #13] complained of head pain. V/S WNL, pupils reactive, [Resident #13] was alert and oriented x4. [Resident #13] was sent to ER via ambulance. Record review of hospital medical records dated 3/1/24 revealed Resident #13 was transferred from local hospital to higher level of care hospital via helicopter on 2/28/24 with multiple trauma injuries: right subdural hematoma with 3mm leftward shift, T1 (first bone in the spinal column) acute compression fracture and T4 (fourth bone of the spinal column) acute compression fracture. During an interview on 03/24/24 at 10:38 AM Resident # 13 said she was returning from dialysis on 02/28/2024 when Van Driver D pulled into the facility and drove around to the back of the facility which is not where she was normally unloaded. Resident #13 said she was normally unloaded at the front of the facility. She said Van Driver D was unloading her from the van and was not paying attention and did not click the seat belt to hold her in. Resident #13 said Van Driver D started lowering the van lift and about halfway down to the ground she heard Van Driver D say, uh oh and then she fell off the lift and hit the ground on her head. Resident #13 said after she fell staff had come outside and were debating on if they should send Resident #13 to the hospital. Resident #13 said staff picked her up and put her back in her w/c and took her inside the facility. She said once she was back in the facility that is when the facility decided to send her to the ER. Resident #13 said she went to the local hospital and was life flighted to another hospital. Resident #13 said the facility was blaming the incident on her bag that hangs on the back of her w/c for dialysis. Resident #13 said the dialysis bag had nothing to do with the fall and Van Driver D was just not paying attention to what she was doing. Resident #13 said Van Driver D admitted that it was her fault that Resident #13 had fallen. During an interview by phone on 03/24/24 at 11:56 AM Van Driver D said that on 2/28/24 she had parked the van at the end of 500 hall to unload residents off the van. Van Driver D said it was cold outside that day so she parked the van at the end of 500 hall so residents would be closer to their rooms when she unloaded them. She said Resident #13 was on the lift and was about halfway down about even with the van bumper when all of a sudden, Resident #13 fell off of the lift. Van Driver D said she did not remember if the seat belt was latched or not. She said then she ran inside and got the nurse to come and assess Resident #13. She said Resident #13 was brought back inside the building and then sent to the ER. She said the facility had done education with her prior to the incident on how to properly load and unload a resident. Van Driver D said she had not driven the van since the incident. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview and observation on 3/24/2024 at 2:30 pm Van Driver E said he had worked at the facility for about 3 years and was the van driver prior to Van Driver D. Van Driver E said he had taken over transporting residents since the incident on 02/28/2024. Van Driver E demonstrated the process for unloading a resident using the wheelchair mechanical lift. Prior to placing the resident on the lift, the Van Driver E did a safety check of the safety belt by latching and pulling on belt to ensure it was fastened. He then stood on the lift to ensure it was secure. Van Driver E then placed resident on the lift by rolling the resident from the interior of the van onto the lift ramp. Van Driver E secured the wheelchair by locking the wheels, checked the safety belt again to ensure it was secured and fastened, placed the resident's hands on the bars and left all resident belongings or bags in the van until the resident was unloaded. Van Driver E stood behind the wheelchair with hands on the grips as he lowered the resident from the van. Van Driver E said the Maintenance Director had done all of the training with Van Driver D prior to her driving the van. Van Driver E said he rode with Van Driver D for her first week of transporting and did not have any concerns. During an interview on 03/26/24 at 10:25 AM Van Driver D said she had worked at the facility since 1/2024. She said on 2/28/24 she parked at the end of 500 hall to unload Resident #13. Van Driver D said she had two other residents on the van that she unloaded first without incident. She said she went to open the facility door for the first two residents that she had already unloaded and then came back to the van to unload Resident #13. She said the ramp was already down with the seat belt latched. She said she raised the lift back up and went to unbuckle Resident #13 from inside the van. Van Driver D said she rolled Resident #13 back on to the lift with Resident #13 facing the windshield and locked her wheelchair brakes. She said she had already latched the seat belt previously, so she did not latch it again. Van Driver D then said she is not a hundred percent sure she latched the seatbelt because it becomes like muscle memory and said she did not remember seeing if the seatbelt was latched. She said she was standing outside of the van and started lowering the lift. She said when the lift was about halfway down level with the van bumper, Resident #13 and her w/c fell off the back of the lift. Van Driver D said she tried to catch the resident but was not able to. She said she did not move Resident #13; she ran inside to get the nurse. Van Driver D said she stayed with Resident #13 until she was sent out to the hospital. Van Driver D said she had not driven the van since the incident. Van Driver D said she had been given a new job title of hospitality aide and would no longer be driving the van. During an interview and observation on 03/26/24 at 10:42 AM The Maintenance Director said he had worked at the facility since 2013. He said he did not witness the incident with Resident #13 on 02/28/2024. He said he inspected the van after the incident on 02/28/2024 and did not find any issues with the van. He said he inspects the van every Friday. He said the drivers were to inspect the van daily before transporting any residents. The Maintenance Director said prior to placing a resident on the lift, the Van Driver should do a safety check of the safety belt by latching and pulling on belt to ensure it was fastened. The Maintenance Director demonstrated the lift being raised and lowered to demonstrate the safety features of the lift. The Maintenance Director demonstrated that if anything touches the back ramp of the lift the lift will automatically stop moving. The Maintenance Director said he had completed Van Driver D's van training upon hire before transporting any residents and had no concerns. During an interview on 03/26/24 at 11:08 AM the DON said she had been the DON for 6-7 years. She said her expectation is for all residents to arrive timely and safely to appointments. She said she had not been trained on the facility van. She said she expects all van drivers to be trained and follow the policy and procedures when loading/unloading residents. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 03/26/24 at 11:11 AM the Regional Nurse Consultant said she expects van drivers to follow policy and procedures and protect the residents when transporting. During an interview on 03/26/24 at 11:11 AM the ADO said he expects van drivers to follow policy and procedures and protect the residents when transporting. During an interview on 03/26/24 at 11:11 AM the Administrator said she expects van drivers to follow policy and procedures of loading/unloading residents and protect the residents when transporting. Record review of employee disciplinary report revealed: Van Driver D was placed on investigatory suspension pending an investigation into allegations of resident treatment on 02/28/2024. Record review of witness statement provided by Van Driver D on 02/28/2024 at 3:30 PM revealed: [Resident #13] was in the van, and I had unlocked her straps and seatbelt. I pushed her back onto the ramp, and locked her wheels. Coming halfway down, the seatbelt popped off, and her chair went back. Her wheels were locked. She then fell backward and landed on her side and hit the back of her head. I didn't want to risk moving her, so I ran inside and got a nurse and aides. They checked her and got her up. She didn't have any obvious injuries other than a bump on her head. They brought her inside and sent her to the hospital. Signed by Van Driver D. Record review of witness statement provided by the Maintenance Director undated revealed: February 28, 2024. I [Maintenance Director] did investigate with a wheelchair on the lift in the van it flipping over. I tried using my legs and hands pushing back against it trying to flip the wheelchair to flip over. The wheelchair never flipped over. I tried this using the seatbelt and not using the seatbelt. Both actions produced the same thing of not flipping over. Signed by the Maintenance Director. Record review of a witness statement provided by the DON undated revealed: On Saturday 03/02/2024, I was working as a CNA covering 500 hall. Myself and the ADON, was making rounds and went into [Resident #13's] room to check on her. We spoke to her regarding the incident on the van .I then asked if she remember the van driver locking her wheels and securing the seatbelt behind her, she replied yes, but they must have come undone, because when she started lowering me down, I started rolling back and flipped out of my chair backwards and landed on the ground. Signed by the DON. Record review of vehicle inspection report dated 02/23/2024 revealed: 1. Seat belts clean and in good working condition was marked acceptable. 2. Wheelchair tie-downs inspected and working properly was marked acceptable. Vehicle inspector: Van Driver E/Maintenance Director. Record review of personnel file for Van Driver D revealed, Van Driver D had completed all employee auto training on 01/05/2024. Record review of the facility Employee Auto Training Handbook undated revealed: Wheelchair lifts make it possible to load wheelchairs of all weights in an efficient and safe manner. However, lifts are potentially hazardous equipment. They must be maintained and operated properly. Considerable caution and awareness is needed when operating a lift. Unloading: 4. Staff will stand behind wheelchair and will pull the resident onto the lift, lock brakes, place seatbelt around the rider (if available) and encourage the rider to hold handrails (if available). Staff will then lower the lift to ground until completely on the ground before unloading resident from the lift. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of QAPI notes dated 02/28/2024 indicated that the meeting was attended by the following members: Administrator, DON, ADON, Medical Director, Social Services, Dietary, MDS nurse, Activity Director, Assistant Business Office Manager, Human Resources Coordinator, Therapy, Maintenance Director and Medical Records. The interventions and plan for correction included: 1. Self report to HHSC. 2. The facility van was removed from service on 2/28/24. 3. On 2/28/24 & 2/29/24 the Maintenance Director and Administrator tested the lift with a staff member in a wheelchair to ensure that nothing was causing the wheelchair to tip. 4. No resident transport in the facility van until it has been assessed by maintenance staff for proper functioning of all safety devices/equipment. 5. Suspend known perpetrators immediately pending investigation. 6. Take statements from everyone involved or with potential knowledge/involvement. 7. Begin Abuse/Neglect in-service and/or assign course regarding abuse/neglect for all staff who transport or assist with transporting residents in the van. 8. The Maintenance Director and/or designee verified that all resident's wheelchair locks are functioning properly. 9. Inservice staff who transport or assist with transporting resident in the van on the following (with return demonstration): Staff members not inserviced will not transport residents. a. How to safely load and unload resident in the van using the lift. b. Insure when lift safety belt is buckled you hear an audible click. Once clicked, pull the belt as to try and pull it out of the buckle. If no click heard or the belt pulls loose from the buckle, notify the administrator and maintenance director immediately and do not attempt to lift or lower resident. c. When loading or unloading a resident, make sure the vehicle is parked on as flat a surface as possible. d. Properly securing a resident in the van. 10. Inservice all nursing staff to report immediately to the maintenance director if a resident's wheels do not lock once engaged . 11. Maintain a list of staff who have completed training and provided return demonstration regarding transporting a resident in the van. Staff not listed will not transport residents. 12. Complete risk management entry as other in Point Click Care. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of sign in sheets for in-service dated 2/28/24 through 3/5/24 indicated that 64 staff members had signed the sign in sheet for the in-service on Abuse & Neglect P&P. Record review of sign in sheets for in-service dated 2/28/24 indicated that 58 staff members had signed the sign in sheet for the in-service on Report immediately to the Maintenance Director any loose, broken, missing brakes on w/c that do not engage. Record review of sign in sheets for in-service dated 2/28/24 indicated that 3 staff members had signed the sign in sheet for the in-service on Securing Residents in Van. Record review of sign in sheets for in-service dated 2/28/24 indicated that 3 staff members had signed the sign in sheet for the in-service on When loading or unloading a resident make sure the vehicle is parked on as flat a surface as possible. Record review of sign in sheets for in-service dated 2/28/24 indicated that 3 staff members had signed the sign in sheet for the in-service on Ensure when the lift safety belt is buckled you hear an audible click. Record review of sign in sheets for in-service dated 2/28/24 indicated that 3 staff members had signed the sign in sheet for the in-service on No Bags, Luggage or other storage containers are to be on w/c during loading and unloading residents. Record Review of Van Driver D re-education on Employee Auto Training Handbook completed dated 2/28/24. Record review of Van Incident Monitoring dated 2/29/24 through 3/22/24 revealed 5 resident wheel chairs each week were checked to ensure brakes are functioning properly, and 5 instances a week of loading/unloading of a resident using the van lift to ensure the lift was used correctly. On 3/25/24 at 9:32 am the Administrator, and DON were informed of IJ. The non-compliance was identified as past non-compliance. The IJ began on 2/28/24 and ended on 3/5/24. The facility had corrected the noncompliance before the investigation began.

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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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46273 Based on observation, interview, and record review the facility failed to ensure that a resident who needs respiratory care is provided such care consistent with professional standards of practice, the person-centered care plan, and residents' goals and preferences for 2 of 12 residents (Residents #41 and #81) reviewed for respiratory care. The facility failed to ensure that Resident #41 was safe to perform her own tracheostomy (a hole that surgeons make through the front of the neck and into the windpipe (trachea)) care. The facility failed to ensure Resident #81's nebulizer mask was dated and stored properly between use. These failures could place residents requiring respiratory therapy at risk of hypoxia, infections and not receiving prescribed care and services. Findings include: 1. Record review of a facility face sheet dated 3/26/24 for Resident #41 indicated that she was a [AGE] year-old female admitted to the facility on [DATE] with diagnosis of acute respiratory failure with hypoxia (a serious condition that causes fluid to build up in your lungs; it results in low oxygen in the blood). Record review of a Comprehensive MDS assessment dated [DATE] for Resident #41 indicated that she had a BIMS score of 12, which indicated that she had a moderate cognitive impairment. Section O indicated that Resident #41 received tracheostomy care. Record review of a Comprehensive Care Plan dated 3/24/24 for Resident #41 did not address that resident was safe to perform own tracheostomy care, that she often refused staff to perform tracheostomy care, or that she was performing it on her own. Review of a physician order report dated 3/24/24 for Resident #41 indicated that she had the following physician orders: Tracheostomy care every day and evening shift; and Tracheostomy care every 6 hours as needed. Record review of Resident #41 electronic medical record indicated there was no safe assessment for her to safely perform her own tracheostomy care. Record review of a physician order dated 2/29/24 for Resident #41 indicated that she had the following order: Augmentin Oral tablet 500-125 mg. Give 1 tablet by mouth two times a day for infection until 3/10/24. Record review of a Skin/Soft-Tissue Infection or Cellulitis Note dated 3/4/24 for Resident #41 indicated that the location of infection was stoma/trach (a hole in the windpipe). (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675960	A. Building B. Wing	03/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Castle Pines Health and Rehabilitation	2414 W Frank Ave Lufkin, TX 75904

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and interview on 3/24/24 at 3:41 pm Resident #41 was observed lying in bed, head of bed elevated, with overbed table in front of her. An opened tracheostomy care kit was on table, and she was cleaning her inner cannula without wearing gloves. Resident #41 said that she always performed her own tracheostomy care. Hand sanitizer observed on table next to tracheostomy care supplies, Resident #41 was not observed using hand sanitizer, she simply said that her hands were already clean. During an interview on 3/14/24 at 3:50 pm LVN B said that Resident #41 was very particular and would not allow nurses to perform her tracheostomy care. She said that she had educated her multiple times on the risks of not wearing gloves, but that Resident #41 continued to insist on performing it herself. She said that Resident #41 never wore gloves because she claimed that her hands were sterile. During an interview on 3/25/24 at 3:45 pm LVN C said Resident #41 preferred to perform her own tracheostomy care and normally would not allow the nurses to do it. She said she would document refused on the treatment record when she cared for Resident #41, and she would not allow her to perform it. She said she had educated her multiple times on the risks, but Resident #41 was very adamant that she knew what she was doing. During an interview on 3/25/24 at 4:00 pm Resident #41 said that staff bring her the kits to perform her own tracheostomy care and that she has had the tracheostomy care for about 8 years. She said, I know what I am doing. She said she was aware of the risks and that staff would tell her all the time about the risk of infection. She said she had not had any issues with infections. During an interview on 3/25/24 at 4:30 pm DON said that the staff educated Resident #41 often on risks but that she preferred to do her own tracheostomy care despite the risks, and she was very noncompliant. DON said she would educate Resident #41 again on the risks and if she wished to continue performing her own care she would have her sign a Negotiated Risk Assessment form. During an interview on 3/26/24 at 8:45 am DON said that Resident #41's physician was aware of her performing her own tracheostomy care. She said that Resident #41 could be at increased risk of infections by performing her own tracheostomy care. Record review of a Negotiated Risk Agreement dated 3/25/24 and signed by Resident #41 and DON indicated that resident had been informed of risks of providing own trach care such as respiratory failure, risk of infection, choking and death. Resident signed form acknowledging that she had been informed of the risks and that she would continue to perform own trach care. Record review of an attestation dated 3/20/24 indicated that Resident #41 desire to continue performing her own tracheostomy care despite being educated on the risks was discussed in a QAPI meeting with physician on 3/20/24. 2. Record review of facility face sheet dated 3/25/2024 indicated Resident # 81 was [AGE] years old and was admitted to the facility on [DATE] with diagnosis of dementia. Record review of admission MDS assessment dated [DATE] indicated Resident # 81 had a BIMS of 10 indicating moderately impaired cognition. (continued on next page)

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	675960	A. Building B. Wing	03/26/2024

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of a comprehensive care plan dated 10/02/2023 indicated Resident # 81 had shortness of breath and to monitor and treat as needed. Record review of a physician order dated 10/02/2023 revealed Resident #81 had an order for budesonide inhalation suspension one inhalation two times a day for shortness of breath. Record review of consolidated physician orders dated 3/25/2024 revealed no order for changing Resident #81's nebulizer mask. During an observation and interview on 03/24/24 at 10:32 AM Resident # 81 had a nebulizer mask laying on her bedside table that was not bagged and the tubing was not dated. She said the nurse changed the nebulizer last week some time and she used her nebulizer at least two times a day. She said there had not been a bag for the mask to go into that she recalled, and it just lays on her table. During an observation on 3/26/2024 at 9:00 AM Resident #81 had a nebulizer mask laying on her bedside table that was not bagged for storage. During an interview on 03/26/24 at 09:30 AM LVN C said she had worked at the facility for one year. She said residents that received nebulizer treatments should have an order for the medicine and for a weekly change in the mask. She said when the nebulizer mask was changed it should be signed off on the treatment record and then dated and placed in a plastic bag. She said that she was not aware that Resident #81 did not have an order to change her nebulizer mask weekly and that it was not properly stored. She stated Resident #81 did have a plastic bag for her mask, but it was in her bedside table drawer. She stated if nebulizer masks were not changed and stored properly it could cause infections. During an interview on 03/26/24 at 9:46 AM the DON stated that all nebulizer orders were the responsibility of the nurse entering the order and the order should include a weekly change of the mask. She stated the nebulizer mask should be dated when it was changed and then placed in a plastic bag after use. She stated she and the ADON made rounds daily to check for oxygen and nebulizers and they must have missed Resident #81's not being dated and bagged. She stated she expected the staff to follow the facility policy for nebulizers to prevent cross contamination. During an interview on 3/26/24 at 11:32 am Administrator said that residents performing their own tracheostomy care could be at risk of possible obstruction and causing problems with the tracheostomy leading to breathing problems. She said going forward they would provide more education to nurses and residents on the increased risks. She said they might possibly have staff members observe her while doing tracheostomy care if Resident #41 would allow it. She said she would have staff keep the physician notified of any changes or incidents with Resident #41's tracheostomy care. She said that nebulizer masks not being dated and bagged could also lead to increased risks of infections. She said she would educate staff on dating and bagging masks and ensure that it was done going forward. Record review of a facility procedure titled Tracheostomy Care Procedure dated 2003, revised on 10/19/09 read .Tracheostomy care is a procedure designed to maintain a patient airway and a sterile/clean area in and around a patient's tracheostomy. This procedure is performed using aseptic (clean) technique at least every 12 hours and as needed .the procedure requires 2 people . (continued on next page)

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	675960	A. Building B. Wing	03/26/2024

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of a facility policy titled Breathing Therapy Devices dated 2/13/2007 indicated, .7.store in a clean plastic bag for future use . 46436

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40124 Based on observation, interview, and record review, the facility failed to ensure that the menu was followed for 2 out of 2 meals (the lunch meal on 03/25/24 and breakfast 03/26/24) reviewed for food and nutrition services. The facility failed to ensure residents (Resident # 8 and Resident #150) were served margarine listed on the menu during the lunch meal on 03/25/24 and breakfast 03/26/24. This failure could place residents at risk for unwanted weight loss and decrease satisfaction with meals. Findings included: Review of Resident #8's face sheet, dated 03/26/24, reflected he was an [AGE] year-old male who admitted to the facility on [DATE]. His diagnosis included muscle weakness, difficulty walking and lack of coordination. Review of Resident #8's Admission MDS Assessment, dated 02/15/24, reflected he had a BIMS of 14 indicating he was cognitively intact and required set up service only for meals. Review of Resident #8's Physician Order summary for March 2024 indicated an order for a regular no salt on table diet. Review of Resident #150's face sheet, dated 03/26/24, reflected she was a [AGE] year-old female who admitted to the facility on [DATE]. Her diagnosis included protein calorie malnutrition (lack of protein intake) and pneumonia (lung infection). Review of Resident #150's Admission MDS Assessment, dated 02/14/24, reflected she had a BIMS of 15 indicating she was cognitively intact and required set up service only for meals. Review of Resident #150's Physician Order summary for March 2024 indicated an order for a regular diet. Review of the facility's menu for the lunch meal on 03/25/24 revealed margarine was listed. Review of the facility's menu for the breakfast meal on 03/26/24 revealed margarine was listed. During an interview on 03/24/24 at 11:04 AM with family and Resident #8, family of Resident #8 said he was admitted to the facility for therapy after surgery on his leg for fracture. Resident #8 said he rarely gets his margarine for a roll, and it will be listed on the sheet of paper (listing all items given to him with meals that comes with the meal). (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 03/25/24 at 12:30 PM, lunch trays for 6 residents on 100 hall did not receive any margarine on the trays and it is listed on all of the tray cards. Record review of a tray card for Resident #8 reflected regular diet margarine is listed on the tray card but was not provided. During an observation and interview on 03/26/24 at 08:01 AM, CNA A was passing out breakfast trays on the 200 hall. CNA A said that the kitchen staff checks the trays for accuracy and puts the condiments on the trays. She said the nursing staff do not add any items before passing them out to the residents. During an observation on 03/26/24 at 08:05 AM breakfast trays for 6 residents on the 100 hall, there was no margarine for the toast and oatmeal on the 6 trays. All 6 tray slips indicated margarine was to be served. During an observation and interview on 03/26/24 at 08:10 AM Resident #150 was eating from her breakfast tray, there was no margarine on the tray. Resident #150 said she did not get margarine today for her toast and oatmeal. She said it is listed on her tray card to be included with her meal. She said that happens a lot, but she hates to complain about it. During an observation and interview on 03/26/24 at 08:15 AM with Dietary Director, a large bowl of margarine packets was sitting by the window in the kitchen. The Dietary Director asked the Cook why the margarine was not on the trays, and he shrugged his shoulders. The Dietary Manager said that the margarine should be added to the trays as they are made in the kitchen and should be verified by the nursing staff when they check the tray cards. The Dietary Director said the condiments such as margarine should be provided as indicated on the tray card because they are a part of the diet orders for the daily menus and provide additional calories. Not getting condiments could keep the residents from enjoying meals. During an interview on 03/26/24 at 11:30 AM the Administrator said the facility started a performance improvement plan regarding the residents not receiving the condiments on the menu. The Administrator provided a Dietary Performance Improvement Activity Plan to begin on 3/25/24 with action items of condiments will be available and provided per resident choice, Goal: Ensure safe and palatable meals and the Dietary Manager and the Administrator are responsible. The Administrator said not getting the condiment could cause the residents not to enjoy their meals. Record review of an undated Facility policy titled Resident Meal Service and Hour of Sleep snack indicated, . 1.Upon admission and periodically thereafter, the resident and or family member will be interviewed by the dietary manager or designee to determine individual Food preferences, dislikes and allergies resident preferences will be honored .

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49017 Based on observation, interview, and record review, the facility failed to store and distribute food in accordance with professional standards for food service safety in 1 of 1 kitchen. The facility failed to store foods in accordance with professional standards. The facility failed to date opened items placed in the refrigerator and correctly date dry storage items in the kitchen. These failures could place residents who ate the food from the kitchen at risk for food-borne illness. Findings include: During an observation and interview on [DATE] at 9:15 AM the refrigerator contained a plastic container of a thickened white liquid and a large square plastic container with a red lid that had a gelatin type substance inside that was not dated. The dietary manager identified the white liquid as thickened milk. She said that both items were recently made. During an observation and interview on [DATE] at 9:30 AM, the large plastic dry goods storage for sugar and breadcrumbs had a label with an open date of [DATE] and good by date of [DATE]. The dietary manager said that the items were not out of date and that the containers were just filled and that the labels were not changed when the containers were last filled. During an interview on [DATE] at 09:30 AM dietary aide who has been working in the facility for 1 week said that any foods stored after opening or cooking must be labeled with date that is opened and date to be used by. She said that residents are at risk for food poisoning and getting sick if they eat food that is spoiled. During an interview on [DATE] at 09:35 AM with cook who has been working for the facility for 3 months, he said that after an item is placed in a container that can be closed or sealed a label is placed on the item with the open date and a use by date. He said that all items that are placed in the refrigerator and freezer must be dated. He said that residents could become ill and even die if they are given food past expiration date. During an interview on [DATE] at 09:45 AM with the dietary manager, who has been working at the facility for 8 months, she said that all foods that are placed in the refrigerator and freezer and any opened items in dry storage should have a label with the opening date and a use by date. She said that she expects the staff to label and put correct dates on products. She said that staff putting the food away is responsible for making sure that labels are on items. She said that the residents can get sick if expired foods are given to residents. She said that she plans on educating the staff on food storage and labeling and she plans to do monitoring of foods and labels the days that she is in the building. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on [DATE] at 10:00 AM with the administrator, she said that the dietary manager will be conducting inservices with the dietary staff on labeling and storage of foods in the kitchen. She said that the dietary manager will do daily checks of all items being stored and the administrator will do weekly rounds in the kitchen and will check labels of items being stored. She said that she expects the dietary manager to do frequent education with her staff. She said that improperly labeling food after opening puts the resident at risk for food borne illness. Record review of a facility policy titled Food Storage and Supplies dated 2012 indicated, .open packages are stored in closed containers .and dated as to when opened .

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43994 Based on observations, interviews, and record reviews, the facility failed to establish and 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 8 residents (Resident #23 and #24) and 1 of 5 staff (MA H) reviewed for infection control. MA H failed to perform hand hygiene during medication administration for Residents #23 and #24 on 3/25/2024. These failures could place residents at risk of exposure to communicable diseases and infections. Findings include: 1.Record review of an Admission Record for Resident #23 dated 3/25/2024 indicated he admitted to the facility on [DATE] and was [AGE] years old with diagnosis of dementia (a group of thinking and social symptoms that interfere with daily living), Type 2 diabetes, systolic heart failure (a heart failure that occurs in the bottom chambers of the heart) and BPH (enlarged prostate). Record review of a care plan for Resident #23 revised on 2/12/2024 indicated he had a current pressure ulcer with potential for further pressure that included interventions to administer medications as ordered. Record review of an active physician order summary report dated 3/26/2024 for Resident #23 indicated he had an order that the facility may crush medications or open capsules as needed unless contraindicated (no reason to), Record review of an Admission MDS assessment for Resident #23 dated 12/31/2023 indicated he had moderate impairment in thinking with a BIMS score of 11. During a medication pass observation on 3/25/2024 at 8:05 Am, MA H did not sanitize or wash her hands before she took Resident #23's blood pressure. She unlocked the medication cart and took out his medications and placed them in a small plastic cup. She locked the medication cart and reentered the room of Resident #23 and administered the medications to him. She exited the room and did not wash or sanitize her hands. 2. Record review of an Admission Record for Resident #24 dated 3/26/2024 indicated she admitted to the facility on [DATE] and was [AGE] years old with diagnosis of type 2 diabetes, lymphedema (swelling caused by a blockage) and major depressive disorder (persistent feeling of sadness or loss of interest). Record review of an Annual MDS Assessment for Resident #24 dated 12/29/2023 indicated she had moderate impairment in thinking with a BIMS score of 11. (continued on next page)

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	675960	A. Building B. Wing	03/26/2024

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of a care plan for Resident #24 revised on 12/5/2021 indicated she was on diuretic (fluid medication) therapy that included interventions to administer medications as ordered. During a medication pass observation on 3/25/2024 at 8:17 AM, MA H did not wash or sanitize her hands before unlocking the medication cart to get medications for Resident #24. She placed the medications for Resident #24 into a small plastic cup and entered the room to administer the medications to Resident #24. While in Resident #24's room, Resident #24 questioned MA about the little pill and wanted to know why she did not get it. MA H told Resident #24 that she would check, and she left the room and reentered the medication cart without washing or sanitizing her hands and took out a furosemide 20 mg tablet (fluid pill) that should have been given at the time of the other medications. MA H administered the furosemide tablet to Resident #24. After MA H exited the room, she sanitized her hands. Record review of an active physician order summary report for Resident #24 dated 3/26/2024 indicated an order for furosemide 20 mg give one tablet one time a day by mouth for edema with a start date of 8/3/2021. During an interview on 3/25/2024 at 8:42 AM, MA H said she had been employed at the facility since November 2023 and worked the day shift from 6 am to 2 pm and always worked the same hall. She said another medication aide in the facility trained her and did a check off with her on medication administration. She said during the observation of medication pass, she should have sanitized her hands before she opened the cart, and before and after administering medications to each resident. She said sanitizer was in her cart, but she was nervous during the observation and did not sanitize her hands. She said residents could be at risk for transfer of germs and possible diseases. Record review of a Medication Aide Proficiency Audit dated 11/17/2023 for MA H indicated she demonstrated satisfactory proficiency with infection control and proper handwashing by the DON. During an interview on 3/26/2024 at 9:15 AM, the ADON said there were two ADON's and the DON at the facility that were responsible for conducting skill check offs with staff. She said the check offs were conducted on hire and annually. She said hand hygiene during medication administration should be conducted before, between, after each resident and any time hands were visibly soiled. She said residents could be at risk for infections with staff spreading germs by not washing or sanitizing their hands. During an interview on 3/26/2024 at 9:25 AM, the DON said there were two ADON's and herself that were responsible for conducting skill check offs with staff on hand hygiene. She said they tried to conduct them at least every quarter with each staff. She said hand hygiene during medication administration should be done before and after and anytime hands were visibly soiled. She said going forward, she would continue to educate with in-service training to the staff. She said residents could be at risk for contamination with viruses and infection if staff did not perform hand hygiene during medication administration. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/26/2024 at 9:30 AM, the Administrator said the ADON's, and the DON were responsible for providing education with in-service training and return demonstration to all staff on hand hygiene. She said hand hygiene during medication administration should be done before, after, and in between residents and any time going from dirty to clean. She said going forward they would continue to monitor for compliance and with return demonstration on hand hygiene. She said residents could be at risk for infections. Record review of a facility policy titled Fundamentals of Infection Control Precautions undated indicated, .A variety of infection control measures are used for decreasing the risk of transmission of microorganisms in the facility. 1. Hand Hygiene continues to be the primary means of preventing the transmission of infection, when coming on duty; before and after direct resident contact; upon and after coming in contact with a resident's intact skin; after completing duty .