

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675981	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/26/2024
NAME OF PROVIDER OR SUPPLIER Mineola Heights Healthcare Centre		STREET ADDRESS, CITY, STATE, ZIP CODE 716 Mimosa Street Mineola, TX 75773	

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)
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37495</p> <p>Based on interview and record review, the facility failed to ensure residents had the right to be free from abuse, neglect, misappropriation of resident property, and exploitation for 1 of 7 residents (Resident #150) reviewed for abuse.</p> <p>The facility failed to ensure LVN H did not verbally abuse Resident #150 during shift change.</p> <p>This failure could place residents at risk of abuse, humiliation, intimidation, fear, mental distress, depression, and decreased quality of life.</p> <p>Findings included:</p> <p>Record review of Resident #150's face sheet, dated 06/19/24, indicated he was an [AGE] year-old male who admitted to the facility on [DATE] with diagnoses of depressive disorder (mood disorder causing persistent sadness and a loss of interest), major depressive disorder with psychotic features single episode (mood disorder causing persistent sadness and a loss of interest along with hallucinations, delusions or a state of near-unconsciousness or insensibility), Parkinson's Disease (chronic and progressive disease that affects the brain and spinal cord causing tremors, slowness of movement, rigidity, and difficulty with balance), hypertension (high blood pressure), angina pectoris (chest pain or discomfort due to a lack of blood to the heart muscle), cerebrovascular accident (lack of blood flow or bleeding in the brain), acute myocardial infarction (blood flow to the heart muscle is abruptly cut off, causing tissue damage) and chronic diastolic congestive heart failure (the heart's left ventricle, main pumping chamber, becomes stiff and unable to fill properly). He was discharged from the facility on 07/17/23.</p> <p>Record review of Resident #150's Quarterly MDS assessment dated [DATE] indicated he was cognitively intact and used a wheelchair for mobility. Resident #150 had diagnoses of hypertension (high blood pressure), angina pectoris (chest pain or discomfort due to a lack of blood to the heart muscle), acute myocardial infarction (blood flow to the heart muscle is abruptly cut off, causing tissue damage), chronic diastolic congestive heart failure (the heart's left ventricle, main pumping chamber, becomes stiff and unable to fill properly), cerebrovascular accident (lack of blood flow or bleeding in the brain), Parkinson's Disease (chronic and progressive disease that affects the brain and spinal cord causing tremors, slowness of movement, rigidity and difficulty with balance) and depression (mood disorder causing persistent sadness and a loss of interest).</p> <p>(continued on next page)</p>

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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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of Resident #150's Care Plan revised on 03/12/23 indicated he had delirium or acute confusional episodes and interventions included to reassure and deescalate the situation. Resident #150 had an attention seeking behavioral problem related to perceived medical conditions that was initiated on 04/13/23 and interventions included to anticipate and meet his needs and to de-escalate by educating on condition, notify the doctor and reassure.</p> <p>A provider investigation report dated 07/07/23 completed by the previous Administrator indicated on 07/03/23 at 8:00 a.m., Resident #150 reported to the Administrator on 07/02/23 at 6:00 p.m. that he was at the nursing station during shift change while LVN H was giving report to the oncoming nurse. Resident #150 said LVN H told him to leave because he was pissing him off and he returned to his room. The Administrator sent LVN H a text message for him to call her. He did not return her calls and he responded back indicating he quit. LVN H LVN H did not return to the facility after he clocked out at the end his shift on 07/02/23. The facility conducted resident safe surveys and in-serviced staff on their Abuse/Neglect policy and the types of abuse. The facility confirmed the allegation of abuse.</p> <p>A witness statement dated 03/13/2023 written by LVN D indicated LVN H told Resident #150 to go and pointed down the hallway. Resident #150 told LVN H that was rude and LVN H said because you are pissing me off.</p> <p>During a phone interview on 06/20/24 at 3:16 PM, LVN D said she was the charge nurse and worked the 6:00 p.m.-6:00 a.m. shift. LVN D said she worked on 07/02/23 and witnessed the incident between LVN H and Resident #150. LVN D said Resident #150 was at the nursing station while LVN H was giving report to the oncoming night shift nurse (unknown). LVN H told Resident #150 he needed to leave because he was giving report to the nurse. LVN D said Resident #150 did not leave and remained at the nursing station. LVN D said LVN H pointed down the hallway and told Resident #150 again he needed to leave. LVN D said LVN H did not yell or scream at Resident #150, but by the tone of his voice, she could tell he was frustrated and annoyed with the resident. LVN D said Resident #150 told LVN H that was rude. LVN D said a staff member cussing at, speaking rudely to, exchanging words or arguing with a resident was verbal abuse. LVN D said residents were at risk for mental distress or depression if they are verbally abused.</p> <p>During an interview on 06/20/24 at 3:46 PM, the Administrator said she was the abuse coordinator and expected staff to report an allegation of abuse to her immediately. The Administrator said she started working at the facility in February 2024 and the incident between Resident #150 and LVN H was investigated by the previous administrator. The Administrator said according to the provider investigation report the previous administrator confirmed the allegation of abuse had occurred. The Administrator said a staff member cussing at, speaking rudely to, exchanging words or arguing with a resident was verbal abuse. The Administrator said residents are at risk for mental distress or depression if they are verbally abused.</p> <p>Record review of the facility's Abuse, Neglect, Exploitation and Misappropriation Prevention Program policy dated 04/2021 indicated, Residents have the right to be free from abuse .1. Protect residents from abuse .by anyone including, but no necessarily limited to: a. facility staff .5. Establish and maintain a culture of compassion and caring for all residents and particularly those with behavioral, cognitive or emotional problems .</p>		

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<p>F 0607</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Develop and implement policies and procedures to prevent abuse, neglect, and theft.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37495</p> <p>Based on observation, interview, and record review, the facility failed to implement their written policies and procedures that prohibit and prevent the abuse of residents for 1 of 7 residents (Resident #149) reviewed for abuse.</p> <ol style="list-style-type: none"> The facility failed to ensure the Administrator was notified immediately when Resident #149 accused CNA L of sexual abuse. The facility failed to ensure Resident #149 and other vulnerable residents were protected from CNA L. CNA L was not immediately suspended and remained in the facility until the end of his shift. The facility failed to ensure allegations of abuse were thoroughly investigated. The facility did not include evidence of Resident #149's interview, resident safe surveys, and LVN D's one-on-one education of the abuse policy in their provider investigation report. The facility failed to ensure allegations of sexual abuse was reported to local law enforcement. <p>An IJ was identified on 06/21/24. The IJ template was provided to the facility on [DATE] at 5:30 p.m While the IJ was removed on 06/23/24, the facility remained out of compliance at scope of isolated and a severity level of no actual harm with potential for more than minimal harm that is not immediate jeopardy due to the facility's need to evaluate the effectiveness of their corrective systems.</p> <p>This failure could place residents at risk of abuse, neglect, physical harm, pain, mental anguish, emotional distress, and serious harm.</p> <p>Findings included:</p> <p>Record review of Resident #149's face sheet, dated 06/20/24, indicated he was a [AGE] year-old male who admitted to the facility on [DATE] with diagnoses of hypertension (high blood pressure), depressive disorder (mood disorder causing persistent sadness and a loss of interest), mild cognitive impairment, anxiety disorder, Type 2 diabetes (chronic condition that affects how the body regulates and uses sugar), left below the knee amputation cerebrovascular disease (condition that affects blood flow to the brain) and left sided hemiplegia and hemiparesis following cerebral infarction (left sided mild weakness and severe paralysis due to a stroke). Resident #149 was discharged from the facility on 08/11/23.</p> <p>Record review of Resident #149's MDS assessment dated [DATE] indicated he had had moderately impaired cognition and required extensive one person assistance with toileting. Resident #150 had diagnoses of hypertension (high blood pressure), depression (mood disorder causing persistent sadness and a loss of interest), mild cognitive impairment, anxiety disorder, Type 2 diabetes (chronic condition that affects how the body regulates and uses sugar), left below the knee amputation cerebrovascular disease (condition that affects blood flow to the brain) and hemiplegia or hemiparesis (mild weakness or severe paralysis), and depression (mood disorder causing persistent sadness and a loss of interest).</p> <p>(continued on next page)</p>		

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<p>F 0607</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Record review of Resident #149's Care Plan dated 05/27/23 indicated he was abusive to staff, made false accusations. Interventions stated to allow resident to express his feelings about what he believed the situation might have been, give reassurance no one was trying to hurt him, interview other residents to verify if staff member was being abusive to them, investigate remarks resident made against staff, obtain statement from any witnesses that might have been present when such problem occurred (initiated 07/19/22). Resident #150 had an ADL self-care performance deficit related to cerebrovascular accident (bleeding in the brain) and interventions included he required one staff member to assist with toileting.</p> <p>Record review of Resident #149's progress notes dated 08/09/23 at 1:00 a.m. by LVN D indicated she spoke with CNA L about the complaint. CNA L asked LVN D to go into his room because the resident accused him of putting his finger up his butt. LVN D agreed and supervised all care that was done for the resident. There was no documentation in Resident #149's progress notes by LVN D to indicate she supervised the resident's care.</p> <p>Record review of Resident #149's progress notes by LVN D, after her entry on 08/09/23 at 1:00 a.m. to the end of her shift on 08/09/23 6:00 a.m., indicated there was no documentation she supervised the resident's care.</p> <p>A provider investigation report dated 08/11/23 signed by the DON indicated the incident with the allegation of abuse occurred in Resident #149's room on 08/08/23 at 11:00 p.m Resident #149 was interviewable with the capacity to make informed decisions and had no history of similar allegations. Resident #149 identified the alleged perpetrator CNA L by name. The Administrator was informed on 08/09/23 by CNA K that Resident #149 told him that CNA L stuck his finger up his butt and turned him in a rough manner on 08/08/23 during care. CNA K reported the incident to the Administrator. Resident #149 was assessed with no injuries then sent to the hospital. The facility notified the physician, responsible party, and Adult Protective Services. There was no documentation to indicate the facility notified the local police department. CNA L, the alleged perpetrator, was notified on 08/09/23; he was suspended pending the outcome of the investigation. CNA L denied the allegations. Provider action taken post-investigation indicated all nurses were in-serviced one on one regarding who the abuse coordinator was and when to call. LVN D received written counselling regarding reporting any reports of abuse or neglect and completed compliance education with test. The nurses were instructed to call if any verbal accusations are made no matter if they knew them to be unfounded. There was no witness statement for Resident #149 documented in the provider investigation report.</p> <p>Record review of LVN D's timecard for August 2023 indicated she clocked in at the facility on 08/08/23 at 5:44 p.m. and clock out on 08/09/23 at 6:11 a.m</p> <p>Record review of CNA L's timecard for August 2023 indicated he clocked in at the facility on 08/08/23 at 10:05 p.m. and clock out on 08/09/23 at 6:11 a.m</p> <p>Record review of LVN D's employee file indicated there was no documentation in her file she had received written counselling regarding reporting any reports of abuse or neglect related to Resident #149.</p> <p>(continued on next page)</p>		

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<p>F 0607</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During an interview on 06/21/24 at 2:08 p.m., Resident #149 said CNA L was cleaning him up after he had a bowel movement and stuck his finger in his asshole. Resident #149 said it felt uncomfortable like he was being raped. Resident #149 said he told CNA L what he had done, and his response was that he did not. Resident #149 said he did not recall seeing his nurse come in with CNA L when he checked on him a few times after that. Resident #149 said he transferred to another nursing facility a few days after the incident happened. Resident #149 said he felt safer in the facility that he was at now than in the other facility where the incident occurred.</p> <p>During a phone interview on 06/20/24 at 3:16 p.m., LVN D said she was the charge nurse and worked the 6:00 p.m. - 6:00 a.m. shift. LVN D said she worked on 08/08/23 and provided care to Resident #149. LVN D said sometime after midnight on 08/09/23, CNA L asked her if she would go with him into Resident #149's room when he needed to provide him care because the resident had accused him of sticking his finger up his butt. LVN D said she assessed Resident #149 after he made the allegation. LVN D said she never asked Resident #149 about the incident during her assessment, and he never mentioned it to her. LVN D said Resident #149 had no emotional distress and the only complaint he had was pain to the stump of his left below the knee amputation. LVN D said Resident #149 never mentioned the incident to her or showed emotional distress during her assessment. LVN D said she did not notify the Administrator because she felt that Resident #149 was not in any danger after she assessed him and decided to supervise CNA L's care with Resident #149. LVN D said she went into Resident #149's room with CNA L 2-3 more times before the end of her shift. LVN D said the facility contacted her about the incident and she was in-serviced one on one by the DON about the types of abuse and who to report it to.</p> <p>During an interview on 06/20/24 at 3:24 p.m., CNA L said he worked the 10:00 p.m. to 6:00 a.m. shift on 08/08/23 and provided care to Resident #149. CNA L said he provided incontinent care to Resident #149 after he had a bowel movement. CNA L said he was cleaning Resident #149's anal area when Resident #149 told him he had stuck his finger up his butt. CNA L said he told Resident #149 he did not and was having a difficult time getting the area cleaned because his bowel movement was like a thick paste. CNA L said he left Resident #149's room after he finished cleaning him up and told LVN D, Resident #149 had accused him of sticking his finger up his butt during incontinent care. CNA L said LVN D went into Resident #149's room with him 2-3 times during his shift. CNA L thought he would be sent home immediately after he told LVN D about Resident #149's allegations he made against him and thought it was odd he was allowed to complete his shift. CNA L said the facility notified him on 08/09/23 that he was suspended during the investigation. CNA L said he did not stick his finger up Resident #149's butt.</p> <p>(continued on next page)</p>		

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<p>F 0607</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During an interview on 06/20/24 at 3:34 p.m., the DON said she assisted the previous administrator with the investigation involving Resident #149 and CNA L. The DON said the facility first learned of the allegation on 08/09/23 during the 2:00 p.m.-10:00 p.m. when Resident #149 told CNA K that on 08/08/24 CNA L stuck his finger up his butt. The DON said CNA K notified the previous Administrator immediately and CNA L was notified he was suspended. The DON said LVN D did not call the administrator on 08/08/24 when she first learned of the allegation. The DON said CNA L remained in the facility until his shift ended and was not suspended until the following day. The DON said all staff were in-serviced on types of abuse and who to report it to. The DON said she did a one-on-one in-service on types of abuse and who to report it to with LVN D. The DON said when an allegation of abuse was made, the person identified as alleged perpetrator should be removed from the facility immediately and suspended during the facility's investigation to ensure residents are protected. The DON said Resident #149 and the other residents were at risk for abuse when CNA L was not suspended immediately on 08/08/24.</p> <p>During an interview on 06/20/24 at 3:46 p.m., the Administrator said she started working at the facility in February 2024. The Administrator said she was the abuse coordinator and expected staff to report an allegation of abuse to her immediately. The Administrator said when an allegation of abuse is made, the person who is identified as alleged perpetrator should be removed from the facility immediately and suspended at that time during the facility's investigation to ensure residents are protected. The Administrator said the police should be notified when there is an allegation of physical abuse or sexual abuse. The Administrator said the incident between Resident #149 and CNA L was investigated by the previous administrator. The Administrator said the previous administrator did not notify the police and she should have because it involved sexual abuse.</p> <p>During an observation and interview on 06/21/24 at 3:01 p.m. with the local police department's assistant at the front desk revealed (he/she) checked their database system and said they had no records on file that showed the facility called them on 08/09/23 to report an incident involving Resident #149.</p> <p>Record review of the facility's Abuse, Neglect, Exploitation and Misappropriation Prevention Program policy dated 04/2021 indicated, Residents have the right to be free from abuse .1. Protect residents from abuse .by anyone including, but no necessarily limited to: a. facility staff .</p> <p>Record review of the facility's Abuse Investigation and Reporting policy dated 04/2017 indicated, All reports of resident abuse .shall be promptly reported to local, state and federal agency (as defined by current regulations) and thoroughly investigated by facility management .Role of the Administrator: .4. The Administrator will suspend immediately any employee who has been accused of resident abuse, pending the outcome of the investigation Role if the Investigator: .d. Interview any witnesses to the incident. e. Interview the resident (as medically appropriate) .2. The following guidelines will be used when conducting interviews: . c. Witness reports will be obtained in writing. Either the witness will write his/her statement and sign and date it, or the investigator may obtain a statement, read it back to the member and have him/her sign and date it .</p> <p>The Administrator was notified on 06/21/24 at 5:25 p.m. that an Immediate Jeopardy situation was identified due to the above failures. The Administrator was provided the Immediate Jeopardy template on 06/21/24 at 5:30 p.m</p> <p>The facility's Plan of Removal was accepted on 06/22/24 at 6:08 p.m. and included:</p> <p>(continued on next page)</p>		

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<p>F 0607</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Identify responsible staff/ what action taken to prevent further abuse:</p> <ul style="list-style-type: none"> o ADON, MDS coordinator and Administrator will conduct 100% resident rounds to determine if further allegations of abuse are alleged. This will be completed by 6/22/24. o Safe surveys will be conducted by Social Worker, Human Resources and Activity Director for all cognitive residents. This will be completed by 6/22/24. <p>In-Service conducted</p> <ul style="list-style-type: none"> o In-servicing was initiated by Regional Nurse Consultant, Administrator and ADON on 06/21/24 and will continue until it is complete. o In-service will be provided to all staff on Immediate Notification of Allegations to Facility Abuse Coordinator, Investigating Allegations of Abuse and Neglect, Reporting of Abuse Neglect and Misappropriation, and notification of proper local and state entities, education included that any individual accused of abuse would be escorted immediately out of the building and resident would be protected. o The Abuse Coordinator was educated on 6-21-24 by the Regional Director of Clinical Services on how to investigate allegations of abuse and the importance of a thorough investigation and written documentation of statements and in-services. o This will be completed by 6/22/24. o Agency staff that work in the facility or staff on PTO or LOA will have in-servicing completed prior to working the floor. o Abuse and Neglect training will be a part of the new hire orientation effective immediately. o Any staff member who is an alleged perpetrator for any allegation will be suspended immediately pending investigation and will be escorted out of the facility immediately by the senior staff member on duty or law enforcement and will not be allowed to return to the building until the investigation is complete. <p>Implementation Date of Changes</p> <ul style="list-style-type: none"> o 06/21/24 <p>Involvement of Medical Director</p> <p>The Medical Director was notified about the immediate Jeopardy on 06/21/24.</p> <p>Involvement of QA</p> <p>QAPI will review and approve Plan of Removal</p> <p>(continued on next page)</p>		

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<p>F 0607</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>On 06/23/24 the surveyor confirmed the facility implemented their plan of removal sufficiently to remove the Immediate Jeopardy (IJ) by:</p> <p>Verifying the Medical Director had been informed of the Immediate Jeopardy on 06/21/24 from documentation by the Administrator.</p> <p>Record review of in-services indicated all staff were educated on Immediate Notification of Allegations to Facility Abuse Coordinator, Investigating Allegations of Abuse and Neglect, Reporting of Abuse Neglect and Misappropriation, and notification of proper local and state entities, education included that any individual accused of abuse would be escorted immediately out of the building and resident would be protected.</p> <p>Record review of resident rounds for all cognitive residents indicated rounds were conducted and completed on 06/22/24. Documentation indicated there were no identified complaints or allegations of abuse.</p> <p>Record review of LVN D's Counseling Form dated 06/22/24 indicated she received a verbal and written warning for violating the abuse and reporting policy on 08/08/23 by not reporting an allegation of sexual abuse immediately.</p> <p>Interviews with 5 Licensed Nurses (6 a.m.-6 p.m., 6 p.m.-6 a.m. and Weekend Doubles including agency), 7 CNAs (6 a.m.- 2 p.m., 2 p.m.-10 p.m., 10 p.m.- 6 a.m. including agency), 1 Laundry Staff, 1 Housekeeping Staff, 1 Dietary Staff, and 1 Social Worker were performed on 06/22/24 and 06/23/24. All staff were able to correctly identify Immediate Notification of Allegations to Facility Abuse Coordinator, Investigating Allegations of Abuse and Neglect, Reporting of Abuse Neglect and Misappropriation, and notification of proper local and state entities, education including that any individual accused of abuse would be escorted immediately out of the building and resident would be protected.</p> <p>During an interview on 06/23/24 at 9:46 a.m., the Administrator said she was educated on how to investigate allegations of abuse, the importance of a thorough investigation, written documentation of statements and in-services.</p> <p>On 06/23/24, the Administrator was informed the IJ was removed; however, the facility remained out of compliance at scope of isolated and a severity level of no actual harm with potential for more than minimal harm that is not immediate jeopardy due to the facility's need to evaluate the effectiveness of their corrective systems.</p>		

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure each resident receives an accurate assessment.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47723</p> <p>Based on observation, interview, and record review, the facility failed to ensure an MDS accurately reflected the resident's status for 2 of 2 dialysis residents (Residents #14 and #33) reviewed for MDS assessment accuracy.</p> <p>The facility failed to accurately code Resident #14 quarterly MDS assessment for Hemodialysis treatment on his quarterly MDS assessment dated [DATE], 2/29/2024, and 12/15/2024.</p> <p>The facility failed to accurately code Resident #33 quarterly MDS assessment for Hemodialysis treatment on his quarterly MDS assessment dated [DATE].</p> <p>These failures could place residents at risk for not receiving the appropriate care and services to maintain the highest level of well-being.</p> <p>Findings included:</p> <p>1. A review of Resident #14's face sheet and physician's orders for June 26, 2024, indicated Resident # 14 was [AGE] year-old male who admitted to the facility on [DATE] with a diagnosis including, right leg below knee amputation, chronic kidney disease, type 2 diabetes, hypertension, congestive heart failure (a condition in which the heart does not pump blood well), gastro-esophageal reflux disease (GERD), and End Stage Renal Disease (ERSD), a condition in which the kidneys lose the ability to remove waste and balance fluids).</p> <p>A review of Resident #14's in-patient hospital Physician progress notes dated 5/11/2023 indicated end-stage renal disease on hemodialysis: Nephrology input, continue maintenance hemodialysis Tuesday, Thursday and Saturday's.</p> <p>A review of Resident # 14's physician's orders dated June 26, 2024, indicated RD to eval and treat, order date 05/23/2023. Renal Diet (regular texture, regular consistency double protein portions at all meals), and 1000ml per 24 hours, order date 12/06/2023. Identified no documentation of hemodialysis facility orders.</p> <p>A review of Resident #14's quarterly MDS (Section O 0110 special treatment (J1) Dialysis, dated 03/03/2024, 2/29/2024, and 12/15/2024, coded (No) on admission, and coded (No) while a Resident. The MDS nurse confirmed that neither the quarterly MDS meeting, nor the care plans addressed the diagnosis of the resident's ESRD.</p> <p>A review of Resident #14's Admission/Readmission Evaluation dated 05/23/2024 (Section I) 1a. History and risk factors: 3. kidney disease checked and identified. Admission assessment was completed and signed by a staff RN.</p> <p>A review of Resident #14's Baseline Care Plans dated 05/23/2023, identified no documentation of hemodialysis care plans initiated or updated. The baseline care plan did not address Resident # 14 End Stage Renal Disease (ESRD), a condition in which the kidneys lose the ability to remove waste and balance fluids).</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675981	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/26/2024
NAME OF PROVIDER OR SUPPLIER Mineola Heights Healthcare Centre		STREET ADDRESS, CITY, STATE, ZIP CODE 716 Mimosa Street Mineola, TX 75773	
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)		
<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A review of Resident # 14's dialysis communication forms dated 3/12/2024, 3/21/2024, and 06/25/2024 was completed by nursing facility staffs, signed by Resident #14, and sent with Resident to the dialysis center.</p> <p>During an observation and interview 06/25/2024 at 10:00a.m., Resident #14 was in a self-propelled wheelchair, fully dressed in clean personal clothing, alert and oriented times three. Resident # 14 arrived in Resident Council meeting late today said he would have to leave the meeting early because he was scheduled to for hemodialysis today.</p> <p>During an observation on 06/25/2024 at 10:35a.m. Observed Dietary Manager served Resident #14 lunch tray to room, Dietary Manager said Resident #14 is scheduled to have early lunch on his dialysis days.</p> <p>2. A review of Resident #33's face sheet and physician's orders for June 26, 2024 indicated Resident #33 was a [AGE] year-old male who admitted to the facility on [DATE] with diagnosis including, myocardial infarction (heart attack), heart failure, left hemiplegia (partial or complete paralysis of one side of the body), anxiety, chronic obstructive pulmonary disease (COPD), end stage renal disease (a condition in which the kidneys lose the ability to remove waste and balance fluids), chronic kidney disease, dependence on renal dialysis.</p> <p>A review of Resident #33's physician's orders dated 06/26/2024 indicated admitting diagnosis: END STAGE RENAL DISEASE dated 12/5/2023: Medical Management chronic kidney disease, dated 12/5/2023: Dr orders reviewed indicated an order dated 12/05/2023 to receive Dialysis treatment Monday, Wednesday, and Friday with the area Kidney Care unit. NO BLOOD PRESSURE OR VENIPUNCTURE ON EXTREMITY WITH DIALYSIS ACCESS SITE EXTREMITY, and every shift MONITOR DIALYSIS SHUNT.</p> <p>A review of Resident #33's quarterly MDS (Section O 0110 special treatment (J1) Dialysis, dated 3/8/2024 coded (No) on admission, and coded (No) while a Resident.</p> <p>A review of Resident #33's Admission/Readmission Evaluation dated 12/05/2023(Section I) 1a. History and risk factors: 1. Urinary disorders, 2. Bladder disorders, 3. kidney disease checked and identified. Admission assessment was completed and signed by a staff RN.</p> <p>A review of the facility's scheduled care plan meetings for Resident #33 held on 3/18/24 and 06/17/2024 meet with staffs to assist in establishing a formal plan of care. The baseline care plan did not address Resident # 14 End Stage Renal Disease (ESRD), a condition in which the kidneys lose the ability to remove waste and balance fluids). A review of a comprehensive care plans dated 04/22/2024, identified no documentation of hemodialysis care plans initiated or updated.</p> <p>During an observations and interview on 06/24/2024 at 10:43a.m. Resident #33 in room sitting up in bed, was well groom, call light was in reach, no signs of abuse/neglect. The resident said he goes to dialysis at 1:30a.m., stated his regular scheduled days are on Mondays, Wednesdays, and Fridays. Resident #33 said, he will eat a light lunch prior to going to dialysis.</p> <p>During an interview on 06/24/2024 at 11:00 a.m. Dietary Manager said she see's Resident # 33 every Monday, Wednesday and Fridays, to review if he wanted an early lunch or take a sack lunch to dialysis. She said the resident usually refuse to take a sack lunch but will eat a light lunch prior to dialysis.</p> <p>(continued on next page)</p>		

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 06 /26/2024 at 1:30p.m. The MDS Coordinator, said the RAI manual was use as the guideline for completing the MDS assessment, she said the policy would be to follow the Resident Assessment Instrument (RAI). She said the initial admission assessment are done by a Register Nurse and the DON co-signs the assessment. The MDS Coordinator said, Resident #14 and Resident #33, section O 0110 special treatment (J1) dialysis should had been coded as receiving Hemodialysis which would have led to the rest of the assessment being completed. The MDS nurse confirmed the doctor orders did not address hemodialysis. The MDS nurse confirmed that neither the quarterly MDS meeting, nor the care plans addressed the diagnosis of the residents ESRD. The MDS nurse confirmed that the resident's treatments of dialysis were not addressed on the admission assessment.</p> <p>During an interview on 6/26/2024 at 2:30: p.m., LVN E, said she had been an LVN for [AGE] years, and LVN C said she had been an LVN for four and half years. Both are agency nurses and today was their first day at this facility. Both nurses said they had been trained and in-serviced on taking care of dialysis Residents and would document on the dialysis communication form or the progress notes when the Residents returned to the facility. They both were able to verbalize teach-back communication on the assessment that would be completed, the access type assessment and how to report if any problems or concerns.</p> <p>During an interview on 06/26/2024 at 3:30p.m. The DON said a resident receiving dialysis, she expected the MDS assessment to be coded. The DON said not coding the hemodialysis could cause a discrepancy when completing the resident's care plan. The DON said the MDS Coordinator was responsible for ensuring the MDS assessments were accurate and said the RAI manual was use as the guideline for the MDS assessment, she said the policy would be to follow the Resident Assessment Instrument (RAI). The DON confirmed that neither the quarterly MDS meeting, nor the care plans addressed the diagnosis for Resident #14 and Resident #33 ESRD. The DON confirmed Resident #14 doctor orders did not address hemodialysis. The DON confirmed that Resident #14 and Resident #33 treatments of dialysis were not addressed on the admission assessment.</p> <p>47204</p>		

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<p>F 0655</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47723</p> <p>Based on interview and record review , the facility failed to develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the residents that meet professional standards of quality care within 48 hours of the resident's admission for 2 of 2 dialysis residents (Residents #14, and Resident #33).</p> <p>The facility failed to ensure Residents # 14 and # 33's, baseline care plans included instructions to address both residents' admission diagnoses of ESRD and physician orders within 48 hours of admission.</p> <p>This failure could place newly admitted residents at risk of receiving inadequate care and services.</p> <p>Finding included:</p> <p>1. A review of Resident #14's face sheet and physician's orders for June 26, 2024, indicated Resident # 14 was [AGE] year-old male who admitted to the facility on [DATE] with a diagnosis including, right leg below knee amputation, chronic kidney disease, type 2 diabetes, hypertension, congestive heart failure (a condition in which the heart does not pump blood well), gastro-esophageal reflux disease (GERD), and End Stage Renal Disease (ESRD), a condition in which the kidneys lose the ability to remove waste and balance fluids).</p> <p>A review of Resident #14's quarterly MDS assessments dated 03/03/2024, 2/29/2024, and 12/15/2024 revealed special treatments section for dialysis, was coded no on admission, and coded no while a resident.</p> <p>A review of Resident #14's Baseline Care Plans dated 05/23/2023 , identified no documentation of hemodialysis care plans initiated. The baseline care plan did not address Resident # 14 End Stage Renal Disease (ESRD). There were no updated care plans that addressed Resident # 14 End Stage Renal Disease (ESRD) or dialysis interventions, and goals.</p> <p>A review of Resident # 14's physician's orders dated June 26, 2024, indicated RD to eval and treat, order date 05/23/2023. Renal Diet (regular texture, regular consistency double protein portions at all meals), and 1000ml per 24 hours, order date 12/06/2023. Identified no documentation of hemodialysis facility orders.</p> <p>A review of Resident #14's in-patient hospital Physician progress notes dated 5/11/2023 indicated end-stage renal disease on hemodialysis: Nephrology input, continue maintenance hemodialysis Tuesdays, Thursdays, and Saturdays.</p> <p>A review of Resident #14's Admission/Readmission Evaluation dated 05/23/2024 history and risk factors: 3. kidney disease checked and identified. Admission assessment was completed and signed by a staff RN.</p> <p>(continued on next page)</p>

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<p>F 0655</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A review of Resident # 14's dialysis communication forms dated 3/12/2024, 3/21/2024, and 06/25/2024 revealed they were completed by nursing facility staff, signed by Resident #14, and sent with Resident to the dialysis center.</p> <p>During an observation and interview on 06/25/2024 at 10:00a.m., Resident #14 was in a self-propelled wheelchair fully dressed in clean personal clothing, alert and oriented to times, place, and person. Resident # 14 arrived in Resident Council meeting late said he would have to leave the meeting early because he was scheduled to for hemodialysis that day.</p> <p>During an observation on 06/25/2024 at 10:35a.m. Observed Dietary Manager serve Resident #14's lunch tray to his room. Dietary Manager said Resident #14 is scheduled to have early lunch on his dialysis days.</p> <p>2. A review of Resident #33's face sheet and physician's orders for June 26, 2024 indicated Resident #33 was a [AGE] year-old male who admitted to the facility on [DATE] with diagnosis including myocardial infarction (heart attack), heart failure, left hemiplegia (partial or complete paralysis of one side of the body), anxiety, chronic obstructive pulmonary disease (COPD), end stage renal disease (a condition in which the kidneys lose the ability to remove waste and balance fluids), chronic kidney disease, dependence on renal dialysis.</p> <p>A review of Resident #33's quarterly MDS (Section O 0110 special treatment (J1) Dialysis, dated 3/8/2024 coded (No) on admission, and coded (No) while a Resident.</p> <p>A review of a baseline care plan 12/05/2023, did not address Resident # 14 End Stage Renal Disease (ESRD), a condition in which the kidneys lose the ability to remove waste and balance fluids).</p> <p>A review of a comprehensive care plans dated 04/22/2024, identified no documentation of hemodialysis care plans initiated or updated.</p> <p>A review of Resident #33's physician's orders dated 06/26/2024 indicated admitting diagnosis: END STAGE RENAL DISEASE dated 12/5/2023: Medical Management chronic kidney disease, dated 12/5/2023: Doctor orders reviewed indicated an order dated 12/05/2023 to receive Dialysis treatment Monday, Wednesday, and Friday with the area Kidney Care unit. NO BLOOD PRESSURE OR VENIPUNCTURE ON EXTREMITY WITH DIALYSIS ACCESS SITE EXTREMITY, and every shift MONITOR DIALYSIS SHUNT.</p> <p>A review of Resident #33's Admission/Readmission Evaluation dated 12/05/2023(Section I) 1a. History and risk factors: 1. Urinary disorders, 2. Bladder disorders, 3. kidney disease checked and identified. Admission assessment was completed and signed by a staff RN.</p> <p>A review of the facility's scheduled care plan meetings for Resident #33 revealed they were held on 3/18/24 and 06/17/2024.</p> <p>During an observations and interview on 06/24/2024 at 10:43a.m., Resident #33 was in his room sitting up in bed, was well groom, call light was in reach, no signs of abuse/neglect . The resident said he went to dialysis at 1:30 a.m He states his regular scheduled days are on Mondays, Wednesdays, and Fridays. Resident #33 said, he will eat a light lunch prior to going to dialysis.</p> <p>(continued on next page)</p>		

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<p>F 0655</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 06/24/2024 at 11:00 a.m. The Dietary Manager said she saw Resident # 33 every Monday, Wednesday and Fridays, to review if he wanted an early lunch or take a sack lunch to dialysis. She said the resident usually refuse to take a sack lunch but will eat a light lunch prior to dialysis.</p> <p>During an interview on 06 /26/2024 at 1:30p.m. The MDS Coordinator said the RAI manual was used as the guideline for performing the MDS assessment, she said the policy would be to follow the Resident Assessment Instrument (RAI). She said the initial admission assessment are done by a Register Nurse and the DON co-signs the assessment. The MDS Coordinator said Resident #14 and Resident #33, section O 0110 special treatment (J1), dialysis should had been coded as receiving hemodialysis ,which would have led to the rest of the assessment being completed. The MDS nurse confirmed that neither the quarterly MDS meeting, nor the care plan addressed the diagnosis of the resident's ESRD. The MDS nurse confirmed the doctor orders did not address hemodialysis. The MDS nurse confirmed that the resident's treatments of dialysis were not addressed on the admission assessments.</p> <p>During an interview on 6/26/2024 at 2:30: p.m ., LVN E said she had been an LVN for [AGE] years, and LVN C said she had been an LVN for four and half years. Both were agency nurses and today was their first day at this facility. Both nurses said they had been trained and in-serviced on taking care of dialysis residents and would document on the dialysis communication form or the progress notes when the residents returned to the facility. They both were able to verbalize teach-back communication on the assessment that would be completed , the assessment of the resident's fistula or the hemodialysis catheter, and how to report if any problems or concerns became apparent.</p> <p>During an interview on 06/26/2024 at 3:30p.m., The DON said with a resident receiving dialysis, she expected the MDS assessment to be coded. The DON said not coding the hemodialysis could cause a discrepancy when completing the resident's care plan. The DON said that she and the ADON were responsible for reviewing the admission care plans and updating the current plans. She said she was the nurse who reviewed Resident # 33's baseline care plan. The DON said the MDS Coordinator was responsible for ensuring the MDS assessments were accurate and said the RAI manual was use as the guideline for the MDS assessment , she said the policy would be to follow the Resident Assessment Instrument (RAI). The DON confirmed that neither the quarterly MDS meeting, nor the care plans addressed the diagnosis for Resident #14 and Resident #33 ESRD. The DON confirmed Resident #14 doctor orders did not address hemodialysis. The DON confirmed that Resident #14 and Resident #33 treatments of dialysis were not addressed on the admission assessment.</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47204</p> <p>Based on observation, interview and record review, the facility failed to ensure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals to meet the needs of each resident for 1 of 4 residents (Resident #11) reviewed for pharmacy services.</p> <p>1.The facility failed to provide 7 (seven) of 11 doses of Resident #11's physician prescribed Lotemax (Loteprednol) Ophthalmic Suspension (eye drops used to treat conditions of the eye that cause itching) between the dates of 06/20/2024 - 06/25/2024.</p> <p>2.There was documentation in the MAR indicating 2 of the 7 doses were administered when the Lotemax eye medication was not available in the facility.</p> <p>3.The facility failed to utilize available resources to obtain and administer the initial dose of physician prescribed Lotemax Ophthalmic Suspension for almost 19 hours after being prescribed and for 3 (three) days after learning the medication was not in the facility resulting in a total of 7 missed doses of Lotemax Ophthalmic Suspension.</p> <p>These failures could place residents at risk for not receiving the intended therapeutic response of prescribed medications and not having accurate records of medication administration which could result in diminished health and well-being.</p> <p>Findings included:</p> <p>Record review of a face sheet dated 06/25/2024 indicated Resident #11 was a [AGE] year-old female who admitted to the facility on [DATE] with diagnoses which included Chronic Obstructive Pulmonary Disease (a group of lung diseases that block airflow and make it difficult to breathe), Multiple Sclerosis (a disease in which the immune system destroys the protective covering of nerves resulting in nerve damage), Cerebral Infarction (stroke) with right sided paralysis, Depression (a mental health disorder characterized by a persistently depressed mood or loss of interest in activities), Anxiety (feelings of unease such as worry or fear), and Dementia (a general term for loss of memory).</p> <p>Record review of a quarterly MDS assessment dated [DATE] noted Resident #11 had a BIMS score of 12 indicating her cognition was moderately impaired. The same MDS indicated Resident was dependent on staff for bathing, mobility, and toileting.</p> <p>Record review of Resident #11's physician orders indicated an order was written on 06/20/2024 at 01:33 PM for resident #11 to receive 1 (one) drop in each eye twice daily of Lotemax Ophthalmic Suspension.</p> <p>Record review of Resident #11's MAR dated for June 2024 indicated LVN F administered the 06:00 PM scheduled dose of Lotemax Ophthalmic Suspension on 06/20/2024 at 06:00 PM.</p> <p>Record review of the Pharmacy Packing Slip Proof of Delivery indicated the Lotemax eye drops were not delivered to the facility until 06/21/2024 at 05:10 AM.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Record review of Resident #11's June 2024 MAR indicated she did not receive the initial dose of Lotemax eye drops until 08:15 AM on 06/21/2024, approximately 19 hours after being ordered by the physician.</p> <p>Record review of Resident #11's June 2024 MAR indicated the ADON was unable to administer the 09:00 AM scheduled dose of the Lotemax eye drops on 06/23/2024 because she could not locate the medication in the facility. Her documentation noted the Lotemax eye drops were unavailable.</p> <p>Record review of Resident #11's June 2024 MAR indicated LVN G administered a 06:00 PM dose of Lotemax eye drops on 06/23/2024 after the ADON had documented the eye medication was not in the facility earlier that day.</p> <p>Record review of Resident #11's June 2024 MAR for 06/24/2024 at 09:00 AM and 06:00 PM indicated LVN A did not administer those 2 (two) doses of the Lotemax eye drops because the nurse was unable to locate the medication.</p> <p>Record review of Resident #11's June 2024 MAR for 06/25/2024 at 09:00 AM and 06:00 PM indicated LVN A did not administer those 2 (two) doses of Lotemax eye drops because the nurse was unable to locate the medication.</p> <p>Record review of progress notes dated 06/25/2024 at 10:17 AM indicated the order for the twice daily administration of Lotemax Ophthalmic Suspension was placed on hold until delivered from pharmacy.</p> <p>Record review of the facility's Order Audit Report for Lotemax Ophthalmic Suspension indicated the medication was initially ordered from the pharmacy on 06/20/2024 at 01:13 PM. The report indicated no further requests to refill or replace the missing Lotemax Suspension until after surveyor was made aware the medication was not available for administration on 06/25/2024.</p> <p>During observation and interview of LVN A administering medications to Resident #11 on 06/25/2024 at 09:13 AM, LVN A said she could not administer Resident #11's Lotemax eye drops because she did not have them. She said she also did not have the eye drops the day before on 06/24/2024. She said she was going to tell the DON about it.</p> <p>During an interview on 06/25/2024 at 11:00 AM, LVN A said she told the DON about the missing Lotemax Ophthalmic Suspension and said the DON was going to obtain the eye drops from a local pharmacy. LVN A said she should have told the DON and notified the pharmacy on 06/24/2024 when she first realized the eye medication was not in the facility. She said she got busy and forgot.</p> <p>(continued on next page)</p>

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 06/25/2024 at 11:31 AM, the DON said she tried to get the Lotemax medication delivered from a local pharmacy, but they did not have it in stock. She said the eye drop medication would be delivered early on 06/26/2024. The DON said the physician ordered the Lotemax Ophthalmic Suspension on 06/20/2024 after Resident #11 told the doctor her eyes were itching. The DON said she expected the nurses to notify her anytime a medication was not available for administration. She said neither LVN F, LVN G, nor the ADON had informed her of Resident #11 not having the ordered Lotemax medication available for use. The DON said the pharmacy should have been made aware of the needed medication and if the pharmacy could not deliver it timely, then the pharmacy would have contacted a local pharmacy for delivery of the medication. The DON said the nurses (LVN F and LVN G) who documented they administered the Lotemax Ophthalmic Suspension on 06/20/2024 at 06:00 PM and on 06/23/2024 at 06:00 PM, respectively, could not have administered the eye medication because it was not in the facility. She said she thought the nurses signed the MAR before they realized the medication was not there and then failed to make a correction to their entries.</p> <p>During an interview and observation on 06/25/2024 at 12:09 PM, Resident #11 said she had not received any eye drops. She said her eyes were scratchy. No eye redness or drainage was observed.</p> <p>During an interview on 06/25/2024 at 03:31 PM, the ADON said she could not find the Lotemax eye drops on 06/23/2024 for the 06:00 AM administration. She said she looked in both medication carts, the medication room, the refrigerator in the medication room, and the overflow medication storage but did not find the eye drop suspension. The ADON said she notified the physician of the missing medication and put in an order to the pharmacy to re-order the medication. She said the pharmacy did not deliver on Sunday. The ADON provided a copy of a late progress note entry dated 06/25/2024 for 06/23/2024 indicating she reordered the Lotemax medication from the pharmacy and notified the physician. The ADON said Resident #11 showed no adverse reaction for not receiving the prescribed eye drops as ordered.</p> <p>During an interview on 06/26/2024 at 02:21 PM, the Pharmacy Consultant said if the facility needed a medication for administration prior to the next pharmacy delivery, then the facility could request a stat (a common medical abbreviation for urgent, rush, or immediately) medication delivery. She said the facility did not request a stat delivery of the Lotemax Ophthalmic Suspension on 06/20/2024 when it was first ordered nor on 06/25/2024 when it was re-ordered. The Pharmacy Consultant also said she found no record of a refill request on 06/23/2024. She also said the pharmacy had staff on duty at the pharmacy 24 hours a day, 365 days a year and was able to make deliveries 7 (seven) days a week.</p> <p>LVN F and LVN G were not present during the survey and attempts to reach out to them by phone were unsuccessful.</p> <p>A review of in-services for the last 6 months did not indicate any training had been done with the nurses on the process for acquiring medications when there was an inadequate supply on hand for administration.</p> <p>A review of the facility's policy dated 2001/Revised 2012 regarding medication administration indicated the following:</p> <p>Administering Medications</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675981	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/26/2024
NAME OF PROVIDER OR SUPPLIER Mineola Heights Healthcare Centre		STREET ADDRESS, CITY, STATE, ZIP CODE 716 Mimosa Street Mineola, TX 75773	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Medications shall be administered in a safe and timely manner, and as prescribed</p> <p>3. Medications must be administered in accordance with the orders, including any required time frame</p> <p>A review of the facility's contracted pharmacy's manual titled Policies and Procedures for Pharmacy Services indicated the following:</p> <p>4.1.3. Urgent Orders</p> <p>New orders or refill orders requiring urgent delivery should be indicated on the order form or communicated verbally. The pharmacy has services available to deliver medications in a timely manner, depending on time and location of receiving facility.</p> <p>5. Service Disruptions</p> <p>5.1. Medication Shortages</p> <p>Upon discovery that facility has an inadequate supply of a medication to administer to a resident, facility should immediately initiate action to obtain the medication from pharmacy .</p> <p>6.1 Delivery Schedules .</p> <p>Orders requiring more urgent delivery will be communicated by the facility to the pharmacy either by fax or verbally. The pharmacy will expedite delivery of those medications within a 4-hour window.</p>

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47204</p> <p>Based on interview and record review, the facility failed to maintain clinical records in accordance with accepted professional standards and practices that are complete and accurately documented for 1 of 4 Residents (Resident #11) reviewed for medical records accuracy.</p> <p>The facility failed to insure LVN F and LVN G accurately documented the administration of Lotemax Ophthalmic Suspension on 2 (two) occasions when they indicated the eye drops medication had been administered when the medication was not available in the facility.</p> <p>This deficient practice could affect residents whose records are maintained by the facility and could place them at risk for errors in care and treatment.</p> <p>The findings included:</p> <p>Record review of a face sheet dated 06/25/2024 indicated Resident #11 was a [AGE] year-old female who admitted to the facility on [DATE] with diagnoses which included Chronic Obstructive Pulmonary Disease (a group of lung diseases that block airflow and make it difficult to breathe), Multiple Sclerosis (a disease in which the immune system destroys the protective covering of nerves resulting in nerve damage), Cerebral Infarction (stroke) with right sided paralysis, Depression (a mental health disorder characterized by a persistently depressed mood or loss of interest in activities), Anxiety (feelings of unease such as worry or fear), and Dementia (a general term for loss of memory).</p> <p>Record review of a quarterly MDS assessment dated [DATE] noted Resident #11 had a BIMS score of 12 indicating her cognition was moderately impaired. The same MDS indicated Resident was dependent on staff for bathing, mobility, and toileting.</p> <p>Record review of Resident #11's physician orders indicated an order was written on 06/20/2024 at 01:33 PM for resident #11 to receive 1 (one) drop in each eye twice daily of Lotemax Ophthalmic Suspension.</p> <p>Record review of Resident #11's MAR dated for June 2024 indicated LVN F administered the initial dose of Lotemax Ophthalmic Suspension on 06/20/2024 at 06:00 PM.</p> <p>Record review of the Pharmacy Packing Slip Proof of Delivery indicated the Lotemax eye drops were not delivered to the facility until 06/21/2024 at 05:10 AM. The Proof of Delivery Packing Slip was signed by LVN F.</p> <p>Record review of Resident #11's June 2024 MAR indicated she did not receive the initial dose of Lotemax eye drops until 08:15 AM on 06/21/2024.</p> <p>Record review of Resident #11's June 2024 MAR indicated the ADON was unable to administer the 09:00 AM scheduled dose of the Lotemax eye drops on 06/23/2024 because she could not locate the medication in the facility. Her documentation noted the Lotemax eye drops were unavailable.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Mineola Heights Healthcare Centre		STREET ADDRESS, CITY, STATE, ZIP CODE 716 Mimosa Street Mineola, TX 75773	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of Resident #11's June 2024 MAR indicated LVN G administered a 06:00 PM dose of Lotemax eye drops on 06/23/2024 after the ADON had documented the eye medication was not in the facility earlier that day.</p> <p>Record review of Resident #11's June 2024 MAR for the next day, 06/24/2024, at 09:00 AM indicated LVN A could not administer the Lotemax eye drops because the medication was not available in the facility.</p> <p>Record review of the facility's Order Audit Report for Lotemax Ophthalmic Suspension indicated the medication was initially ordered from the pharmacy on 06/20/2024 at 01:13 PM. The report indicated no further requests to refill or replace the missing Lotemax Suspension until 06/25/2024.</p> <p>Review of Progress Notes dated 06/23/2024 through 06/25/2024 indicated Resident #11 did not have Lotemax Ophthalmic Suspension available in the facility for administration.</p> <p>During an interview on 06/25/2024 at 11:31 AM, the DON said the nurses (LVN F and LVN G) who documented they administered the Lotemax Ophthalmic Suspension on 06/20/2024 at 06:00 PM and on 06/23/2024 at 06:00 PM, respectively, could not have administered the eye medication because it was not in the facility. She said she thought the nurses signed the MAR before they realized the medication was not there and then failed to make a correction to their entries.</p> <p>During an interview on 06/25/2024 at 03:31 PM, the ADON said she could not find the Lotemax eye drops on 06/23/2024 for the 06:00 AM administration. She said she looked in both medication carts, the medication room, the refrigerator in the medication room, and the overflow medication storage but did not find the eye drop suspension.</p> <p>LVN F and LVN G were not present during the survey and attempts to reach them by phone on 06/26/2024 at 11:00 AM</p> <p>03:06 PM were unsuccessful.</p> <p>Record review of a Pharmacy Packing Slip Proof of Delivery indicated the refill of the Lotemax eye drops were not delivered to the facility until 06/26/2024 at 05:08 AM.</p> <p>A review of the facility's policy regarding medication administration indicated the following:</p> <p>Administering Medications</p> <p>19. The individual administering the medication must initial the resident's MAR on the appropriate line after giving each medication .</p>		