STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676014	A. Building B. Wing	02/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Twilight Home	3001 W Fourth Ave Corsicana, TX 75110

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44700 Based on interview and record review, the facility failed to immediately consult with the resident's physician when there was a significant change in the resident's physical status (that is, a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications) for one (Resident #1) of seven residents reviewed for changes in condition, in that: The facility failed to ensure Resident #1's NP or physician was notified on 1/17/2025 that he had developed a fever (elevated body temperature) after Resident #1 was tested on [DATE] for a urinary tract infection . The failure could place residents at risk of a delay in treatment uncontrolled pain, development of sepsis (systemic infection of the body) and a decreased quality of life. Findings include: Review of Resident #1's face sheet dated 1/24/2025 reflected a [AGE] year-old male admitted to the facility on [DATE] with diagnoses including Spondylosis (degenerative condition of the spine), Type 2 Diabetes Mellitus (blood sugar regulation disorder), Fusion of the Spine - Cervical Region, Hyperlipidemia (high cholesterol), Chronic Pain, muscle weakness, and lack of coordination, Review of Resident #1's unspecified MDS assessment dated [DATE], reflected a BIMS of 14 suggesting Resident #1 had no cognitive deficits. Review of section H - Bladder and Bowel reflected Resident #1 had an indwelling catheter (a flexible tube inserted in the body to collect and drain urine.) Review of Resident #1's care plan dated 12/23/2024 reflected the problem The resident has indwelling catheter due to Neurogenic bladder (condition that occurs when the nervous systems' connection to the balder is disrupted) & possible bladder neck obstruction; with interventions that included Monitor/record/report to MD for s/sx UTI: pain, burning, blood-tinged urine, cloudiness, no output, deepening of urine color, increased pulse, increased temp, urinary frequency, foul smelling urine, fever, chills, altered mental status, change in behavior, change in eating patterns. Review of Resident #1's temperature log reflected the following: 1/17/2025, 8:14 [am], 101.7 [degrees] F, forehead, recorded by LVN #1. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #1's orders indicated a UA was ordered on 1/16/2025 and collected on 1/16/2025 after 8am. [the exact time on the UA report is not legible.] Review of Resident #1's progress notes dated 1/17/2025 by LVN #1 at 12:37 pm, revealed Resident #1's UA results had been received and NP #2 had been notified. Progress note further indicated they were still waiting on C&S results. Review of Resident #1's progress notes dated 1/17/2025 by LVN #1 at 3:54 pm, revealed temperature reading of T-100.4 [degrees F]. Further review of Resident #1's progress notes from 1/16/2025 to 1/18/2025 reflected no entries from LVN #1 indicating she had notified NP #2 of Resident # 1's elevated temperature readings at two different times on 1/17/2025. During an interview on 2/10/2025 at 11:02 am with LVN #1, she stated she had assessed Resident #1's vital signs on 1/17/2025 at 8:14 am and he had a temperature of 101.7F. She stated she had also taken his vital signs on 1/17/2025 at 3:54 pm and he had a temperature of 100.4F. She stated both of those readings indicated Resident #1 had a fever and indicated a change in condition and NP #2 should have been notified. She stated she thought she had contacted NP #2 with that information but to my 100% knowledge, I don't know if I did. She stated if she had contacted NP #2, I would have documented this in a progress note. LVN #1 was informed there was no progress note in the EMR about her contacting and notifying [NP #2] of Resident #1's fever. She stated, This means [NP# 2] was not notified. She stated with Resident #1 running a fever she would have concerns about infection, or a UTI. Resident #1 could have developed a serious infection, possibly sepsis (systemic infection of the entire body), which could lead to death . During an interview with NP #2 on 2/10/2025 at 11:16 am, she stated she had ordered a UA for Resident #1 on 2/16/2025 because nursing staff had noticed he had dark colored urine draining into his indwelling catheter bag. She stated she was never contacted about Resident #1 having a fever on 1/17/2025. She stated if she had known that, per the facility policy she would have started a broad-spectrum antibiotic to start treating Resident #1's suspected UTI. She stated the antibiotic could have started to work on the infection while they were waiting for the lab results to come back and reduced Resident #1's discomfort. NP #2 stated Resident #1's UA came back positive on 2/17/2025 for bacteria present. A positive UA indicated he had an infection, so a Culture & Sensitivity (C&S) test was initiated. She stated a C&S is done to ensure the infection is treated with the appropriate antibiotic. She stated the facility received the results of the C&S back on 9/19/2025, and she gave orders to start antibiotics, but before they could initiate antibiotic therapy, Resident #'1's RP requested he be sent to the emergency room (ER), so the facility sent him out to the ER. During an interview with the MD on 2/10/2025 at 3:19 pm, he stated he was not aware that Resident #1 was febrile (had a fever) and met the criteria for initiation of antibiotic therapy per the facility antimicrobial stewardship policy . He stated if a resident showed clinical signs of a fever where a UTI was suspected, they would start a broad-spectrum antibiotic while they waited for additional testing results to come back from the lab. He stated, It would have been nice if they notified us. We could have started him on an antibiotic. The MD stated his expectations were that the nursing staff would notify either him or NP #2 when a resident had a fever with a suspected UTI so they could give orders to start antibiotics. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/10/2025 at 4:05 pm, the DON stated she was not aware Resident #1 had run a fever on 1/17/2025 and that NP #2 had not been contacted by LVN #1. She stated her expectation was that LVN #1 should have called the practitioner and made them aware of Resident #1 running a fever. She stated Resident #1's infection could have gotten worse, or the resident could have even developed sepsis. During an interview on 2/10/2025 at 4:15 pm, the ADM stated she was not aware that Resident #1 had developed a fever and her expectation was that the nurse would call the provider. She stated when Resident #1 ran a fever that indicated a change in condition and could have indicated his infection had been getting worse. She stated Resident #1 could have become septic. Review of undated facility policy Antimicrobial Stewardship reflected the following: Policy - Treatment with antibiotics is only appropriate when the practitioner determines, on the basis of an assessment, that the most likely cause of the patient's symptoms is a bacterial infection. Procedures - 1. When the facility staff suspects a resident has an infection, the nurse should perform and document a complete assessment of the resident using established and accepted assessment protocols to determine if the resident's status meets minimum criteria for initiating antibiotics. A. Suspected Urinary Tract Infection, with indwelling catheter; at least one of the following: Fever (>100 degrees F), New costovertebral tenderness [tenderness where the ribs meet the spine], Rigors [shivering with a rise in temperature] or New onset of delirium [altered mental status]. Review of facility policy Notifying the Physician of Change in Status dated Rev March 11, 2013, reflected the following: 1. The nurse will notify the physician immediately with significant change in status. The nurse will document signs and symptoms of significant change, time/date of call to physician, and interventions that were implemented in the resident's clinical record.