

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676043	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/08/2024
NAME OF PROVIDER OR SUPPLIER Houston County Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 100 N E Loop 304 Crockett, TX 75835	

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 0604</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46273</p> <p>Based on interview, and record review, the facility failed to ensure that the resident was free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms for 1 of 3 residents (Resident #188) reviewed for physical restraints.</p> <p>The facility failed to obtain physician order, informed consent, and pre-restraint assessment for Resident #188 before implementing bed alarm (position change alarm) on [DATE].</p> <p>This failure could place residents in the facility at risk of decreased quality of life, injury and being subjected to restraints for purposes of convenience or discipline.</p> <p>Findings included:</p> <p>Record review of a facility face sheet dated [DATE] for Resident #188 indicated that he was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses including: malignant neoplasm of prostate (prostate cancer that had spread to other locations in the body), hypertension (high blood pressure), and type 2 diabetes mellitus (uncontrolled blood sugar).</p> <p>Record review of a comprehensive MDS dated [DATE] for Resident #188 indicated that he was rarely/never understood and was unable to complete BIMS interview. Section C (Cognitive Patterns) indicated that he was severely cognitively impaired. Behavior section indicated that he exhibited verbal and physical behaviors directed toward others and other behavioral symptoms not directed at others. Section P (Restraints and Alarms) incorrectly reflected that he did not use a bed alarm.</p> <p>Record review of a comprehensive care plan dated [DATE] for Resident #188 indicated that use of a position change alarm was not addressed.</p> <p>Record review of Resident #188's closed record indicated that there was no signed informed consent or pre-restraint assessment.</p> <p>Record review of nurses notes in Resident #188's closed chart indicated that bed alarm use was documented on the following dates:</p> <p>[DATE] at 3:00 pm</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 0604</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>[DATE] at 1:30 am</p> <p>[DATE] at 9:00 am</p> <p>[DATE] at 11:00 am</p> <p>[DATE] at 4:30 am</p> <p>[DATE] at 12:45 pm</p> <p>[DATE] at 10:10 pm</p> <p>[DATE] at 7:30 am</p> <p>[DATE] at 8:00 am</p> <p>[DATE] at 10:00 pm</p> <p>[DATE] at 12:30 am</p> <p>[DATE] at 8:15 am</p> <p>Record review of nurses notes for Resident #188 indicated that he expired on [DATE] and was not observed or interviewed.</p> <p>During an interview on [DATE] at 9:38 am CNA H said that there were no residents currently using bed alarms that she was aware of.</p> <p>During an interview on [DATE] at 9:45 am LVN G said that she was unaware of any current residents using bed alarms.</p> <p>During an interview on [DATE] at 10:10 am DON said, hospice probably brought that (bed alarm) in and they normally write the orders.</p> <p>During an interview on [DATE] at 1:15 pm DON said that Resident #188 was on hospice and the hospice company had brought the bed alarm in but did not write the order. She said it was ultimately her responsibility to ensure the proper orders were in place. She said going forward she would ensure that hospice orders were entered correctly. She said residents could be at risk of lack of proper care if orders, consents, and proper assessments were not done.</p> <p>During an interview on [DATE] at 1:40 pm Administrator said that Resident #188 had been on hospice, and they must not have put the order in. He said residents who use bed alarms without proper consents, orders and care plans could be at risk of falls and harm.</p> <p>(continued on next page)</p>

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<p>F 0604</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of a facility policy titled Restraints undated, read .The resident has the right to be free from any physical or chemical restraints imposed for purpose of discipline or convenience, and not required to treat the resident's medical symptoms. The intent is for each resident to reach his/her highest practicable well-being in a restraint free environment unless the resident has medical symptoms that warrant the use of restraints. For those residents whose care plans indicate the need for restraints, we will engage in a systematic process of implementation, reduction, or elimination of restraints to assure that the least restrictive device required is used .</p> <p>Record review of a facility policy titled Physician Orders undated, read .All care given to the resident will have the direct order of the attending physician .</p> <p>Policy for Bed Alarms requested none provided prior to exit.</p>		

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives an accurate assessment.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46273</p> <p>Based on interview, observation and record review, the facility failed to ensure the MDS assessment accurately reflected the resident's status for 2 of 13 residents (Resident #33 and Resident #188) reviewed for accuracy of assessments.</p> <p>The facility failed to accurately code the [DATE] MDS for a restraint (geri-chair with tray) used for Resident #33.</p> <p>The facility failed to accurately code the comprehensive MDS dated [DATE] for a bed alarm use for Resident #188 with a physician order summary report effective [DATE] for the use of the bed alarm.</p> <p>This failure could put residents at risk for lack of proper care and decreased quality of life.</p> <p>Findings included:</p> <p>Record review of a facility face sheet dated [DATE] for Resident #33 indicated that he was an [AGE] year-old male admitted to the facility on [DATE] with diagnoses including: Alzheimer's disease, dementia, and history of falling.</p> <p>Record review of a quarterly MDS assessment dated [DATE] for Resident #33 indicated that he was rarely/never understood and could not complete BIMS interview. Section C (Cognitive Patterns) indicated that he had severely impaired cognition. Section P (Restraints and Alarms) incorrectly reflected that Resident #33 did not use a geri-chair with tray to prevent rising (trunk restraint).</p> <p>Record review of a comprehensive care plan dated [DATE] for Resident #33 indicated that he was at high risk for falls and had an intervention to provide a safe environment, follow doctors' orders for geri-chair with tray, due to disease process.</p> <p>Record review of a physician order summary report dated [DATE] for Resident #33 indicated that he had the following physician orders:</p> <p>Patient to be up to geri-chair with tray (trunk restraint) in place due to inability to support unstable trunk and significant fall risk; every shift; dated [DATE].</p> <p>Remove geri-chair tray every 2 hours and reposition resident. Remove tray during mealtime; every day and night shift; dated [DATE].</p> <p>Record review of a form titled Informed Consent for Use of Restraints indicated that Resident's responsible party had signed the form on [DATE].</p> <p>Record review of medical record for Resident #33 indicated that a Pre-Restraining Assessment form was completed on [DATE] and on [DATE].</p> <p>Record review of a form titled Restraint Implementation/Reduction/Elimination Trial dated [DATE] through [DATE] indicated that elimination trial was attempted during these dates and was unsuccessful.</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 - Few</p>	<p>During an observation on [DATE] at 9:39 am Resident #33 was observed at nurses' station, sitting in geri-chair. Geri-chair tray not in place, staff member approached resident saying, it is time to put your tray back in place. Tray applied to geri-chair per staff member. Resident #33 not interviewed due to inability to answer questions.</p> <p>Record review of a facility face sheet dated [DATE] for Resident #188 indicated that he was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses including: malignant neoplasm of prostate (prostate cancer that had spread to other locations in the body), hypertension (high blood pressure), and type 2 diabetes mellitus (uncontrolled blood sugar).</p> <p>Record review of a comprehensive MDS dated [DATE] for Resident #188 indicated that he was rarely/never understood and was unable to complete BIMS interview. Section C (Cognitive Patterns) indicated that he was severely cognitively impaired. Section P (Restraints and Alarms) incorrectly reflected that he did not use a bed alarm.</p> <p>Record review of a comprehensive care plan dated [DATE] for Resident #188 indicated that use of a position change alarm was not addressed.</p> <p>Record review of Resident #188's closed record indicated that there was no signed informed consent or pre-restraint assessment.</p> <p>Record review of nurses notes in Resident #188's closed chart indicated that bed alarm use was documented on the following dates:</p> <p>[DATE] at 3:00 pm</p> <p>[DATE] at 1:30 am</p> <p>[DATE] at 9:00 am</p> <p>[DATE] at 11:00 am</p> <p>[DATE] at 4:30 am</p> <p>[DATE] at 12:45 pm</p> <p>[DATE] at 10:10 pm</p> <p>[DATE] at 7:30 am</p> <p>[DATE] at 8:00 am</p> <p>[DATE] at 10:00 pm</p> <p>[DATE] at 12:30 am</p> <p>[DATE] at 8:15 am</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 - Few</p>	<p>Record review of nurses notes for Resident #188 indicated that he expired on [DATE] and was not observed or interviewed.</p> <p>During an interview on [DATE] at 1:15 pm DON said that someone offsite in the state of Oklahoma was currently doing their MDS's until they could get someone trained. She said they would send her the information and she would complete them. She said residents could be at risk of not getting appropriate care if MDS's and care plans were not completed accurately.</p> <p>During an interview on [DATE] at 1:40 pm Administrator said that going forward he was expecting the new MDS nurse that was currently in training to complete assessments accurately. He said residents could be at risk of not getting the care they needed since care plan focus areas were pulled over from assessment data.</p> <p>Record review of a facility policy titled MDS undated, read .The Director of Nursing/MDS Coordinator will assess residents in a timely manner .</p>

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46273</p> <p>Based on interview and record review the facility failed to develop and implement a comprehensive person-centered care plan for 1 of 12 residents (Resident #188) reviewed for care plans.</p> <p>The facility failed to develop a comprehensive care plan for the use of a bed alarm for Resident #188 that was put into use on [DATE]</p> <p>This failure could place residents at risk of inappropriate care and decreased quality of life.</p> <p>Findings included:</p> <p>Record review of a facility face sheet dated [DATE] for Resident #188 indicated that he was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses including: malignant neoplasm of prostate (prostate cancer that had spread to other locations in the body), hypertension (high blood pressure), and type 2 diabetes mellitus (uncontrolled blood sugar).</p> <p>Record review of a comprehensive MDS dated [DATE] for Resident #188 indicated that he was rarely/never understood and was unable to complete BIMS interview. Section C (Cognitive Patterns) indicated that he was severely cognitively impaired. Section P (Restraints and Alarms) incorrectly reflected that he did not use a bed alarm.</p> <p>Record review of a comprehensive care plan dated [DATE] for Resident #188 indicated that use of a position change alarm was not addressed.</p> <p>Record review of nurses notes in Resident #188's closed chart indicated that bed alarm use was documented on the following dates:</p> <p>[DATE] at 3:00 pm</p> <p>[DATE] at 1:30 am</p> <p>[DATE] at 9:00 am</p> <p>[DATE] at 11:00 am</p> <p>[DATE] at 4:30 am</p> <p>[DATE] at 12:45 pm</p> <p>[DATE] at 10:10 pm</p> <p>[DATE] at 7:30 am</p> <p>[DATE] at 8:00 am</p> <p>(continued on next page)</p>

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>[DATE] at 10:00 pm</p> <p>[DATE] at 12:30 am</p> <p>[DATE] at 8:15 am</p> <p>Record review of nurses notes for Resident #188 indicated that he expired on [DATE] and was not observed or interviewed.</p> <p>During an interview on [DATE] at 1:15 pm DON said that someone offsite in the state of Oklahoma was currently doing their MDS's and care plans until they could get someone trained. She said they would send her the information and she would complete them. She said residents could be at risk of not getting appropriate care if MDS's and care plans were not completed accurately.</p> <p>During an interview on [DATE] at 1:40 pm Administrator said that going forward he was expecting the new MDS nurse that was currently in training to complete assessments and care plans accurately. He said residents could be at risk of not getting the care they needed since care plan focus areas were pulled over from assessment data on the MDS.</p> <p>Record review of a facility policy titled Care Plan undated, read .The care plan will describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being .</p> <p>Record review of a facility policy titled Restraints undated, read .For those residents whose care plans indicate the need for restraints, we will engage in a systematic process of implementation, reduction or elimination of restraints to assure that the least restrictive device required is used .</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43994</p> <p>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 1 of 5 staff (CNA H) reviewed for infection control.</p> <p>The facility failed to ensure CNA H washed or sanitized her hands when passing out meal trays to residents on Hall 400 in rooms [ROOM NUMBER] on 5/6/2024.</p> <p>These failures could place residents at risk of exposure to communicable diseases and infections.</p> <p>Findings included:</p> <p>During an observation on 5/6/2024 from 11:50 AM-12:05 PM, CNA H was on hall 400 to pass lunch trays. CNA H went into the room of 401, 402 and 404 on hall 400, touching bedside tables and set up meal trays and did not sanitize her hands before or after passing trays to the residents.</p> <p>During an interview on 5/6/2024 at 12:05 PM, CNA H said she had been employed at the facility for 2 years and at mealtimes was responsible for passing out the trays. She said staff were required to set up for the ones that needed it and assist as needed. She said she was taught to sanitize her hands before and after passing the trays. She said she did not sanitize after each tray that was given to the residents on hall 400. She said she did after some, and she must have forgotten on the others. She said residents could be at risk for infections if staff did not sanitize their hands while passing meal trays.</p> <p>During an interview on 5/8/2024 at 1:15 PM, the DON said staff should be sanitizing their hands between residents when passing trays. She said they have had trainings on infection control with hand hygiene recently. She said residents could be at risk of infections. She said going forward they would continue to in-service staff on hand hygiene and continue to monitor. She said the facility did not have a policy for infection control during dining or meal service.</p> <p>During an interview on 5/8/2024 at 1:20 PM, the Administrator said all staff should sanitize their hands when passing meal trays before and after and there was a risk of cross contamination. He said they would in-service staff and do a return demonstration with hand hygiene going forward with passing meal trays.</p> <p>Record review of CDC.gov/hand hygiene last reviewed January 30, 2020 indicated, .Hand Hygiene Guidance: Healthcare personnel should use an alcohol-based hand rub or wash with soap and water for the following clinical indications: Immediately before touching a patient; after touching a patient or the patient's immediate environment; Healthcare facilities should: Require healthcare personnel to perform hand hygiene in accordance with Centers for Disease Control and Prevention (CDC) recommendations .</p>		