

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 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>40124</p> <p>Develop and implement policies and procedures to prevent abuse, neglect, and theft.</p> <p>Based on interviews and record review, the facility failed to implement written policies and procedures that prohibit and prevent abuse, neglect, and exploitation of residents for 5 of 14 staff (CNA B, CNA C, CNA D, CNA E and CNA F) reviewed for abuse policies.</p> <p>The facility failed to implement their own written policy and procedure for screening by not completing a Nurse Aide Registry (NAR) check for CNA B, CNA C, CNA D, CNA E and CNA F annually for 2023 and 2024.</p> <p>This failure could place residents in the facility at risk of Abuse, Neglect, or Exploitation.</p> <p>Findings included:</p> <p>During an interview 05/07/2024 5:00 PM, the Administrative Assistant said she obtained the employee misconduct registry search (EMR) on 5/06/24, upon the entrance of the survey team, for all employees. She said she did not run the NAR annually because the nurse aide certification date was listed on the EMR when she accessed the EMR site. She said she thought the EMR was good enough.</p> <p>During an interview 05/08/24 8:00 AM the DON she said criminal history checks, EMR and NAR are required on hire as outlined in the policy. The EMR and NAR were required annually per state requirements. She said not doing the EMR/NAR annually put the facility at risk of employing staff that have criminal charges and prevent them from being employable.</p> <p>During an interview 05/08/24 1:30 PM the Administrator said the Administrative Assistant was responsible for performing EMR/NAR and criminal history checks on hire. The NAR should be conducted on hire and annually for Nurse Aides. The EMR on all other employees on hire and annually. He said not doing an EMR/NAR annually on the CNA's put the facility at risk of employing staff that have criminal charges and prevent them from being employable. He said the Administrative Assistant would complete the NAR on the Nurse Aides today and put them in the employee file.</p> <p>During a record review of nurse aide employee files, there was no evidence of annual NAR checks on Nurse Aides:</p> <p>CNA B hire date 04/15/2020.</p> <p>CNA C hire date 09/16/2022.</p> <p>CNA D hire date 09/04/2007.</p> <p>CNA E hire date 06/25/2022.</p> <p>CNA F hire date 09/06/2021.</p> <p>Record Review of an undated Abuse Policy</p> <p>(continued on next page)</p>		

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<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Abuse Prevention Page No. A3a</p> <p>POLICY:</p> <p>Facility will prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property but not limited to, facility staff, other residents, consultants or volunteers, staff of other agencies serving the residents, family members or legal guardians, friends or other individuals through the implementation of seven components:</p> <ol style="list-style-type: none"> 1. Screening of potential employees. 2. Training of employees (both new and ongoing training for all employees). <ol style="list-style-type: none"> 1. Prevention of occurrences. 2. Identification of possible incidents and allegations which need investigation. 3. Investigation of incidents and allegations. 4. Protection of residents during investigation, and 5. Reporting of incidents, investigations, and facility response to the results of their investigations . <p>Page A3c</p> <p>The Administrator, or designee, is responsible for implementing policies and procedures that prohibit mistreatment, neglect, abuse, and misappropriation of resident property.</p> <p>I. The facility will screen potential employees for a history of abuse, neglect, or mistreatment of residents, including checking with the appropriate licensing boards and registries. (Criminal Background Check, Registry and Driving Checks: Pre-Employment).</p> <p>The facility will not employ individuals who:</p> <ul style="list-style-type: none"> o Have been found guilty by a court of law of abusing, neglecting, or mistreating others o Had a finding entered the State Nurse Aide Registry concerning abuse, neglect, mistreatment of others or misappropriation of their property. 		

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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 0700</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43994</p> <p>Based on observation, interview, and record review the facility failed to attempt to use appropriate alternatives prior to installing a side or bed rail, assess the resident for risk of entrapment from bed rails prior to installation, and review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation for 1 of 35 residents (Resident #16) reviewed for bed rails.</p> <p>The facility failed to obtain an order, complete an assessment, obtain informed consent, or attempt to use an alternative for the use of bedrails for Resident #16 who had full bed rails on both sides of her bed from 5/6/2024 to 5/8/2024.</p> <p>This failure could place residents at risk of entrapment or injury.</p> <p>Findings included:</p> <p>Record review of an Admission Record dated 5/8/2024 for Resident #16 indicated she admitted to the facility on [DATE] and was [AGE] years old with diagnosis of morbid obesity (overweight), polyneuropathy (nerve damage that affects the hands and feet), monoplegia of lower limb (paralysis that affects one side of the body such as the arm or leg), and PVD (decreased blood flow to the legs and feet).</p> <p>Record review of active physician orders dated 5/8/2024 for Resident #16 did not indicate an order for bedrails.</p> <p>Record review of a Quarterly MDS dated [DATE] for Resident #16 indicated she did not have any impairment in thinking with a BIMS of 15, required partial/moderate assistance with transfers from chair to bed. Restraints and alarms did not indicate the use of bed rails.</p> <p>Record review of a Care Plan dated 4/28/2024 for Resident #16 indicated she was at risk for falls related to BLE (both lower extremities) impairment with interventions to anticipate and meet her needs. Bedrails was not on the care plan.</p> <p>Record review of a monthly summary dated 4/3/2024 for Resident #16 indicated she required extensive assistance with bed mobility and did not have any restraints that included bedrails.</p> <p>Record review of assessments for Resident #16 indicated there were no assessments for bed rails.</p> <p>Record review of a resident care plan conference report dated 4/9/2023 for Resident #16 indicated there was not a consent of siderail by the resident or representative.</p> <p>(continued on next page)</p>		

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<p>F 0700</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an observation and interview on 5/6/2024 at 10:47 AM, Resident #16 was sitting up in a wheelchair. She had side rails on both sides of the bed that were down and said she put them up when in bed on occasions when she had bad leg spasms and the rails had been on the bed for years. She said she had gotten into trouble once before when she had them up at night and a staff member told her she could not use them. She said the staff do not pull them up or down for her as she can do it on her own.</p> <p>During an interview on 5/8/2024 at 9:30 AM, the DON said that Resident #16 was able to move the bedrails up and down on her own. When questioned if the resident had an order or consent for the bedrails, she stated that she did not. She said that Resident #16 was the only resident in the facility that had bed rails on their bed.</p> <p>During an interview on 5/8/2024 at 11:15 AM, LVN G said she had been employed at the facility since October 2023 and was the charge nurse in the facility for her shift. When questioned if there were any residents in the facility that used bedrails, she stated there was not anyone in the facility, then clarified that Resident #16 had bed rails. She said Resident #16 was able to use them on her own and could pull them up and down. She said the nursing staff do not complete any assessments on bedrails for Resident #16.</p> <p>During an interview on 5/8/2024 at 11:20 AM, the DON said Resident #16 had bedrails since admission to the facility and used them on her own. She said she used them for her leg due to having spastic leg cramps and was unable to control her left leg as it could make her flip off of the bed. She said she was not aware that Resident #16 was using the bed rails and alternative were not discussed with her. She said Resident #16 did not have a consent for the bedrails because they were not aware the resident was using them. She said no one in the facility was monitoring or assessing the use of bed rails. She said going forward, they would discuss with Resident #16 about taking the bed rails off or if she would like to keep them and obtain an order and consent for them. She said residents could get entrapped and injure themselves if bed rails were used. She said the bed rails came with the bed. She said the facility did not have a policy for bedrails.</p>

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	
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43994</p> <p>50071</p> <p>Based on observation, interview, and record review the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety in the facility's only kitchen reviewed for food safety requirements and kitchen sanitation.</p> <ol style="list-style-type: none"> 1. The facility failed to ensure the DA wore a hairnet effectively to cover all of her hair on [DATE]. 2. The facility failed to ensure foods stored in the refrigerators, freezers and dry pantry were labeled, dated, and not kept past their expiration dates on [DATE] 3. The facility failed to ensure items were not stored on the floor in the dry pantry area on [DATE]. 4. The facility failed to ensure personal foods for staff were not kept in the refrigerators that were designated for the kitchen on [DATE]. 5. The facility failed to ensure one of the freezers (freezer #2) was at an appropriate temperature to keep foods frozen solid on [DATE]. 6. The facility failed to procure eggs from vendors that meets federal, state, or local approval on [DATE] 7. The facility failed to ensure containers of flour and sugar were not stored on the floor, were clean and sealed properly on [DATE]. 8. The facility failed to ensure the dish rack that stored cups and bowls were clean on [DATE]. <p>These failures could place residents at risk of foodborne illness and food contamination.</p> <p>Findings included:</p> <p>During an initial tour observation in the kitchen on [DATE] 9:30 a.m., revealed DA had on a hair net that did not completely cover her hair. She had hair that was sticking out on the sides of her head by her ears and at the back of her head.</p> <p>During an interview on [DATE] at 9:32 AM, DA said her hair was fine in texture and it would not stay underneath the hairnet. She said she knew it was supposed to be all covered and that parts of her hair could get in the resident's food.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>During an observation and interview on [DATE] at 9:33 AM, freezer #1 had two packages of a white, blocked type substance in plastic bags identified by the [NAME] as diced chicken. There was one small cup of thawed and refrozen ice cream. There was an item wrapped in plastic wrap that was not dated and the DA said she could not identify what it was, and the [NAME] said she believed it was turkey. One single corn dog was sitting on the shelf with on date, two frozen plastic bags of an orange hard substance and the [NAME] said she believed there were peaches used to make desserts that was not dated or labeled. There was a lemon and pecan pie with no dates.</p> <p>During an observation and interview on [DATE] at 9:40 AM, refrigerator #1 had one head of lettuce that was not dated or labeled, one bottle of chocolate syrup with an expiration date of 2021, two dozen brown eggs that the [NAME] said belonged to an employee at the facility who would bring them in for the kitchen to use and they were yard eggs; three containers of Greek yogurt were in a plastic bag and the DA said they belonged to the DM; two sheet pans of bacon were prepped on parchment paper stacked on top of each other not dated or labeled; and one bowl of ribs covered with plastic wrap dated [DATE].</p> <p>During an observation and interview on [DATE] at 9:50 AM, freezer #2 temperature was 40 degrees that had a tray of melted pudding, three bags of soft hashbrowns that was not dated or labeled in plastic bags, two packages of thawed chicken and dumplings not dated or labeled. The [NAME] said the chicken and dumplings was removed and placed in the freezer to thaw out of the upcoming meal; two bags of soft tator tot box that was open and not dated or labeled; one bag of soft rolls identified by the [NAME] not dated or labeled; two bags of soft, baby carrots not dated or labeled, two bags of okra that was soft and not dated or labeled; one bag of a meat substance identified by the [NAME] at beef tips was not dated or labeled. The [NAME] said that they were aware that freezer #2 was not working properly. She said it was supposed to be getting fixed and the Administrator was aware.</p> <p>During an observation and interview on [DATE] at 10:00 AM, refrigerator #2 had four containers of prepped meals dated [DATE], [DATE], [DATE] and [DATE]. [NAME] said they belonged to the Assistant Administrator.</p> <p>During an observation on [DATE] at 10:03 AM, the dry pantry area had (four) five-gallon bottles of water stored on the floor with aluminum foil on the tops secured with rubber bands; one box of chicken bouillon cubes that expired ,d+[DATE]; and one container of hot chocolate that expired ,d+[DATE].</p> <p>During an interview on [DATE] at 10:08 AM, the DA and [NAME] both said it was the responsibility of all staff that worked in the kitchen to make sure items were dated and labeled along with all leftovers to be thrown away in three days. They both said there were three staff that worked in the kitchen and that included them and the DM.</p> <p>During an observation and on [DATE] at 2:30 PM, a revisit in the kitchen revealed clean dishes that consisted of cups and bowls were stored on a dish rack that was dirty with the bowls facing top down. The [NAME] said she cleaned the rack when it looked dirty and said she would clean it. DA was present and her hair was not completely covered by the hairnet and had hair sticking out by her ears and at the back of her neck.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>During an interview on [DATE] at 2:35 PM, DM stated she had been employed at the facility for two years. She assured she labeled everything she put in the freezers and the refrigerators. She stated she checked other labels and dates when she had time but stayed very busy and could not check them more than once per week. She stated the Administrator had to call someone to come out and repair freezer #2. She stated they had issues with the freezer off and on and it had been repaired in the past. She stated the Administrator, and the Assistant Administrator always stored their personal food items in the kitchen refrigerators and freezers and said they should not be storing personal items in the kitchen. She stated that outdated food items should be thrown away and not served and if it were served to residents, it could make them sick. She said the water bottles were stored on the floor and should not be. She stated there was no other place than on the floor to store them and that they had been in the same place since she started over two years ago. She said staff that were in the kitchen had to wear a hairnet and if hair was not completely covered then hair could get into the resident's food. She stated when storing canned or packaged goods they should be rotated with the nearest date in front of the farthest date. She said that she was very nervous when the Surveyor entered the kitchen for observations and was doing the best she could. She said there were only three people that worked in their kitchen and on the days that the [NAME] was off, she worked in her place so a lot of things that should be done, she could not do.</p> <p>During an observation on [DATE] at 8:25 AM, the DM was wearing gloves and prepping meat for the Hamburger Steak that was on the lunch menu by placing the patties on a sheet pan. She dropped a piece of paper on the floor and picked it up and proceeded to prepare the meat with the same gloves on.</p> <p>During an interview on [DATE] at 8:27 AM, the Surveyor asked the DM about picking up a piece of paper off the floor and proceeding to prep the meat for lunch. She stated she did not remember picking up the paper and was nervous. The DM told the Surveyor that she should have removed her gloves, washed her hands, changed her gloves and that by not using proper sanitation it could contaminate the food.</p> <p>Record review of an In-Service dated [DATE] titled hand washing was conducted by the DM to the kitchen staff.</p> <p>During an observation on [DATE] at 11:05 AM, the DM did not remove her gloves after she prepped the steam table food. She looked through several drawers for a thermometer and came back to the steam table and began checking the temperatures of the hamburger patties without washing her hands or changing gloves. She was observed not using alcohol wipes between checking the temperatures of the foods on the steam table, she rinsed the thermometer under water from the hand sink and wiped it off with a paper towel that she was holding in her hand prior to rinsing the thermometer. She checked the temperature of the hamburger patties and mashed potatoes with the same technique. The RD was present in the kitchen and intervened and told her to use alcohol wipes to sanitize the thermometer when checking the temperatures of the remainder of the foods on the steam table.</p> <p>During an interview on [DATE] at 11:00 AM, the RD stated he recognized areas of concern during his observation in the kitchen and would in-service kitchen staff in the attempt to make some corrections. The RD stated he would Inservice staff on infection control, cross contamination, dating, and labeling items stored in the refrigerator and freezer as well as discarding expired foods.</p> <p>Record review of monthly in-services conducted by the RD on [DATE] to the dietary staff included cross contamination and labeling and dating of foods.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>During an interview on [DATE] at 9:00 AM, the Assistant Administrator said the meals in the kitchen that were prepped and stored in one of the refrigerators were for her and the Administrator. She said the kitchen staff would prepare them a meal at lunch and they saved them a tray after the residents ate. She said they were not going to store their personal meals in the refrigerators in the kitchen anymore and was not aware until the Surveyor said something about it. She said they would correct the issues and check daily by the Administrator going forward. She said they would take the issues found in the kitchen to QAPI (Quality Assurance and Performance Improvement) at their next meeting. She said all staff in the kitchen should wash their hands between tasks and no items should ever be stored on the floor. She said personal foods for staff should be kept separate and foods should be labeled and dated when they arrived. She said items removed from the original box should be dated and labeled as well. She said the kitchen staff had a cleaning schedule that they should go by. She said the kitchen should have two thermometers, one designated for hot and another one for cold foods. She said thermometers should be cleaned using alcohol wipes between foods. She said hair should totally covered under a hairnet. She said foods stored in the freezer should be frozen solid. She said they would in-service staff in the kitchen and would come up with a checklist for them to use.</p> <p>During an interview on [DATE] at 1:20 PM, the Administrator said the DM was responsible for the kitchen and expected all staff that worked in the kitchen to follow infection control practices and all the processes. He said staff should have their hair covered by a hairnet when in the kitchen. He said foods should be labeled and dated. He said he was not aware of freezer #2 needing repair until [DATE]. He said freezer #2 has had issues in the past that needed to be repaired. He said going forward they would train all staff in the kitchen on all of the processes. He said he was aware of all of the issues that were observed in the kitchen on [DATE] and [DATE]. He said the RD did conduct in-services with the kitchen staff on [DATE]. He said residents could be at risk of cross contamination and food borne illnesses if staff did not follow the processes in the kitchen.</p> <p>Record review of a facility policy titled Good Hygiene Practices for Food Services Employees revised , d+[DATE] indicated, .Hair Restraints: Nutrition Service employees will wear hair restraints such as hats, hair coverings or nets, that are designed and worn to effectively control and keep their hair from contacting exposed food, clean equipment, utensils; Egg Guidelines: Use only pasteurized egg products; Food brought into the facility from an outside source is discouraged and will not be stored in, prepared by or served by the Nutrition Services Department; Maintain efficient refrigeration through proper cleaning and maintenance of the unit .</p> <p>Record review of a facility policy titled Sanitation of Nutrition Services Department revised ,d+[DATE] indicated, .The Nutrition Services Staff will maintain the sanitation of the Nutrition Services Department through compliance with a written, comprehensive cleaning schedule developed for the facility by the Manager of Nutrition Services in conjunction with the Dietitian. Cleaning Procedures: 1. d. Food must be stored at least 6 inches above the floor .</p> <p>Record review of a facility policy titled Storage of Dry Food and Supplies revised ,d+[DATE] indicated, .The Nutrition Services Department will store dry food and supplies according to policy guidelines and state regulations. Container guidelines: Metal or plastic containers with tight fitting covers, labeled top and side, must be used for storing products. Date and properly rotate all products to ensure freshness .</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Record review of a facility policy titled Food Storage revised ,d+[DATE] indicated, .Food Storage areas are maintained in clean, safe, and sanitary manner. 2. All foods or food items not requiring refrigeration should be stored at least 6 above the floor, on shelves, racks, dollies, or other surfaces which facilitate thorough cleaning. All packaged food, canned foods, or food items stored will be kept clean and dry at all times. 4. Frozen foods will be stored at 0 degrees F or below at all times. (Note: There is an accurate thermometer in each refrigerator, freezer, an in storerooms used for perishable foods.) 5. All foods stored in walk-in refrigerators and freezers will be stored above the floor on shelves, racks, dollies, or other surfaces that facilitate thorough cleaning .</p> <p>Record review of the FDA Food Code 2022 indicated, .Chapter 2. Management and Personnel; [DATE].14 When to Wash. F. During food preparation, as often as necessary to remove soil and contamination and to prevent cross contamination when changing tasks; ,d+[DATE] Hair Restraints: Food employees shall wear hair restraints such as hats, hair coverings or nets that are designed and worn to effectively keep their hair from contacting exposed food; [DATE].15 Gloves, Use Limitation: A. If used, single use gloves shall be used for only one task such as working with ready-to eat food or with raw animal food, used for not other purpose, and discarded when damaged or soiled, or when interruptions occur in the operation .</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>

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<p>F 0919</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Make sure that a working call system is available in each resident's bathroom and bathing area.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40124</p> <p>43994</p> <p>Based on observation, interview, and record review, the facility failed to be equipped to allow residents to call for staff through a communication system which relays the call directly to a centralized staff work area for 2 of 15 residents (Resident #4 and Resident #13) reviewed for call lights.</p> <p>The facility failed to ensure Resident #4's emergency call button in the bathroom had a pull cord on 5/6/2024 and 5/7/2024.</p> <p>The facility failed to ensure Resident #13's call light was within reach while in bed on 5/6/2024 and 5/7/2024</p> <p>These failures could place residents at risk of injury, pain, hospitalization, and a diminished quality of life.</p> <p>Findings included:</p> <p>1. Record review of a face sheet dated 5/07/2024 for Resident #4 indicated she was a 90-year female admitted [DATE] with diagnosis of dementia (altered thinking related to aging), history of healed fracture of the hip and weakness.</p> <p>Record review of a quarterly MDS dated [DATE] for Resident #4 indicated she had moderate impairment in thinking with a BIMS score of 7. She required setup/clean up assistance with toileting and was continent of bowel and occasionally incontinent of urine.</p> <p>Record review of a care plan dated 12/29/2023 revised on 5/4/2024 for Resident #4 indicated, TOILETING AND TOILET TRANSFERS, Resident #4 is independent at this time.</p> <p>During an observation and interview on 5/06/2024 at 9:10 AM the bathroom call button in Resident #4's room did not have a pull string. The call button was attached to the wall in the bathroom by the grab bar with only three inches of metal cord hanging down. Resident #4 was in the room and said she had been at the facility for several years and used her bathroom all the time. She said most days she transferred herself to the toilet but required help sometimes.</p> <p>During an interview on 5/07/2024 at 1:42 PM, CNA A said she had been employed at the facility for a while and was assigned to the hall where Resident #4 resided frequently and cared for her. She said Resident #4 admitted to the facility several years ago and required assistance to transfer at times, but she was able to transfer herself most of the time depending on how she was doing that day.</p> <p>(continued on next page)</p>		

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<p>F 0919</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an observation and interview on 5/07/2024 at 3:00 PM in the bathroom of Resident #4, housekeeping said she was unaware that the strings attached to the call light in the bathrooms needed to go to the floor. She said she had not been trained to look for the cords while she was cleaning. She said she could see that it would be a problem if a resident fell and could not reach the call light because they were lying on the floor. She said the Administrator would be responsible for checking them and replacing them as needed.</p> <p>2. Record review of an Admission Record dated 5/7/2024 for Resident # 13 indicated she admitted to the facility on [DATE] and was [AGE] years old with diagnoses of Alzheimer's Disease (brain disorder that affects memory, thinking, and behavior), hypothyroidism (thyroid gland does not produce enough thyroid hormone to keep the body running normally), scoliosis (curve in the spine) and hypertension (high blood pressure).</p> <p>Record review of a Quarterly MDS dated [DATE] for Resident #13 indicated she was rarely/never understood. She was always incontinent of bowel/bladder.</p> <p>Record review of a care plan revised 4/30/2024 for Resident #13 indicated she was at risk for falls related to unaware of safety needs from impaired cognition with interventions to be sure call light is within reach and encourage to use it for assistance as needed; answer promptly.</p> <p>During an observation on 5/6/2024 at 11:02 AM, Resident #13 was lying in bed, no call light observed, unable to answer questions. Call light for Resident #13's room with no string attached only a small metal string noted on the wall that was unreachable by the resident.</p> <p>During an observation on 5/6/2024 at 3:39 PM, Resident #13 was in bed awake, pleasantly confused with the call light on the wall with only a short metal string, no string in place that would reach to the resident.</p> <p>During an observation on 5/7/2024 at 9:26 AM, Resident #13 was in bed awake, call light on wall with only metal string, not in reach for the resident.</p> <p>During an interview on 5/7/2024 at 2:25 PM, CNA A said she had been employed at the facility since 2010 and worked full time. She said all staff were responsible for the call lights. She said she had been at work since 6 am and noticed earlier that Resident # 13 did not have a string attached to the call light. She said she reported it to the Administrator who attached a string for the resident. She said the resident had been known to remove the string in the past and she had been able to find it. She said call lights should be in reach all the time and if not, a resident could fall or try to get up without assistance.</p> <p>During an interview on 5/7/2024 at 3:15 PM, the DON said the call light strings should be long enough to reach the floor. She said the Administrator was responsible for checking the call lights. She said that they have no log or policy regarding the call light system. She said if the call light strings in the bathrooms were not long enough, or if they were not in reach for a resident in the bed, residents could fall and not be able to call for help.</p> <p>(continued on next page)</p>

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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 0919</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 5/8/2024 at 1:30 PM, the Administrator said he owned and operated the facility and served as maintenance also. He said he was responsible for checking the calls lights in all the rooms in the facility. He said staff notified him if any call lights were missing strings. He said he checked Resident #4's call lights yesterday 5/7/2024 and added a string to the metal cord and added a string to Resident #13's call light earlier that day. He said a resident would be on the floor for a while if they had a fall and could not reach the string to call for help.</p> <p>A copy of a policy on call lights was requested and none was provided prior to exit.</p>		