STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676053	A. Building B. Wing	10/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Merkel Nursing Center	1704 N 1st Merkel, TX 79536

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 - Some	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** 45458 Based on observations, interviews, and records reviews, the facility failed to immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is a significant change in the resident's physical, mental, or psychosocial status for 1 (Resident #10) of 3 residents reviewed for change of condition. The facility failed to notify Resident #10's physician after Resident #10's change in condition did not improve after she returned from the hospital. This failure could place residents at risk of not having their change of condition communicated to their physician, delay of treatment, and a decline in the residents' health and well-being. The findings include: Record review of Resident #10's Facesheet, dated 10/15/2024, revealed Resident #10 was a [AGE] year-old female, with an admitted into the facility of 06/11/2024. Diagnoses included Hypothyroidism (underactive thyroid), Depression (mood disorder that can affect how a person feels, thinks, and behaves), Insomnia (trouble falling asleep), and Essential hypertension (high blood pressure that was multifactorial and does not have one distinct cause). Record review of Resident #10's Quarterly Minimum Data Set (MDS), dated [DATE], revealed Resident #10's BIMS score was 13, which indicated intact cognitive response. Section E - Behavior, E0100 - potential indicators of psychosis, indicated Resident #10 had no indicators of hallucinations or delusions, and E0200 Behavior Symptom - presence & frequency, revealed Resident #10 exhibited no physical, verbal, or behavioral symptoms toward others. Record review of Resident #10's clinical records revealed there was no Care Plan in the facility's electronic health record system. Record review of Resident #10's admission document from the emergency room at the hospital, dated 10/09/2024, revealed Resident #10 was seen at the ER at 7:35 p.m. transported by family. Resident #10 presented with complaint of difficulty sleeping and family was concerned of UTI due to reported confusion, decreased appetite, and acting different. Family reported symptoms began around Sunday (10/06/2024). (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #10's hospital Physician's Progress Note, dated 10/10/2024, revealed Resident #10 was treated with IV antibiotics for the diagnosis of Urinary tract infection and Resident #10 tolerated the IV antibiotic treatment well with no visual hallucinations and no pain of any kind reported. Record review of Resident #10's hospital discharge summary, dated 10/11/2024, revealed Resident #10's discharge diagnoses were E. coli Urinary tract infection, and dizziness and visual hallucinations, resolved. Reviewed revealed Resident #10 was, up in the recliner having lunch. She denied HA/CP/SOB. No further visual hallucinations. No pain of any kind reported. She was dc' ed back to her facility in stable condition. Record review of Resident #10's hospital discharge document, dated 10/11/2024, revealed Resident #10 was discharged to return to the nursing facility and to call the doctor if Resident #10 experienced worsening symptoms. Record review of Resident #10's Progress Notes, dated 10/11/2024 indicated the following: At 4:45 p.m., documented by LVN A, revealed Resident #10 returned to the facility and was readmitted to the facility. LVN A documented Resident #10 stated, to other nurse that she felt like people were shunning her. At 11:28 p.m., documented by LVN A, revealed Resident #10 refused to take her 10:00 p.m. medication and Resident #10 stated she was not going to take them. LVN A documented Resident #10 did come out of her room and ambulated in the hallway. Resident #10 exhibited paranoia, did not trust anyone, and thought people were shunning her. Further review revealed there was no evidence LVN A notified the physician or nurse practitioner of the resident's behaviors. Record review of Resident #10's Progress Notes, dated 10/12/2024 indicated the following: At 5:11 a.m., documented by LVN B, revealed Resident #10 reused to take her morning medication and called 911 three (3) times and asked the policemen to come get her and take Resident #10 home. Further review revealed there was no evidence LVN B notified the physician or nurse practitioner of the resident's behaviors. At 7:49 a.m., documented by LVN A, revealed Resident #10 refused to take her morning medication and refused to eat breakfast. LVN A documented, Resident #10 was confused, stating she was going to the doctor today and the ER. Hard to redirect. Resident #10 had some of her personal belongings packed. Further review revealed there was no evidence LVN A notified the physician or nurse practitioner of the resident's behaviors. Record review of Resident #10's Progress Notes, dated 10/13/2024 at 10:07 p.m., documented by LVN C, revealed Resident #10 called her family member to report Resident #10 was saying she was located at the courthouse in a different city and was not aware of what Resident #10 was being charged with. LVN C documented Resident #10's family did not know what was going on with Resident #10 or what to do with her, because this was not their family member. Further review revealed there was no evidence LVN C notified the physician or nurse practitioner of the resident's behaviors. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #10's Progress Notes, dated 10/14/2024 at 6:24 a.m., documented by LVN D, revealed Resident #10 called 911 twice and the dispatcher called the facility back on a wellness check. LVN D documented Resident #10 was hard to redirect and reorient to time, place, and situation. LVN D documented Resident #10 refused morning medication and change of condition was not a new onset for the shift and appeared to be ongoing. LVN D documented Resident #10 appeared to have some episodes of unsteadiness on her feet during ambulation. Record review of Resident #10's Progress Notes, dated 10/15/2024 at 10:37 a.m., documented by LVN E, revealed Resident #10 was very paranoid and refused meds. Further revealed LVN E documented family member was notified, and an order was received from nurse practitioner to attempt to obtain a urine sample. During an observation and interview on 10/15/2024 at 2:35 p.m., Resident #10 was observed in her room, fully dressed as she sat on the chair on her mobility walker. Resident #10 had a bag of clothing on her lap and another bag on her bed. Resident #10 identified herself and when asked if she had been in the hospital recently, Resident #10 replied, I am in the hospital. During an observation and attempted interview on 10/16/2024 at 4:05 a.m., Resident #10 was observed in her room as she sat in her recliner, fully dressed. Resident #10 was observed as she put her shoes on. Attempted to interview Resident #10 but she did not respond to conversation as she looked around the room. During an interview on 10/16/2024 at 4:19 a.m., LVN B said Resident #10 had not slept during the night, been fully dressed, and sat in her recliner or was up rearranging her belongings. LVN B said Resident #10 was confused and told LVN B she was at the hospital and asked LVN B when Resident #10 would be going home. LVN B said when Resident #10 was admitted into the facility she was very social and very active. LVN B said Resident #10 showed symptoms of confusion on 10/07/2024 approximately. LVN B said the doctor was aware of Resident #10's change of condition before she went to the hospital to be treated for a UTI. LVN B said the symptoms of paranoia should have been documented in Resident #10's clinical record and the doctor should have been contacted at that time the behavior was observed. During an interview and observation on 10/16/2024 at 5:58 a.m., LVN A said between 10/11/2024 and 10/15/2024, Resident #10 displayed non-compliant behaviors of refusing medication, confusion, and change of condition. LVN A said due to Resident #10's behaviors, she would have notified the doctor and the documentation should be in her progress notes. LVN A said she usually texted the nurse practitioner. After LVN A reviewed the progress notes, LVN A said she could not see that she documented that the nurse practitioner or doctor was contacted. LVN A said she would have deleted any texts off her phone and there was no other documentation that the doctor or nurse practitioner was contacted. During an interview on 10/16/2024 at 10:49 a.m., Physician F said he was not notified of Resident #10's change of condition before or after hospitalization , but the facility may have contacted the nurse practitioner. Physician F said he was not informed of Resident #10 displayed symptoms of confusion, calling 911, not eating, refusing meds, and not sleeping. Physician F said he or the nurse practitioner should had been contacted within 24 to 48 hours after Resident #10 returned from the hospital if symptoms had not resolved. Physician F said this could have been a sign that the treatment from the hospital was not effective. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 10/16/2024 at 11:54 a.m., Nurse Practitioner G said she had not been notified by the facility of Resident #10's change in condition since she had been discharged from the hospital. Nurse Practitioner G said she did not realize Resident #10 had not improved and continued to have symptoms such as calling 911, paranoia, refusing her meds, and refusing to eat. Nurse Practitioner G said the facility notified her on 10/08/2024 prior to Resident #10's hospitalization and reported confusion. Nurse Practitioner G said at that time, she ordered a urine sample to rule out a UTI. Nurse Practitioner G said she was also notified when Resident #10 was admitted into the hospital on 10/09/2024 but had not been notified since that date. Nurse Practitioner G said she was notified the day before, 10/15/2024, by the nurse that worked evenings and was informed Resident #10 was confused and questioned about a UA but was not informed Resident #10 was refusing meds, not eating, calling 911, or not sleeping. During an interview on 10/16/2024 at 1:08 p.m., the Administrator said he was aware Resident #10 had a UTI. The Administrator said his expectation when a resident had a change of condition and displayed behaviors the same as Resident #10 would be to immediately contact the physician or nurse practitioner. The Administrator said the fact that the doctors were not notified was concerning and could cause unnecessary harm to the residents. The Administrator said he was ultimately responsible for monitoring and ensuring the doctor was notified. The Administrator said he supervised the nursing staff, and the process would be to go up the chain of command from the nurse, ADON, DON, to himself. Record review of the facility's policy, Change in a Resident's Condition or Status, dated 05/2017, revealed the facility shall promptly notify the resident, his or her Attending Physician or physician on call when there had been a(an): - accident or incident involving the resident; - discovery of injuries of unknown origin; - adverse reaction to medication; - significant change in the resident's physical/emotional/mental condition; - need to alter the resident's medical treatment significantly; - need to transfer the resident to a hospital/treatment center Record review of the facility's policy, Resident Rights, dated 12/2016, revealed federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to: - communication with and access to people and services, both inside and outside the facility; - be notified of his or her medical condition and of any changes in his or her condition; - be informed of, and participate in, his or her care planning and treatment; - choose an attending physician and participate in decision-making regarding his or her care.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45458 Based on interviews and records reviews, the facility failed to develop and implement a baseline care plan for each resident that included the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care for 1 (Resident #10) of 3 residents reviewed for baseline care plans. The facility failed to ensure Resident #10 had a baseline care plan developed within 48-hours after admission with goals, services, and interventions. This failure could place newly admitted residents at risk of not receiving the care and services needed to promote good health and continuity of services. The findings included: Record review of Resident #10's Facesheet, dated 10/15/2024, revealed Resident #10 was a [AGE] year-old female, with an admitted [DATE]. Diagnoses included Hypothyroidism (underactive thyroid), Depression (mood disorder that can affect how a person feels, thinks, and behaves), Insomnia (trouble falling asleep), and Essential hypertension (high blood pressure that was multifactorial and does not have one distinct cause). Record review of Resident #10's Quarterly MDS, dated [DATE], revealed Resident #10's BIMS score was 13, which indicated intact cognitive response. Section E - Behavior, E0100 - potential indicators of psychosis, indicated Resident #10 had no indicators of hallucinations or delusions, and E0200 Behavior Symptom - presence & frequency, revealed Resident #10 exhibited no physical, verbal, or behavioral symptoms toward others. Record review of Resident #10's clinical records revealed there was no Baseline Care Plan or Comprehensive Care Plan in the facility's electronic health record system. During an interview on 10/15/2024 at 1:10 p.m., the ADON said the admitting nurse would be responsible for the baseline care plan. Record review of the current Employee Roster, dated 10/09/2024, revealed LVN N, who admitted Resident #10 was no longer employed at the facility. During an interview on 10/16/2024 at 1:08 p.m., the Administrator said his expectation was for baseline care plans to be completed upon admission with the first 48 hours. The Administrator said the development Baseline Care Plan was the responsibility of the nursing staff and should be monitored by the DON. The Administrator said the negative outcome of not having a Baseline Care Plan would be improper care. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the facility's policy, Care Plans - Baseline, dated 12/2016, revealed a baseline plan of care to meet the resident's immediate needs shall be developed for each resident within forty-eight (48) hours of admission. The interdisciplinary Team will review the healthcare practitioner's orders and implement a baseline care plan to meet the resident's immediate needs.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45458 Based on observations, interviews, and records reviews, the facility failed to develop and implement a comprehensive person-centered care plan for each resident that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment and describes services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being for 3 (Resident #6, Resident #7, and Resident #10) of 7 residents reviewed for care plan accuracy, in that: Resident #6 and Resident #7 did not have a care plan that addressed smoking, and for Resident #10, the facility failed to develop a comprehensive care plan as required. This failure could place residents at risk of receiving care that is substandard, unable to meet their needs, or cause injury or harm. The findings included: Resident #6 Record review of Resident #6's Facesheet, dated 10/10/2024, revealed Resident #6 was a [AGE] year-old female, with an admitted into the facility of 12/21/2022. Diagnoses included Unspecified Dementia (chronic condition that causes a gradual decline in cognitive abilities, such as thinking, remembering, and reasoning), Unspecified Severity, without behavioral disturbance, psychotic disturbance, mood disturbance, or anxiety). Record review of Resident #6's Quarterly Minimum Data Set (MDS), dated [DATE], revealed Resident #6's BIMS score was 13, which indicated intact cognitive response. Further review of MDS revealed smoking status was not completed. Record review of Resident #6's Smoking Safety Screen, dated 07/05/2024, revealed Resident #6 was a smoker who smoked 10 plus cigarettes per day at multiple times per day. Review of the assessment revealed Resident #6 did not have the ability to light her own cigarette and needed the facility to store her smoking paraphernalia. Further review revealed the IDT decided Resident #6 was safe to smoke with supervision. Record review of Resident #6's Care Plan, dated 09/06/2024, revealed the plan did not contain a focus, goal, or interventions to address Resident #6's smoking deficit. During an observation on 10/09/2024 at 11:17 a.m., Resident #6 was present in the smoking area. The ADON was present and supervised Resident #6 smoking. During an interview on 10/09/2024 at 11:29 a.m., Resident #6 said she was a smoker and smoked during designated smoke breaks on the patio every day. Resident #7 (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #7's Facesheet, dated 10/10/2024, revealed Resident #7 was a [AGE] year-old female, with an admitted into the facility of 03/08/2022. Diagnoses included Psychotic disorder (severe mental illness that causes a person to have abnormal perceptions and thinking, and to lose touch with reality) with delusions due to known physiological condition, Acute atopic conjunctivitis, bilateral (a rare chronic eye condition that causes inflammation of the eyelids and conjunctiva [thin, clear membrane that protects the eye]), Unspecified Dementia (chronic condition that causes a gradual decline in cognitive abilities, such as thinking, remembering, and reasoning), and Unspecified Severity, without behavioral disturbance, psychotic disturbance, mood disturbance, or anxiety). Record review of Resident #7's Quarterly Minimum Data Set (MDS), dated [DATE], revealed Resident #7's BIMS score of 06, which indicated a severe cognitive impact response. Further review of MDS revealed smoking status was not completed. Record review of Resident #7's Smoking Safety Screen, dated 03/16/2024, revealed Resident #7 was a smoker who smoked 5 to 10 cigarettes at multiple times per day. Review of the assessment revealed Resident #7 did not have the ability to light her own cigarette and identified a cognitive loss. Further review revealed the IDT decided Resident #7 needed to have cigarettes and lighter stored from her for safety reasons and was safe to smoke with supervision. Record review of Resident #7's Care Plan, dated 09/22/2024, revealed the plan did not contain a focus, goal, or interventions to address Resident #6's smoking deficit. During an observation on 10/09/2024 at 11:17 a.m., Resident #7 was outside in the designated smoking area as she sat in her wheelchair and smoked. Resident #7 had her purse in her lap and held a cigarette. Resident #7 sat by the ashtray and put her ashes in the ashtray appropriately. During an interview on 10/09/2024 at 11:29 a.m., Resident #7 said she was a smoker but only smoked in the mornings during break. Record review of Resident #10's Facesheet, dated 10/15/2024, revealed Resident #10 was a [AGE] year-old female, with an admitted [DATE]. Diagnoses included Depression (mood disorder that can affect how a person feels, thinks, and behaves), Insomnia (trouble falling asleep), and Essential hypertension (high blood pressure that was multifactorial and does not have one distinct cause). Record review of Resident #10's Quarterly Minimum Data Set (MDS), dated [DATE], revealed Resident #10's BIMS score was 13, which indicated intact cognitive response. Section E - Behavior, E0100 - potential indicators of psychosis, indicated Resident #10 had no indicators of hallucinations or delusions, and E0200 Behavior Symptom - presence & frequency, revealed Resident #10 exhibited no physical, verbal, or behavioral symptoms toward others. Record review of Resident #10's clinical records revealed there was no Care Plan in the facility's electronic health record system. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 10/14/2024 at 11:43 a.m., the DON said she was responsible for updating the comprehensive care plans. The DON said when she started her position on 06/25/2024, the care plans were a mess and she was updating the residents' care plan as each plan came up for renewal. The DON said she convened the IDT and added information to the care plan as needed. The DON said she had not reviewed and revised the care plans for Resident #6 and Resident #7. The DON said she was not sure why Resident #10 did not have a care plan in her clinical records. During an interview on 10/16/2024 at 1:08 p.m., the Administrator said he had expectations of communication among staff in multiple ways but mainly through care plans. The Administrator said he expected the care plan to contain the required information to meet the needs of each resident. The Administrator said he was ultimately responsible for the content of the care plans because he supervised the nursing staff. The Administrator said needed information not in the care plan or no care plan at all could lead to improper care and showed a lack of training. Record review of the facility's policy, Comprehensive Care Plans, dated 10/2022, revealed it was the policy of the facility to develop and implement a comprehensive person-centered plan for each resident, consistent with resident rights, that included measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that were identified in the resident's comprehensive assessment. The comprehensive care plan would describe the services to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. The comprehensive care plan would be reviewed and revised by the interdisciplinary team after each comprehensive assessment and change in condition.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45458 Based on observations, interviews, and records reviews, the facility failed to ensure that the comprehensive care plans were reviewed and revised by the interdisciplinary team after each assessment for 1 (Resident #3) of 3 residents reviewed for care plan revision. Resident #3's comprehensive care plan was not reviewed or revised after Resident #3 fell and sustained a lower, left leg fracture. This failure could place residents at risk for inadequate care. The findings included: Record review of Resident #3's Facesheet, dated 10/10/2024, revealed Resident #3 was an [AGE] year-old female, with an admitted into the facility of 05/30/2024. Diagnoses included Unspecified Dementia (chronic condition that causes a gradual decline in cognitive abilities, such as thinking, remembering, and reasoning) and Unspecified Severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety). Record review of Resident #3's Quarterly Minimum Data Set (MDS), dated [DATE], revealed Resident #3's BIMS score was 11, which indicated moderate cognitive impairment. Section J1700 - Fall History on Admission and Section J1900 - Number of Fall Since Admission were blank. Record review of Resident #3's Care Plan, dated 09/18/2024, revealed Resident #3 was Moderate, risk for falls due to weakness. A goal was identified as Resident #3 would be free from falls. Interventions were to ensure call light was within reach and encourage use, follow facility fall protocol, and Resident #3 would use half rails while in bed. Record review of Resident #3's Fall Incident Report, dated 09/20/2024, revealed Resident #3 had fallen in the bathroom and was noted with swelling to her left ankle. Resident #3 was able to ambulate without assistance. Record review of Resident #3's Progress Note, dated 09/20/2024, documented by LVN B, revealed Resident #3 was found as she sat on the bathroom floor with swelling to her left ankle and voiced pain. LVN B documented the DON was notified and Resident #3 was transported to the ER at 2:35 a.m. LVN B documented at 6:50 a.m., Resident #3 returned from the hospital with a left leg fracture in the fibula. Record review of Resident #3's emergency room Discharge Instructions, dated 09/20/2024, revealed Resident #3's had a clinical impression of a fibula fracture to left leg. Further review revealed to follow-up with regular doctor to get a referral for a specialist visit and to return to the emergency room immediately for further or worsening problems. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/11/2024 at 8:40 a.m., Resident #3 said she fell and broke her ankle. Resident #3 said she lost her balance when she was in the bathroom. Resident #3 said she fell when she tried to get water for her denture cup. During an interview on 10/15/2024 at 3:30 p.m., the Facility Owner said the responsibility for updating and reviewing the care plans after a significant change in condition was the administrator and DONs. The Facility Owner said the administrator and DON knew that interventions to prevent falls should have been in the care plan to address the resident's needs and to prevent further injuries. The Facility Owner said without intervention, the situation could become serious and was surprised the DON did not update the care plans as required. During an interview on 10/16/2024 at 1:08 p.m., the Administrator said his expectation was for care plans to be updated when there was a change in condition. The Administrator said Resident #3's change in condition and a fall with fracture or serious injury would be a reason to review the care plan and interventions and update the care plan if needed. The Administrator said the negative outcome would be improper care. The Administrator said the responsibility was for the DON to review and revise the care plans with the IDT and he was responsible to monitor the nursing staff. Record review of the facility's policy, Change in a Resident's Condition or Status, dated 05/2017, revealed: A significant change of condition is a major decline or improvement in the resident's status that: - will not normally resolve itself without intervention by staff or implementing standard disease-related interventions; - impacts more than one area of the resident's health status; - requires interdisciplinary review and/or revision of the care plan. Record review of the facility's policy, Comprehensive Care Plans, dated 10/2022, revealed: The comprehensive care plan will be reviewed and revised by the interdisciplinary team after each comprehensive assessment and change in condition.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676053	A. Building B. Wing	10/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Merkel Nursing Center	1704 N 1st Merkel, TX 79536

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45458 Based on interviews and records reviews, the facility failed to maintain medical records on each resident that are complete and accurately documented, in accordance with accepted professional standards and practices for 3 (Resident #5, Resident #6, and Resident #7) of 3 residents reviewed for smoking assessments. The facility failed to completely and accurately document quarterly smoking assessments for Resident #5, Resident #6, and Resident #7 per facility smoking policy. This failure could place residents at risk of having incomplete and inaccurate records, which could lead to miscommunication and interruption of services. The findings included: Resident #5 Record review of Resident #5 Facesheet, dated 10/09/2024, revealed Resident #5 was a [AGE] year-old female, with an admitted into the facility of 12/17/2014. Diagnoses included Unspecified Dementia (chronic condition that causes a gradual decline in cognitive abilities, such as thinking, remembering, and reasoning), Unspecified Severity, without behavioral disturbance, psychotic disturbance, mood disturbance, or anxiety), and schizoaffective disorder (chronic mental illness that causes a person to experience symptoms of both schizophrenia and a mood disorder), unspecified. Record review of Resident #5's Annual Minimum Data Set (MDS), dated [DATE], revealed Resident #5's BIMS score was a 10, which indicated moderate cognitive impairment. Section J1300 - Current Tobacco Use was checked yes, which indicated Resident #5 used smoked. Record review of Resident #5's Smoking Safety Screen, dated 04/26/2024, revealed Resident #5 was a smoker who smoked 1 to 2 cigarettes per day in the afternoons. Revealed Resident #5 had dexterity and vision problems. Review of assessment revealed Resident #5 did not have the ability to light her own cigarette and needed the facility to store her smoking paraphernalia. Review revealed the IDT decided Resident #5 required staff present at all times while smoking and was safe to smoke with supervision. Further review revealed here were no other smoking safety screens in the clinical record. Record review of Resident #5's Care Plan, dated 09/22/2024, revealed Resident #5 was a smoker and Resident #5's goal was to not smoke without supervision. Interventions included staff supervision when Resident #5 smoke, to monitor for cigarette burns on skin and clothing, and educate Resident #5 on the risks of smoking and the facility's smoking policy. During an interview on 10/09/2024 at 11:05 a.m., Resident #5 said she was a smoker and smoked on a daily basis. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 10/09/2024 at 11:17 a.m., Resident #5 exited the facility and entered the designated smoking area outside the dining room area. ADON handed Resident #5 a cigarette and placed the lighter to the end of the cigarette and lit it. Resident #5 sat in her wheelchair and smoked. Resident #6 Record review of Resident #6's Facesheet, dated 10/10/2024, revealed Resident #6 was a [AGE] year-old female, with an admitted into the facility of 12/21/2022. Diagnoses included Unspecified Dementia (chronic condition that causes a gradual decline in cognitive abilities, such as thinking, remembering, and reasoning), Unspecified Severity, without behavioral disturbance, psychotic disturbance, mood disturbance, or anxiety, and Chronic Obstructive Pulmonary Disease (common lung disease that causes breathing problems and restricted airflow) with acute exacerbation (flare-up, symptoms become much more severe). Record review of Resident #6's Quarterly Minimum Data Set (MDS), dated [DATE], revealed Resident #6's BIMS score was 13, which indicated intact cognitive response. Section J1300 - Current Tobacco Use was not included in the assessment. Record review of Resident #6's Smoking Safety Screen, dated 07/05/2024, revealed Resident #6 was a smoker who smoked 10 plus cigarettes per day at multiple times per day. Review of assessment revealed Resident #6 did not have the ability to light her own cigarette and needed the facility to store her smoking paraphernalia. Review revealed the IDT decided Resident #6 was safe to smoke with supervision. Further review revealed here were no other smoking safety screens in the clinical record. Record review of Resident #6's Care Plan, dated 09/06/2024, revealed the plan did not contain a focus, goal, or interventions to address Resident #6's smoking deficit. During an observation on 10/09/2024 at 11:17 a.m., Resident #6 was present in the smoking area. ADON was present and supervised residents who smoked. Resident #6 sat in her wheelchair while she smoked. During an interview on 10/09/2024 at 11:29 a.m., Resident #6 said she was a smoker and smoked during designated smoke breaks on the patio every day. Resident #7 Record review of Resident #7's Facesheet, dated 10/10/2024, revealed Resident #7 was a [AGE] year-old female, with an admitted into the facility of 03/08/2022. Diagnoses included Psychotic disorder (severe mental illness that causes a person to have abnormal perceptions and thinking, and to lose touch with reality) with delusions due to known physiological condition, Acute atopic conjunctivitis, bilateral (a rare chronic eye condition that causes inflammation of the eyelids and conjunctiva [thin, clear membrane that protects the eye]), Unspecified Dementia (chronic condition that causes a gradual decline in cognitive abilities, such as thinking, remembering, and reasoning), and Unspecified Severity, without behavioral disturbance, psychotic disturbance, mood disturbance, or anxiety). Record review of Resident #7's Quarterly Minimum Data Set (MDS), dated [DATE], revealed Resident #7's BIMS score of 06, which indicated a severe cognitive impact response. Section J1300 - Current Tobacco Use was not included in the assessment. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #7's Smoking Safety Screen, dated 03/16/2024, revealed Resident #7 was a smoker who smoked 5 to 10 cigarettes at multiple times per day. Review of assessment revealed Resident #7 did not have the ability to light her own cigarette and identified a cognitive loss. Review revealed the IDT decided Resident #7 needed to have cigarettes and lighter stored from her for safety reasons and was safe to smoke with supervision. Section J1300 - Current Tobacco Use was not included in the assessment. Further review revealed here were no other smoking safety screens in the clinical record. Record review of Resident #7's Care Plan, dated 09/22/2024, revealed the plan did not contain a focus, goal, or interventions to address Resident #6's smoking deficit. During an observation on 10/09/2024 at 11:17 a.m., Resident #7 was outside in the designated smoking area as she sat in her wheelchair and smoked. Resident #7 had her purse in her lap and held a cigarette. Resident #7 sat by the ashtray and put her ashes in the ashtray appropriately. During an interview on 10/09/2024 at 11:29 a.m., Resident #7 said she was a smoker but only smoked in the mornings during break. During an interview on 10/14/2024 at 11:43 a.m., the DON said she was responsible for updating the smoking assessments. The DON said when she started her position on 06/25/2024, the resident assessments for smoking were behind and she was responsible to update the assessments. The DON said the smoking assessments were due quarterly and she was aware that assessments were overdue. The DON said she was unable to complete the assessments in a timely manner. During an interview on 10/16/2024 at 1:08 p.m., the Administrator said smoking assessments were completed by the nursing staff and oversight was the responsibility of the DON. The Administrator said the negative outcome of not completing the smoking assessments quarterly, as required, would be putting the residents at risk of harm. Record review of the facility's policy, Smoking Policy, Residents, dated 07/2017, revealed the facility shall establish and maintain safe resident smoking practices - The resident's ability to smoke safely will be re-evaluated quarterly, upon a significant change (physical or cognitive) and as determined by the staff.

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F 0926 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have policies on smoking. 45458 Based on observations, interviews, and records reviews, the facility failed to implement and follow their own established smoking policy for 1 of 1 smoking area reviewed for smoking. The facility failed to follow their policy on smoking on 10/09/2024 when a red, labeled, self-enclosed, covered smoking receptacle in the designated smoking area was observed to contain plastic trash items and was lined with a clear, plastic trashcan liner. This failure could place residents at risk of injury, burns, and an unsafe smoking environment. The findings included: During an observation on 10/09/2024 at 9:45 a.m., the designated outside smoking area had a red, metal container, approximately four (4) feet tall, that had a round cover over the top. A silver side panel pushed inwards to allow cigarettes to be put inside. The metal container was labeled, Flammable Ash Only. When the panel was pushed inwards, a Cheez-it package, and an aluminum soda can were observed. When the lid and outside covering of the container was removed, the container was observed to be lined with a clear, plastic trash liner. At the bottom of the container were several empty cigarette packages, multiple used cigarette butts, a plastic soda bottle, a green aluminum can, and a small, clear trash bag filled with approximately 50 cigarette butts inside. During an interview on 10/16/2024 at 1:08 p.m., the Administrator said he was not aware trash was put in the flammable only cigarette butt container in the designated smoking area until he was notified by the investigator. The Administrator said he was very concerned the container had trash items put in it and that the container was lined with a plastic trash bag. The Administrator said the issue was a fire hazard that could cause burns and harm to residents and staff. During an interview on 10/17/2024 at 2:10 p.m., the Environmental Supervisor said he had been at the facility for four (4) years. The Environmental Supervisor said he was responsible to an extent to monitor the smoking area. The Environmental Supervisor said the housekeeper removed and clean the ashtrays in the designated area. The Environmental Supervisor said he knew the cigarette butts were required to be put in enclosed can after smoking and he would be responsible for ensuring that the red can was clean of trash and non-flammable. The Environmental Supervisor said the trash in the designated smoking container could be a fire hazard, but the staff and resident did not use the receptacle to put used cigarette butts in it. The Environmental Supervisor said he was not sure what the regulations were in the area of smoking containers and had not read or was familiar with the facility's smoking policy. The Environmental Supervisor said the housekeepers were responsible to make sure the butts were out prior to putting them into a trash bag twice a week. Record review of the facility's policy, Smoking Policy, Residents, dated 07/2017, revealed the facility shall establish and maintain safe resident smoking practices - Metal containers, with self-closing cover devices, are available in smoking areas. Ashtrays are emptied only into designated receptacles.