Printed: 10/31/2024
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676053	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/31/2024

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44722 Based on observation, interview, and record review, the facility failed to treat residents with respect, dignity, and care for each resident in a manner that promotes maintenance or enhancement of his or her quality of life for 2 of 15 residents (Resident # 6 and Resident #18) reviewed for dignity. The facility failed to ensure staff treated Resident #6 and # 18 with dignity while assisting residents with their lunch meal. This failure could place residents at risk of a diminished quality of life and lead to loss of self-esteem, isolation, and weight loss. The findings included: Record review Resident #6's electronic face sheet dated 07/31/2024 revealed: a [AGE] year-old female admitted on [DATE] with the following diagnosies: Pressure Ulcer of right buttock stage II, Pressure ulcer of right heel stage III, chronic kidney disease stage 4 (severe stage of kidney damage), Chronic Pain, Essential Hypertension (high blood pressure), Unspecified Dementia, Encephalopathy (brain disease that alters brain function) unspecified, Gastroparesis (a condition that affects the stomach muscles and prevents proper stomach emptying), Muscle weakness (generalized). Record review Resident #6's Quarterly MDS dated [DATE], Section C Cognitive Patterns revealed Resident #6 had a BIMS score of 7 meaning resident had a moderately impaired cognitive status, Section GG Functional Abilities and Goals eating setup or clean-up assistance, toileting dependent, Section H Bladder and Bowel. Record review of Resident #18's electronic face sheet dated 07/31/2024 revealed: an [AGE] year-old male admitted on [DATE] with diagnoses that include Hypoglycemia (low blood sugar), Vascular dementia, Hypertension (high blood pressure), Dietary Zinc deficiency, Vitamin deficiency, Pain, Hypokalemia (low potassium). Record review of Resident #18's Quarterly MDS, dated [DATE] revealed: Section C cognitive Patterns revealed Resident #18' had a BIMS score of 00 meaning resident had severe cognitive impairment. Section GG Functional Abilities and Goals required partial/moderate assistance with eating. (continued on next page)

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

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 07/30/2024 at 12:10 PM, of the dining room, the DON was standing next to Resident # 6, who was seated in her wheelchair at the dining table. The DON was standing over resident and assisting Resident #6 with her noon meal. The AD was sitting next to Resident # 18 holding a spoonful of food, with her left hand, in front of Resident # 18. The AD was looking to her right, the opposite direction of Resident #18, talking with another employee. The AD was observed eating and drinking while assisting Resident #18. During an interview on 07/31/24 at 3:51 PM, the DON stated her expectation when staff assist residents with their meals was staff should have been sitting eye level with resident and staff should have given their attention to the resident. The DON stated staff should not have been having side bar conversations with other staff and should not have been having their own personal food or drink. The DON stated nursing staff should have been monitoring residents while they were other staff were assisting residents. The DON stated the effect on residents could have been a loss in dignity, impaired their meal intake and could have made the resident feel bad. The DON stated what led to failure was staff not being trained. The DON stated she knew better and should have taken the time to sit beside Resident #6. During an interview on 07/31/24 at 5:03 PM, the AD stated she had been trained by other nurse aides on assisting residents while residents ate. The AD stated she realized she had forgotten all she knew about assisting residents with meals. The AD stated she should have kept her focus on Resident #18. The AD stated she should have not been eating or talking with other staff while assisting resident with his meal. The AD stated the effect on the resident could have been the resident could have choked or aspirated on his food. The AD stated it could have made the Resident feel bad because she was not talking to them. The AD stated what led to failure was she was nervous and just forgot what she had been taught. Record review of the facility policy titled Assistance With Meals dated of July 2017 revealed: Policy Statement: Residents shall receive assistance with meals in a manner that meets the individual needs of each resident. Dining Room Residents .3. Residents who cannot feed themselves will be fed with attention to safety, comfort and dignity, for example: Not standing over residents while assisting them with meals; Keeping interactions with other staff to a minimum while assisting residents with meals

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44722 Based on observation, interview, and record review the facility failed to provide services with reasonable accommodation of needs for 1 (Resident #19) of 15 residents reviewed for resident call system. The facility failed to provide a working communication system on 07/29/2024 that was easily at reach and that would allow Resident #19 the ability to safely call for staff for assistance. This failure could place residents at risk of not having a means of directly contacting caregivers in an emergency or when they need support for daily living. The findings included: Record review of Resident #19's face sheet dated 07/31/2024, revealed: an [AGE] year-old-male admitted on [DATE], with the following diagnosis blindness to the right and left eye, pulmonary embolism, Type 2 Diabetes, and dizziness. Record review of Resident #19's Annual MDS dated [DATE] revealed: Section B- Hearing, Speech, and Vision revealed Resident #19's vision was severely impaired (no vision or sees only light); Section C-Cognitive Patterns revealed Resident #19 had a BIMS score of 9(meaning moderately cognitively impaired). Record review of Resident #19's Care Plan dated 05/28/2024 revealed Resident #19 was visibly impaired, had a history of falls and the call light should have been placed in reach. During an observation and interview on 07/29/2024 at 2:40 PM, Resident #19 was sitting in his recliner, in his room, and the call light was not in reach. The call light was laying on the floor behind his he recliner, out of reach. Resident #19 stated he would use his call light when he needed assistance. Resident #19 attempted to locate his call light and stated it was not where he could reach it and could not find the call light. Resident #19 stated he was blind and if the staff had not placed the call light in reach he could not see where the call light was placed. During an interview on 07/31/2024 at 3:51 PM, the DON stated her expectation was call lights should have been placed in a location where residents were able to reach. The DON stated not having the call light in reach could have affected residents by the residents not able to call for assistance and could have tried to get up and had a fall. The DON stated Resident #19 had falls in the past and that he needed the call light placed in reach because he was blind. The DON stated what led to failure was staff not paying attention. The DON stated all staff were responsible to ensure call lights were in reach when a resident's room. The DON stated herself and the ADON were responsible for monitoring, and they monitored when they were out walking the halls. Record review of facility policy titled, Quality of Life- Accommodation of Needs dated August 2009 revealed: Providing access to assistive devices . Installing longer cords or providing remote controlled overhead or task lighting so that they are easily accessible.

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F 0576 Level of Harm - Potential for minimal harm Residents Affected - Many	Ensure residents have reasonable access to and privacy in their use of communication methods. 44722 Based on interview and record review the facility failed to ensure had the had the right to send and receive mail, and to receive letters, packages and other materials delivered to the facility for the resident through the means other than a postal service for 11 of 11 confidential resident group meeting reviewed for resident rights. The facility failed to ensure residents received mail on the weekend. This failure could affect residents by placing them at risk of not receiving mail in a timely manner that could result in residents experiencing diminished psychosocial well-being and quality of life. The findings included: During a confidential group interview on 07/30/2024 at 9:50 AM, the confidential residents stated they did not receive their mail on the weekend, because the OM did not work and she was the one who picked up the mail. During an interview on 7/31/2024 at 3:19 PM, the OM stated residents did not received mail on the weekends. The OM stated she was the only one who had a key to the post office box and would get mail Monday thru Friday . Record review of the facility policy titled Nursing Home Residents' Rights, undated, revealed: Residents of nursing homes have the rights that are guaranteed by the federal Nursing Home Reform Law. The law requires nursing homes to promote and protect the rights of each resident and stresses individual dignity and self-determination. Many states also include residents' rights in state law or regulation .Right of Access to: Individuals, services, community members, and activities inside and outside the facility.

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48883 Based on interview and record review, the facility failed to develop and implement written policies and procedures to prohibit and prevent abuse and neglect for 1 of 1 staff (NA B) reviewed for Resident Abuse . The facility failed to suspend staff named as AP or remove staff named as AP from direct care position during resident abuse investigation . This deficient practice could place residents at risk for abuse and neglect. The findings were: Record review of the Resident #20's face sheet dated 07/31/2024 revealed she was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses to include: hemiplegia and hemiparesis following cerebral infarction affecting right dominant side (right sided weakness following stroke) and vascular dementia (memory deficit from blood flow issues). Record review of Resident #20's annual MDS dated [DATE] revealed: BIMS score of 07 which indicated severe cognitive impairment. Further review of the MDS Section E - Behavior revealed no hallucinations or delusions and did not exhibit any rejections of care or evaluations. MDS Section GG - Functional Abilities and Goals revealed Resident #20 needed substantial assistance with rolling left and right, sitting to lying, and lying to sitting. She required wheelchair for mobility. Record review of Resident #20's care plan dated 07/31/2024 revealed Resident #20 had Focus: self-care performance deficit; Goal: she will maintain current level of function; Interventions / Tasks: bed mobility: she is able to mobilize herself date initiated 05/22/2023. Record review of grievances with facility investigation dated 07/24/2024 revealed on 7/23/2024 no time the Ombudsman demanded that NA B be banned from two resident's rooms and that we should fire him. On 07/23/2024 at approximately 11:00 p.m., NA B was told to not go into certain resident rooms per the D.O.N. request. On 07/24/2024 at approximately 9:00 a.m., the ADMN was informed of the Ombudsman's comments the previous day by the D.O.N. during the morning meeting. A formal investigation was started immediately . Record review of facility document titled Timecard Report dated 07/31/2024 revealed NA B clocked in on 07/23/2024 at 5:54 p.m. and clocked out on 07/24/2024 at 6:12 a.m. During an interview on 07/29/2024 at 10:41 a.m., Resident #20 stated that NA B had been rough with her when turning her over. She stated he grabbed her legs during turning her over and she stated there was no justification for him to turn her. She stated she told staff about what happened but could not name staff that she had reported it to. She stated NA B had entered her room one time since then and she did not want him in her room. During a confidential group meeting on 07/30/2024 at 10:00 a.m., a resident stated that NA B was very rude, rough and she refused to have him care for her. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 07/30/2024 at 10:52 a.m., the Ombudsman stated on 07/23/2024 it was reported to her by two residents NA B had been rough with them and they did not want him caring for them anymore. She stated she reported the allegation to the DON and demanded for the DON to not allow NA B back into those resident's rooms. She stated that she left facility and one of the residents called her after she had gotten home to report NA B had come into her room again. She stated she reported him entering that resident's room to the DON by phone. During an interview on 07/31/2024 at 08:54 a.m., the DON stated she had been trained on abuse. She stated examples of abuse included yelling at residents, being rude to residents, and being rough with residents. The DON stated the ADMN was the abuse coordinator and she denied being afraid to report abuse to him. She stated on 07/23/2024 the Ombudsman reported allegations that residents had made stating NA B had been rough with them. She stated she felt the Ombudsman was pushy and should not demanded that NA B not be allowed in certain rooms. She stated that she did direct for NA B not to go into those resident's rooms, but he did continue to work that night. She stated the Ombudsman did speak to her on the phone later threatening to come back to the facility because one of the residents had stated that NA B entered her room after first discussion had occurred. The DON reported she participated in investigation of abuse allegation by interviewing residents and assessing resident's skin for bruising. She stated she did not see any bruises and did not observe any behavioral changes in residents. The DON stated she felt the investigation revealed some residents preferred a female nurse aid and there were no indications that abuse occurred . During an interview on 07/31/2024 at 10:21 a.m., the ADMN stated he expected staff named as AP in abuse allegation to be suspended until investigation completed. He verified that NA B was not suspended on 07/23/2024. The ADMN stated the DON should have suspended NA B and reported abuse allegation to him at the time that it was made. He stated he completed his investigation on 07/24/2024 and it showed no abuse occurred. He stated that NA B was allowed to work after the investigation. He stated NA B was moved from night shifts to the day shifts so that management could evaluate his interactions with residents more closely. He stated all supervisors monitored that staff followed abuse policy. The ADMN stated he felt the DON did not report and suspend NA B at the time it was reported due to intimidation by Ombudsman. He stated not following policy could put residents at risk for being abused, injured, or neglected. Review of facility policy titled Abuse Investigations with no date revealed Employees of the facility who have been accused of resident abuse may be reassigned to nonresident care duties or suspended from duty until the results of the investigation have been reviewed by the Administrator. Review of facility policy titled Protection of Residents During Abuse Investigations with no date revealed During abuse investigations, residents will be protected from harm by the following measures: Employees accused of participating in the alleged abuse will be immediately reassigned to duties that do not involve resident contact or will be suspended without pay until the findings of the investigation have been reviewed by the administrator. Should the employee(s) be reassigned to non-resident care duties, such assignment will not be in any part of the building which the resident requests.

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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** 44558 Based on interviews, and record reviews, the facility failed to develop and implement a comprehensive person- centered care plan based on assessed needs with measurable objectives that have the ability to be evaluated or quantified to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being for 4 of 15 residents (Resident #16, #17, #19, #24) reviewed for comprehensive person-centered care plans. The facility failed to ensure Resident #16's Care plan incorporated Code status and PASRR status. The facility failed to ensure Resident #17's Care Plan incorporated measurable objectives or interventions for Tracheostomy Care or Feeding Tube. The facility failed to ensure Resident #19's Care plan incorporated interventions for falls. The facility failed to ensure Resident #24's Care Plan was updated after use of Bactrim (antibiotic) and UTI was resolved. This failure could place the residents at risk for decreased quality of life and not having their needs met. The findings include: Record review of Resident #16's electronic face sheet dated 07/31/2024 revealed: [AGE] year-old female admitted [DATE]. Resident #16's diagnoses include: Major depressive disorder, Moderate Intellectual Disabilities, Epilepsy (a disorder in which nerve cell activity in the brain is disturbed, causing seizures), obsessive compulsive disorder. Record review of Resident #16's annual MDS dated [DATE], Section C-Cognitive Patterns revealed Resident #16 had a BIMS score of 2 (severely impaired cognitive function). Record review of Resident #16's Care Plan dated 05/24/2024 revealed: Focus: She is a FULL CODE per family 11.21.23. Her family has signed a DNR for her after an informative discussion. Goal: She will not receive life saving measures in the event of cardiopulmonary arrest. Interventions/Tasks: Code status verified by her family. Family aware they may change her code status at any time. Provide support as needed. They are supportive and participate in her care. Dated Initiated 05/16/2023. No evidence of updated goals and interventions related to PASSR II and HSP (habilitation service plan). Record review of Resident #16's Habilitation Service Plan, dated 06/07/2023 revealed Resident #16 required PASRR services. Record review of Resident #16's Physician orders dated 07/01/2024 revealed: DNR (do not resuscitate). (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 #17's electronic face sheet dated 07/31/2024 revealed a [AGE] year-old male admitted [DATE]. Diagnoses include Malignant neoplasm of Laryngeal Cartilage (throat cancer), Tracheostomy (opening into neck into windpipe) Status, Gastrostomy (opening in abdomen and into stomach used for nutritional support) Status, Dysphagia (difficulty swallowing). Record review of Resident #17's Quarterly MDS dated [DATE] Section C-Cognitive Patterns revealed Resident #17 had a BIMS score of 13 meaning Intact cognitive status. Section K Nutritional Approaches-Feeding tube PEG (percutaneous endoscopic gastrostomy tube). Record review of Resident #17's Care Plan dated 06/07/2024 revealed: Focus: He requires tube feeding related to dysphagia, swallowing problem. 2.28.22 Vital 1.5 200 mL bolus with 100 mL of flush before and after feeding. 4.22.22 formula changed to Peptamin 1.5 200 mL bolus with 100 mL water flush before and after feeding. 7.19.22 Decreased feeding to BID (two times a day) to promote oral food intake. Will monitor weight weekly. Goal: He will remain free of side effects or complications related to tube feeding. He will maintain adequate nutritional and hydration status and weight stable, no S/SX (signs and symptoms) of malnutrition or dehydration. He will be free from aspiration. Interventions/Tasks: G-tube replaced using 20 FR 10 mL catheter. Flushes well. Check for tube placement and gastric contents/residual volume per facility protocol and record. Hold feed if greater than 100 cc aspirate. He needs assistance with tube feeding and water flushes. See MD orders for current feeding orders. Provide local care to G-Tube site as ordered and monitor for S/SX of infection. Focus: 2.28.22 He was readmitted to facility after a vocal cord cancer recurrence. He has a chronic tracheostomy now. Goal: He will have clear and equal breath sounds bilaterally, no abnormal drainage or sign of infection. Interventions/Tasks: 3/23/23 per Dr. [NAME]: change trach tube (#6 Shiley) 4.14.23 new #6 Shiley trach placed per physician .Ensure trach ties are secured at all times. Monitor/document for restlessness, agitation, confusion, increased heart rate and slow heart rate. Use UNIVERSAL PRECAUTIONS as appropriate. Record review of Resident #17's Physician orders dated 07/01/2024 revealed: May cleanse peg tube site with sterile water and apply Benadryl cream PRN (as needed). Trach care: clean shiley trach by removing inner cannula and soaking/scrubbing in a mixture of sterile water and hydrogen peroxide. Dry thoroughly and reinsert inner cannula every day shift. Record review of Resident #19's electronic face sheet dated 07/31/2024 revealed: [AGE] year-old male admitted [DATE]. Diagnosis include Blindness right eye, Type II Diabetes Mellitus, Mild Cognitive Impairment, Dizziness and Giddiness, Pain, unspecified. Record review of Resident #19's annual MDS dated [DATE] Section C Cognitive Pattern revealed Resident #19 had a BIMS score of 9 meaning Moderate cognitive impairment, Section GG Functional Abilities and Goals Mobility Devices- Cane/crutch, Wheelchair Walk 10 feet: supervision or touching assistance. Record review of Resident #19's Care Plan dated 07/12/2024 revealed Focus: He is high risk for falls related to previous (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	falls at home, history of dizziness, impaired mobility, impaired vision, and hearing. 11.4.20 Moderate risk (no falls, aware of limitations). 1.11.21 2 falls same day. Goal: He will be free of falls through the review date. Date initiated:02/11/2022, Revision on: 05/28/2024 Target Date: 07/28/2024. Interventions/Tasks: Anticipate and meet his needs. Be sure his call light is withing reach and encourage him to use it for assistance as needed. Follow facility fall protocol. He needs a safe environment with:(even floors free from spills and/or clutter; adequate, glare-free light; a working and reachable call light, the bed in low position at night half rails if ordered. Record review of Resident #24's electronic face sheet dated 07/31/2024 revealed: [AGE] year-old female who admitted on [DATE]. Diagnosis includes Psychotic disorder with delusions due to known physiological condition, Unspecified Dementia, Anxiety, Presence of right artificial hip joint, Depression, Pain, Chronic Obstructive Pulmonary disease. Record review of Resident #24's quarterly MDS dated [DATE] Section C Cognitive Patterns revealed Resident #24 had a BIMS score of 6 meaning Severe cognitive status. Record review of Resident #24's Care plan dated 06/14/2024 revealed: Focus: She has a Urinary Tract Infection related to: 5.14.22 UTI with E Coli. Bactrim DS 800-160 mg BID (two times a day) x 10 days. Goal: Her urinary tract infections will resolve without complications. Interventions/Tasks: Give antibiotic therapy as ordered. Monitor/document for side effects and effectiveness. Record review of Resident # 24's physician orders dated 07/01/2024 revealed: No current order for Bactrim DS. During an interview on 07/30/2024 at 4:25 PM, the DON stated Code status should be in the care plan. The DON stated interventions should be measurable and a statement of resident going to the doctor would not be an appropriate intervention. The DON stated she had only been here a month and she had a lot of work to do. The DON stated the Interventions were orders and progress notes. The DON stated the effect on the residents of care plan not being done correctly made staff not have a plan and to make sure a resident needs and wants are taken care of and possible receive substandard care. The DON stated the failure occurred due to previous staff not taking the time to update care plan correctly. Record review of facility's policy titled: Care Plans, Comprehensive Person-Centered dated Revised December 2016 Policy statement: A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial, and functional needs is developed and implemented for each resident. Policy Interpretation and Implementation: 1. The Interdisciplinary Team (IDT), in conjunction with the resident and his/her family or legal representative, develops and implements a comprehensive, person-centered care plan for each resident. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. The care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment. The comprehensive, person-centered care plan will: Include measurable objectives and timeframes. Describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental and psychosocial well-being. Describe any specialized services to be provided as a result of PASRR recommendations. Reflect treatment goals, timetables, and objectives in measurable outcomes. m. Aid in preventing or reducing decline in the resident's functional status and/or functional levels; 11. Care plan interventions are chosen only after careful data gathering, proper sequencing of events, careful consideration of the relationship between the resident's problem areas and their causes, and relevant clinical decision making . 44722

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F 0680 Level of Harm - Potential for minimal harm Residents Affected - Many	Ensure the activities program is directed by a qualified professional. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48883 Based on interview and record review the facility failed to have a provide an activities program directed by a qualified professional for 1 of 1 activity directors (AD) reviewed for qualifications. The facility failed to ensure the AD was a qualified therapeutic recreation specialist or an activities professional that met state licensing requirements. This failure could place residents at risk for reduced quality of life due to lack of activities that were individualized to match the skills, abilities, and interests/preferences of each resident. The findings included: Review of the AD's employee file revealed the AD took the position on June 6, 2024, and no evidence of certification or training as a qualified therapeutic recreation specialist or an activities professional that met state licensing requirements. During an interview on 07/31/2024 at 10:40 a.m., the AD stated she did not have her Activity Director certification. She stated she had been working for the facility for about two months and had been waiting on paperwork from the facility to begin classes to complete AD certification. During an interview on 07/31/2024 at 3:06 p.m., the ADMN stated his expectation was for the AD to be certified. He stated the failure occurred due to poor oversite during the hiring process. He stated the OM monitors that staff are certified but ultimately it was his responsibility to monitor that staff have certifications. The ADMN stated residents may receive poor engagement and possible not have their social needs met because of the AD not having her certification. During a follow up interview on 07/31/2024 at 3:42 p.m., the ADMN stated the facility's [NAME] had been training current AD and stated that she had certification as a therapeutic recreation specialist but could not provide evidence of qualification at this time. Review of the facility's job description for Activity Director not dated showed no evidence of education requirements for activity director. During exit conference on 07/31/2024 at 7:10 p.m., the ADMN was not able to provide any additional documents.

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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48883 Based on interviews and record reviews the facility failed to ensure that residents receive care, consistent with professional standards of practice, to prevent pressure ulcers and do not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable and prevent new ulcers from developing for 1 of 13 (Resident #20) residents reviewed for pressure ulcers. The facility failed to perform weekly skin assessments for Resident #20 who was assessed as being at risk for skin breakdown. These failures could place residents at risk of developing pressure ulcers, infections and worsening of wounds from delay in treatment. Findings include: Record review of the Resident #20's face sheet dated 07/31/2024 revealed she was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses to include: hemiplegia and hemiparesis following cerebral infarction affecting right dominant side (right sided weakness following stroke), stage 2 pressure ulcer of other site (red discoloration of skin caused by pressure), cellulitis (skin infection) and vascular dementia (memory deficit from blood flow issues). Record review of Resident #20's annual MDS dated [DATE] revealed: BIMS score of 07 which indicated severe cognitive impairment. Further review of the MDS Section E - Behavior revealed no hallucinations or delusions and did not exhibit any rejections of care or evaluations. MDS Section GG - Functional Abilities and Goals revealed Resident #20 needed substantial assistance with rolling left and right, sitting to lying, and lying to sitting. She required wheelchair for mobility. Further review of the MDS Section M - Skin Conditions revealed resident is a risk of developing pressure ulcers but had no unhealed pressure ulcers at that time. Resident did have moisture associated skin damage. Skin treatments included application of ointments or medication and turning program. Record review of Resident #20's care plan dated 07/31/2024 revealed Resident #20 had Focus: potential for pressure ulcer development; Goal: she will have intact skin, free of redness, blisters, or discoloration; Interventions / Tasks: Assess / record / monitor wound healing at least weekly and as needed date initiated 05/22/2023 .Follow facility policies / protocols for the prevention / treatment of skin breakdown date initiated 05/22/2023. Record review of Resident #20's last Braden assessment dated [DATE] revealed Resident #20 had a quarterly Braden scale for predicting pressure score risk of 15.0 meaning resident at risk. Record review of Resident #20's last skin assessment dated [DATE] revealed no skin issues well hydrated. During an observation and interview on 07/29/2024 at 10:41 a.m., Resident #20 lying was in bed watching television. She stated she had wounds and facility staff were not doing anything for the wounds . (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 07/31/2024 at 2:31 p.m., the ADON stated he expected for skin assessments to be performed by nurses weekly. He stated that Braden risk assessment would be indication of skin breakdown risk. He did not know why skin assessments had not been performed . During an interview on 07/31/2024 at 2:42 p.m., the DON stated she expected for skin assessments to be performed by nurses weekly. She stated she did not know why skin assessments had not been performed for Resident #20 and was not able to find any recent skin assessment for Resident #20. She stated she monitored that skin assessments were performed. She stated that nursing assistance would notify nurse if they observed any new skin issue, but missing skin assessments could lead to residents having skin breakdown. Review of facility policy titled Prevention of Pressure Ulcers / Injuries dated July 2017 revealed The purpose of this procedure is to provide information regarding identification of pressure ulcer / injury risk factors and interventions for specific risk factors .Assess the resident on admission (within eight hours) for existing pressure ulcer / injury risk factors. Repeat the risk assessment weekly and upon any changes in condition . Inspect the skin on a daily basis when performing or assisting with personal care or ADLs .Evaluate, report and document potential changes in the skin.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48883 Based on observations, interviews, and record reviews, the facility failed to maintain an environment that was as free from accident hazards as was possible for 2 of 3 (Back Hall and Front Hall) halls reviewed for accident hazards . The facility failed to ensure shampoo, wound cleanser, nail polish remover, shaving cream, disinfectant spray, and perineal and skin cleanser were locked in the Back Hall Shower room and not accessible to residents. The facility failed to ensure perineal and skin cleanser were locked in the Back Hall bathroom room and not accessible to residents. The facility failed to ensure bottle of shampoo was locked in the front hall bathroom and not accessible to the residents. These failures could place residents at risk of injury due to hazardous chemicals. Findings include: During an observation on [DATE] at 9:56 AM, the Back Hall Shower room door was propped open with a 1-gallon bottle of shampoo, there was a half of a 1-gallon bottle of perineal and skin cleanser, and cabinet that was unlocked filled with a bottle of wound cleanser, a can of disinfectant spray, a bottle of nail polish remover and several cans of shaving cream. The restroom on the back hall that was used by residents contained 3 1-gallon bottles of perineal and skin cleanser. During an observation on [DATE] at 9:25 AM, the restroom on the Front Hall, used by residents, contained a 1-gallon bottle of shampoo. During an interview on [DATE] at 9:42 AM, the ADMN stated his expectations were that shower rooms remain locked when not in use and that items which stated keep out of reach of children or external use only (Shampoos, perineal and skin cleanser, disinfectant spray, and wound cleanser) be locked and not accessible to residents. The ADMN stated these items should not be in bathrooms that was an area residents had access to. He stated if a resident was to access these items it could have caused a resident harm. The ADMN stated what led to failure was lack of staff education by the facility. During an interview on out [DATE] at 3:51 PM, the DON stated her expectation was items such as shampoo, perineal and skin cleanser, wound cleanser, nail polish remover, shaving cream, and disinfectant spray. The DON stated the effect on residents could have been a resident could have drunk them and gotten sick or died ; slipped or fallen if they had leaked on the floor. The DON stated the nurses and aides should have been monitoring the supplies. The DON stated what led to the failure was staff not taking the time to lock the doors or pick the items and putting them back where they belonged. Record review of the facility policy titled Hazardous Areas, Devices and Equipment with the revised date of [DATE] revealed: (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	All hazardous areas, devices and equipment in the facility will be identified and addressed appropriately to ensure resident safety and mitigate accident hazards to the extent possible. Policy Interpretation and Implementation: 1. As part of the facility's overall safety and accident prevention program, hazardous areas and objects in the resident environment will be identified and addressed by the Safety Committee . dentification of Hazards: 1. A hazard is defined as anything in the environment that has the potential to cause injury or illness. Examples of environmental hazards include, but are not limited to: Access to toxic chemicals .Interventions .6. The Safety Committee will recommend measures to ensure that vulnerable residents cannot access hazardous areas in the facility (locks, alarms, supervision, etc.).

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44722 Based on observations, interviews, and record reviews, the facility failed to ensure residents who needed respiratory care were provided respiratory care consistent with professional standards of practice for 3 of 14 resident (Resident #2, Resident #14, and Resident #235's) reviewed for oxygen administration. The facility failed to ensure an Oxygen in Use sign was posted on the outside of Resident #2, Resident #14, and Resident #235's door. These deficient practices could place residents who received oxygen and treatments at risk of respiratory infection. The findings include: Record review of Resident # 2's face sheet dated 07/31/2024 revealed an [AGE] year-old male who was admitted to the facility on [DATE] with diagnoses which included cerebral palsy (group of disorders that affect movement, muscle tone, balance, and posture), paraplegia (paralysis of all or part of your trunk, legs, and pelvic organs), muscle wasting and atrophy (loss or thinning of your muscle tissue), and muscle weakness. Record review of Resident #2's quarterly MDS assessment dated [DATE] revealed: Section C (Cognitive Patterns) BIMS score of 12 meaning moderate cognitively impairment . During an observation on 07/29/2024 at 2:57 PM, Resident #2 was sitting in recliner wearing his oxygen. There was no Oxygen in Use sign on the door. Record review of Resident #14's face sheet dated 07/31/2024 revealed a [AGE] year-old female admitted on [DATE] with diagnoses which included heart disease, Chronic Obstructive Pulmonary Disease, and Dementia. Record review of Resident #14's Quarterly MDS dated [DATE] revealed: Section C-Cognitive Patterns BIMS score of 1 meaning severe cognitive impairment, Section O- Special Treatment, Procedures, and Programs revealed Resident #14 received oxygen therapy . Record review of Resident #14's physician orders revealed a start date of 1/25/2024 Oxygen 2-4 Liters per minute via nasal cannula continuous to keep SPO2 greater than 90%. During an observation on 07/29/2024 at 2:12 PM, Resident #14 was laying in her bed sleeping wearing her oxygen. There was no Oxygen in Use sign on the door. Record review of Resident #235's face sheet dated 07/17/2024 revealed a [AGE] year-old male admitted to the facility on [DATE] with diagnoses that included atherosclerotic heart disease (heart disease that effects blood flow by clogged arteries that could cause chest pain, shortness of breath, fatigue and confusion among other symptoms), and anxiety. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #235's entry MDS dated [DATE] did not reveal a cognitive assessment. During an observation on 07/30/24 at 11:50 AM, Resident #235 was sitting in room wearing his oxygen. There was no Oxygen in Use sign on the door. During an interview on 07/31/2024 at 3:51 PM, the DON stated residents who were using oxygen should have Oxygen in Use signs posted at the entrance of their doors. The DON stated the nurses should have been monitoring when they were passing medications. The DON stated the effect on residents not having the sings on their doors could have been visitors could not be aware of oxygen in use and could have put residents at risk . The DON stated what led to failure was lack of communication and oversight . Record review of facility policy titled Oxygen Administration dated 2010, revealed: Place an Oxygen in Use sign on the outside of the room entrance door. 48883

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F 0728 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that nurse aides who have worked more than 4 months, are trained and competent; and nurse aides who have worked less than 4 months are enrolled in appropriate training. 48883 Based on interview and record review the facility failed to ensure 3 (NA B, NA C, and NA D) of 10 Nurses' Aides were not working in the facility longer than four months without being enrolled in or having completed an approved training course. The facility failed to ensure NA B, NA C, and NA D were certified within the required time frame. This failure place residents at risk for receiving care from an individual whose skill level was not known. Findings include: Review of facilities employee files revealed: -NA B had a hire date of 1/30/2024 and worked full time, -NA C had a hire date of 9/15/2023 and worked full time, and -NA D had a hire date of 3/15/2024 and worked full time. During an interview on 07/31/2024 at 10:18 a.m., NA B stated he had been working at the facility since January. He stated that he had never been certified and was not attending training courses . During an interview on 07/31/2024 at 2:47 p.m., the DON stated that her expectation would be for the facility to have certified nurse assistants. She stated there had been no certified applicants and had only been able to hire NAs. She stated there was no local training programs that was cost effective stating that the closest program she knew of was in a different town and cost more than 900 dollars. She stated that she monitors staffing schedules and was aware that NAs were working without certification but did not know what else the facility could do. She was not sure if facility was able to start certified nurse aide program because they had lost that ability in the past. She stated no negative affect had occurred to residents since LVNs were supervising NAs and felt the NAs had enough supervision with the amount of nursing staff that worked. She stated that she expected for day shift to have 2 LVNS along with ADON and DON. Evening shift to have 1 LVN and night shift to have 1 LVN. Review of facility policy titled Orientation Program for Newly Hired Employees, Transfers, Volunteers dated January 2008 revealed All newly hired personnel / volunteers / transfers must attend a 10-hour orientation program within their first five (5) days of employment. (Note: The orientation program is not included in the basic 75-hour Nurse Aide Training Program.) (continued on next page)

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F 0728 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of facility assessment tool dated 07/29/2024 revealed 23 residents needed 1-2 staff assistance for dressing and 5 residents were dependent on staff for dressing. 17 residents needed 1-2 staff assistance with bathing and 17 residents were dependent on staff for bathing. 19 residents needed 1-2 staff assistance with transfers and 6 residents were dependent on staff for transfers. 15 residents needed 1-2 staff assistance for eating and 3 residents were dependent on staff for eating. 7 residents needed 1-2 staff assistance for toileting and 19 residents were dependent on staff for toileting. Direct care staff 2:35 ratio Days (total licensed or certified), 1-2:35 ratio Evenings, and 1:35 ratio Nights.

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Some	Post nurse staffing information every day. 48883 Based upon observation, interview and record review, the facility failed to ensure staffing information was posted in a prominent place readily accessible to residents and visitors for 3 of 7 days reviewed for nursing services and postings (7/29/24, 7/30/24, and 7/31/24) The facility failed to ensure daily staffing information was posted in a prominent place on 07/29/2024, 07/30/2024, and 07/31/2024 This failure could place residents, their families, and visitors at risk of not having access to information regarding staffing and facility census. Findings include: During an observation of postings in the facility on 07/29/2024 at 09:40 AM no daily nursing staffing posted at nurses' station or any other place in the facility . During an interview on 07/29/2024 at 03:01 PM, the DON stated staff had schedules on their phones that show all staff scheduled for that day. The DON stated if the public or families wanted to know what staff were working, they could ask a staff member and be told who was working. The DON stated daily staffing is not posted anywhere in the facility. The DON stated she did not feel this caused any harm to residents. The DON stated she did not know the daily staffing was a required posting. Record review of Facility Assessment Tool staffing plans (not dated): revealed Staff: Licensed Nurses (LN): RN, LPN, LVN providing direct care. Plan DON: 1 DON RN full-time days, 1 other RN weekends, 1 parttime RN, 1 LVN as Assistant DON/corporate nurse LVN, RN or LVN Charge Nurse: 1 RN or LVN for day/evening shift (1-2) 1 LVN night shift 1 RN for COVID management and weekend coverage .

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44722 Based on observation, interview and record review, the facility failed to ensure the menu was followed for 1 of 2 (Residents #235) residents who received a pureed meal reviewed during 2 of 2 lunch meals. The facility failed to ensure Resident #235, who received a pureed diet, was provided the food according to the menu, including a role on 07/29/2024 and mashed potatoes on 07/30/2024. This failure could place residents that eat food from the kitchen at risk of poor intake, chemical imbalance and/or weight loss. Findings included: Record review of Resident #235's face sheet dated 07/17/2024 revealed a [AGE] year-old male admitted to the facility on [DATE] with diagnoses that included atherosclerotic heart disease (heart disease that effects blood flow by clogged arteries that could cause chest pain, shortness of breath, fatigue and confusion among other symptoms), and anxiety. Record review of Resident #235's entry MDS dated [DATE] did not reveal cognitive assessment documented. Record review of Resident #235's physician orders revealed a start date of 07/17/2024 and Resident #235 had pureed diet. During an observation on 07/29/2024 at 10:15 AM of facility posted lunch menu in dining room dated 7/29/2024 revealed: BBQ Chicken, baked beans, coleslaw, and a roll. During an observation on 07/29/2024 at 12:30 PM puree meal lunch trays left the kitchen without a puree roll on each tray. During an observation and interview on 07/30/2024 at 11:50 AM Resident # 235 received a lunch tray that contained pureed hamburger steak with gravy, broccoli, roll and chocolate pie, Resident's tray did not contain mashed potatoes. Resident #235 stated he liked mashed potatoes and did not know why he did not have mashed potatoes on his tray. During an observation on 07/30/2024 at 11:55 AM, of facility posted lunch menu in dining room dated 7/30/2024 revealed: Pureed Hamburger Steak w/gravy, mashed potatoes, broccoli, and a roll. During an interview on 07/30/24 at 12:07 PM, the ADON stated the nurse should have checked trays prior to nurse aides passing the meal trays to residents. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 07/31/24 02:58 PM, the Dietician stated her expectation was that the puree diets receive what was on the menu. The Dietitian stated staff must have been in a hurry and/or nervous which led to food not being on the meal tray. The Dietitian stated the effect on residents who did not get all of the food items on the menu was they would have not received the calories they were supposed to get which have caused consequences for the residents. During an interview on 07/31/2024 at 3:51 PM, the DON stated resident who received puree meals should have received everything that was on the menu. The DON state the effect on residents could have been residents go hungry or could have weight loss. The DON stated the DM should be monitoring food to make sure residents get all food. The DON stated what led to failure of residents not receiving food that was on the menu was oversight by kitchen staff and nurses. Record review of facility policy titled, Menus dated October 2017 revealed: Menus meet the nutritional needs of residents in accordance with the recommended dietary allowances of the Food and Nutrition Board. Menus provide a variety of foods from the basic daily food groups and indicate standard portions at each meal.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44722 Based on observations, interviews, and record reviews, the facility failed to properly store, prepare, distribute, and serve food in accordance with professional standards for food service safety for 1 of 1 kitchen reviewed. The facility failed to ensure that resident food was discarded when past expiration date. The facility failed to ensure ice scoops were stored covered. The facility failed to ensure items in refrigerator where food was stored were cleaned. The facility failed to ensure dinnerware was in good condition, without chips. These failures could place residents that eat out of the kitchen at risk for food borne illnesses. The findings included: During an observation on [DATE] at 9:45 AM of the kitchen revealed: 1. Two ice scoops were uncovered laying on the counter next to the ice machine. 2. An unopened bottle of buttermilk dated [DATE] in the refrigerator. 3. A tub contained 4 unopened bottles of wine, one bottle had spilled in the bucket, and there was a black substance in bottom of tub. 4. A chipped plate and chipped coffee cup were observed being served to residents. During an interview on [DATE] at 9:45 AM, the DM stated the ice scoop should have been covered and should not have been laying on counter uncovered. The DM stated the expired buttermilk should not have been in the fridge. The DM stated the wine bottle must have spilled and staff had failed to clean the tub which led to mildew was growing in the tub. The DM stated the chipped dinnerware and the uncovered ice scoops could have caused cross contamination and cause residents to become ill. The DM stated what led to failures was oversight and/or got in hurry. The DM stated it was the cook's responsibility to ensure dinnerware were in good condition, the ice scoops were covered, but that she was ultimately responsible for monitoring. During an interview on [DATE] at 2:58 PM, the Dietician stated food items should have been discarded if past their expiration date. The Dietician stated if residents were to eat food that had expired it could have made them ill. The Dietitian stated that food should not have been served on chipped cups or plates, that broken dinnerware should have been discarded. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of facility policy titled, Sanitation dated [DATE] revealed: Plasticware, China and glassware cannot be sanitized or are hazardous because of chips, cracks or loss of glaze shall be discarded. Record review of facility policy titled, Refrigerators and Freezers dated [DATE] revealed Supervisors will be responsible for ensuring food items in pantry, refrigerator, and freezers are not expired or past perish dates. Record Review of facility policy Proper Handling of Ice Scoop, undated revealed: Purpose: To establish guidelines for the safe and hygienic handling of ice scoops to prevent cross-contamination and maintain food safety standards .Scoop: This policy applies to all employees who handle ice scoops in the course of their duties . Ice Scoop Storage: Store the ice scoop in a designated, clean, labeled (ice only), and dry location. Avoid storing the ice scoop in or on the ice machine.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676053	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/31/2024
NAME OF PROVIDER OR SUPPLIER Merkel Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1704 N 1st Merkel, TX 79536	

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F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly 48883 Based on interview and record review, the facility failed to maintain a quality assessment and assurance committee consisting at a minimum the required committee members for 7 of 7 meetings reviewed for QAPI. The facility did not ensure the MD, or a representative attended QAPI meetings in August 2023, October 2023, November 2023, December 2023, April 2024, May 2024, and June 2024. This failure could place residents at risk for quality deficiencies being unidentified, no appropriate plans of action developed and implemented, and no appropriate guidance developed. Findings included: Record review of sign in sheets for QAPI meetings in October 2023, November 2023, April 2024, May 2024, and June 2024 revealed no evidence that the MD attended QAPI meeting. During an interview on 07/30/2024 at 10:45a.m., the ADMN stated he was missing MD's signature on some of the QAPI meeting sign in sheets. He stated the MD does not attend the meetings in person or by phone and the ADMN would take the sign in sheets to MDs office after the meeting for signature. He stated he would go over the meeting with the MD, but that MD does not participate in meeting during the meetings. The ADMN stated that MD was a required member of QAPI meetings. During a follow up interview on 07/31/2024 at 3:05 p.m., the ADMN stated MD should be present during QAPI meetings. He stated poor execution on the facilities part with encouraging MD to attend and communicating with MD the significance of meetings was why the MD had not been present. The ADMN stated he was responsible for monitoring MD participate in QAPI meetings. The ADMN stated this failure could cause residents to receive improper care and treatment and the overall direction of direct care staff could be misled. Record review of facility policy titled, QAPI Plan dated 2017 revealed: We utilize online Performance Improvement tools to systematically monitor, analyze and improve performance to ensure positive resident outcomes and regulatory compliance. We recognize the value in healthcare is the appropriate balance between utilizing good measures, excellent care, professional services and cost .Our QAPI committee consists of a chairperson and seven sub-committees with representation from administration, the medical director, nursing, dietary, housekeeping, laundry, maintenance, health information management, activities, infection preventionist, staff development, therapy, human resources, and the business office. Record review of document titled QAA Committee Members without a date, revealed MD was a member of the committee.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 44558 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 infection control procedures for 1 of 1 ice scoop reviewed for infection control. The facility failed to follow their Infection Control policy regarding CDC guidelines of performing hand hygiene when assisting residents with meals and one ice scoop laying on a counter in the kitchen not covered and one ice scoop laying on a cart uncovered at the nurses' station. This failure could place residents at risk of the spread of infections. Findings included: During an observation on 07/29/2024 at 09:45 AM, Ice scoop was laying on the counter in the kitchen not covered. During an observation on 07/29/2024 at 09:45 AM one ice scoop was laying on a cart beside ice chest at nurses' station. Ice scoop was not covered. During an interview on 07/29/2024 at 09:45 AM The DM stated the ice scoop should have been covered and should not have been laying out. The DM stated this could cause cross contamination and residents to become ill. The DM stated the failure was oversight and being in a hurry. The DM stated it was her responsibility to ensure this did not happen. Record Review of facility policy Proper Handling of Ice Scoop, undated revealed: Purpose: To establish guidelines for the safe and hygienic handling of ice scoop to prevent cross-contamination and maintain food safety standards. Scope: This policy applies to all employees who handle ice scoops in the course of their duties . .3. Ice Scoop Storage: Store the ice scoop in a designated, clean, labeled (ice only), and dry location. Avoid storing the ice scoop in or on the ice machine.

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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 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Regularly inspect all bed frames, mattresses, and bed rails (if any) for safety; and all bed rails and mattresses must attach safely to the bed frame. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48883 Based on observation, interview and record review, the facility failed to conduct regular inspections of all bed frames and bed rails as part of a regular maintenance program to identify areas of possible entrapment for 4 of 4 (Residents #2, #20, #30 and #235) residents reviewed for bed rails. The facility failed to assess bed rails for risk of entrapment for Residents #2, #20, #30 and #235's beds. This failure could place residents who have bed rails at risk for injury related to poor maintenance of the bed rails. The findings included: Resident #2 Record review of Resident # 2's face sheet dated 07/31/2024 revealed a [AGE] year-old male who was admitted to the facility on [DATE] with diagnoses which included cerebral palsy (group of disorders that affect movement, muscle tone, balance, and posture), paraplegia (paralysis of all or part of your trunk, legs, and pelvic organs), muscle wasting and atrophy (loss or thinning of your muscle tissue), and muscle weakness. Record review of Resident #2's quarterly MDS assessment dated [DATE] revealed: Section C (Cognitive Patterns) BIMS score of 12 meaning moderate cognitively impairment; Section GG (Functional Abilities) revealed Resident #2 needed substantial assistance for bed mobility (rolling left to right and going form sitting to lying). Record review of Resident #2's care plan dated 07/31/2024 revealed: intervention SIDE RAILS: half rails up for safety during care provision, to assist with bed mobility. Observe for injury or entrapment related to side rail use .date initiated 09/27/2023). During and observation and interview 07/29/2024 at 3:18 p.m. Resident #2 stated his bed rails were for bed mobility and denied any issue with bed rails. He was sitting in recliner in the room. Bed observed to have half rails in the up position. Resident #20 Record review of Resident #20's face sheet dated 07/31/2024 revealed a [AGE] year-old female who was admitted to the facility on [DATE] with diagnoses which included hemiplegia and hemiparesis following cerebral infarction affecting right dominant side (right sided weakness following stroke) and vascular dementia (memory deficit from blood flow issues). (continued on next page)

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #20's annual MDS dated [DATE] revealed: BIMS score of 07 which indicated severe cognitive impairment. Further review of the MDS Section GG - Functional Abilities and Goals revealed Resident #20 needed substantial assistance with rolling left and right, sitting to lying, and lying to sitting. Record review of Resident #20's care plan dated 07/31/2024 revealed intervention She needs a safe environment with: even floors free from spills and/or clutter; adequate, glare-free light; a working and reachable call light, the bed in low position at night; half rails, handrails on walls personal items within reach . date initiated 05/22/2023. During an observation and interview on 07/29/2024 at 10:41 a.m., Resident #20 was lying in bed that had half rails on both sides of bed. She stated the rails helped her move around in the bed and voiced no concerns with bed rails. Resident #30 Record review of Resident #30's face sheet dated 07/31/2024 revealed a [AGE] year-old male who was admitted to the facility on [DATE] with diagnoses which included disorders of bone density and structure in multiple sites (decrease in bone hardness and formation), difficulty in walking, lack of coordination, and limitation of activities due to disability. Record review of Resident #30's quarterly MDS dated [DATE] Section C (Cognitive Patterns) BIMS assessment revealed a score of 15 indicated moderately impaired and Section GG (Functional Status) revealed Resident #30 needed partial to moderate assistance with bed mobility (rolling left to right, sitting to lying, and lying to sitting). Record review of Resident #30's care plan dated 07/31/2024 revealed intervention BED MOBILITY: He requires assistance by 2 staff to turn and reposition in bed q 2hrs as necessary .date initiated 01/22/2023 . BED MOBILITY: He uses half rales and trapeze to maximize independence with turning and repositioning in bed .date initiated 01/22/2023. During an observation on 07/29/2024 at 2:48 p.m., Resident #30 had half rails present to bed. Resident #235 Record review of Resident #235's face sheet dated 07/17/2024 revealed a [AGE] year-old male admitted to the facility on [DATE] with diagnoses that included atherosclerotic heart disease (heart disease that effects blood flow by clogged arteries that could cause chest pain, shortness of breath, fatigue and confusion among other symptoms), and anxiety. Record review of Resident #235's entry MDS dated [DATE] did not reveal cognitive assessment or mobility assessment. During an observation on 07/29/2024 at 11:10 p.m. revealed Resident #235 had half bed rails on his bed that were in the raised position and resident was lying in the bed. (continued on next page)

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 07/31/2024 at 2:25 p.m., the Maintenance Supervisor stated he had worked at the facility for over 3 years. He stated he had never assessed bed frames, side rails, or mattresses for risk of entrapment. He stated he had not been given any tools to perform that assessment. He stated that he did install and remove bed rails when instructed. He was able to order bed rails separate from bed frame, but they come from the same supplier. He stated he was unsure of who else would perform bed inspections, but the ADON and DON may perform them. During an interview on 07/31/2024 at 2:31 p.m., the ADON stated he had not assessed the space between the mattress and side rails to reduce the risk for entrapment. He stated he did not know who was responsible for performing bed rail assessment. During an interview on 07/31/2024 at 2:42 p.m., the DON stated she had not performed bed assessment for risk of entrapment since she had started working at the facility in June of 2024. She stated she had performed bed rail assessments prior to working at this facility. She stated that beds should be inspected, and assessment documented. She stated she did not know why assessments had not been done. She stated not performing assessment could affect residents by placing them at risk of entrapment. During an interview on 07/31/2024 at 3:00 p.m., the ADMN stated IDT should perform bed rail assessments. He stated the members of the IDT included MS, ADON, DON, and ADMN. He stated poor training and poor oversite led to assessments not being performed. He stated he was who monitors assessments were performed. He stated not performing could place resident at risk of injuries. Record review of the facility policy titled Proper Use of Side Rails dated December 2016 revealed: An assessment will be made to determine the resident's symptoms, risk of entrapment and reason for using side rails. When used for mobility or transfer, an assessment will include a review of the resident's: a. Bed mobility; b. Ability to change positions, transfer to and from bed or chair, and to stand and toilet; c. Risk of entrapment from the use of side rails; and d. That the bed's dimensions are appropriate for the resident's size and weight .The resident will be checked periodically for safety relative to side rail use .If side rail use is appropriate, the facility will assess the space between the mattress and side rails to reduce the risk for entrapment (the amount of safe space may vary, depending on the type of bed and mattress being used) . Facility staff, in conjunction with the attending Physician, will assess and document the resident's risk for injury due to neurological disorders or other medical conditions. ?

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F 0941 Level of Harm - Potential for minimal harm Residents Affected - Some	Develop, implement, and/or maintain an effective training program that includes effective communications for direct care staff members. 48883 Based on interviews and record reviews, the facility failed to implement and maintain an effective communications training program for all new and existing staff for 3 of 9 (DON, NA B, NA D) direct care staff personnel files reviewed for training. The facility failed to train for Communications for the DON, NA B, and NA D during new hire orientation. These failures placed residents at risk for unmet needs due to untrained staff. Findings included: Record review of Personnel Files revealed: 1. DON hire date 06/25/2024 - had no communications training. 2. NA B hire date 01/30/2024 - had no communications training. 3. NA D hire date 03/15/2024 - had no communications training. During an interview on 07/30/2024 at 4:23 p.m., the OM stated she was not working at the time that new employees were onboarded and did not know why trainings were not performed. During an interview on 07/30/2024 at 4:43 p.m., the ADMN stated he expected for staff to have training on communications during onboarding process. He stated the facility needed an OM and had hired one during the times that these employees were hired. He stated the OM that was hired had their own ideas on how onboarding should be done and made inappropriate changes. He stated that he monitored employees were trained appropriately and had no knowledge that these employees had not received training until now. He stated the effect on residents could be staff not able to provide adequate care to residents that could cause injuries, accidents, and improper treatment. Record review of facility policy titled Orientation Program for Newly Hired Employees, Transfers, Volunteers dated January 2008 revealed An orientation program shall be conducted for all newly hired employees, transfers from other departments, and volunteers .An introduction to resident care procedures, which includes, but is not limited to: (1) A review of the facility's Nursing Services Policy and Procedure Manual; (2) A review of the facility's Nursing Assistant's Training Program; (3) A review of the facility's In-Service Training Program; (4) A review of the facility's infection control practices; and (5) A review of the facility's philosophy of care .Our orientation program is an in-depth review of our facility's policies and procedures. A checklist is used to record materials reviewed with each employee/transfer/volunteer . A written record will be maintained of each employee's/volunteer's individual orientation program.

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F 0944 Level of Harm - Potential for minimal harm Residents Affected - Some	Conduct mandatory training, for all staff, on the facility's Quality Assurance and Performance Improvement Program. 48883 Based on record reviews and interviews, the facility failed to maintain a training program to ensure staff were trained for 3 of 16 (DON, NA B, NA D) reviewed for Quality Assurance and Performance Improvement (QAPI) training. The facility failed to ensure the DON, NA B, and NA D were trained for QAPI upon hire. This failure placed residents at risk of at receiving care from incompetent/untrained staff. Findings included: Record review of Personnel Files revealed: 1. DON hire date 06/25/2024 - had no QAPI training. 2. NA B hire date 01/30/2024 - had no QAPI training. 3. NA D hire date 03/15/2024 - had no QAPI training. During an interview on 07/30/2024 at 4:23 p.m., the OM stated she was not working at the time that new employees were onboarded and did not know why trainings were not performed. During an interview on 07/30/2024 at 4:43 p.m., the ADMN stated he expected for staff to have training on communications during onboarding process. He stated the facility needed an OM and had hired one during the times that these employees were hired. He stated the OM that was hired had their own ideas on how onboarding should be done and made inappropriate changes. He stated that he monitored employees were trained appropriately and had no knowledge that these employees had not received training until now. He stated the effect on residents could be staff not able to provide adequate care to residents that could cause injuries, accidents, and improper treatment. Record review of facility policy titled Orientation Program for Newly Hired Employees, Transfers, Volunteers dated January 2008 revealed An orientation program shall be conducted for all newly hired employees, transfers from other departments, and volunteers .An introduction to resident care procedures, which includes, but is not limited to: (1) A review of the facility's Nursing Services Policy and Procedure Manual; (2) A review of the facility's Nursing Assistant's Training Program; (3) A review of the facility's In-Service Training Program; (4) A review of the facility's infection control practices; and (5) A review of the facility's philosophy of care .Our orientation program is an in-depth review of our facility's policies and procedures. A checklist is used to record materials reviewed with each employee/transfer/volunteer . A written record will be maintained of each employee's/volunteer's individual orientation program.

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F 0949 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide behavior health training consistent with the requirements and as determined by a facility assessment. 48883 Based on record reviews and interviews, the facility failed to maintain a training program to ensure staff were trained for 2 of 16 (DON, and NA D) reviewed for behavioral health training. The facility failed to ensure the DON, and NA D upon hire were trained for Behavioral Health or an assessment tool to behavioral health. This failure could place residents at risk at receiving care from of incompetent/untrained staff. Findings included: Record review of Personnel Files revealed: 1. DON hire date 06/25/2024 - had no behavioral health training. 2. NA D hire date 03/15/2024 - had no behavioral health training. During an interview on 07/30/2024 at 4:23 p.m., the OM stated she was not working at the time that new employees were onboarded and did not know why trainings were not performed. During an interview on 07/30/2024 at 4:43 p.m., the ADMN stated he expected for staff to have training on communications during onboarding process. He stated the facility needed an OM and had hired one during the times that these employees were hired. He stated the OM that was hired had their own ideas on how onboarding should be done and made inappropriate changes. He stated that he monitored employees were trained appropriately and had no knowledge that these employees had not received training until now. He stated the effect on residents could be staff not able to provide adequate care to residents that could cause injuries, accidents, and improper treatment. Record review of facility policy titled Orientation Program for Newly Hired Employees, Transfers, Volunteers dated January 2008 revealed An orientation program shall be conducted for all newly hired employees, transfers from other departments, and volunteers .An introduction to resident care procedures, which includes, but is not limited to: (1) A review of the facility's Nursing Services Policy and Procedure Manual; (2) A review of the facility's Nursing Assistant's Training Program; (3) A review of the facility's In-Service Training Program; (4) A review of the facility's infection control practices; and (5) A review of the facility's philosophy of care .Our orientation program is an in-depth review of our facility's policies and procedures. A checklist is used to record materials reviewed with each employee/transfer/volunteer . A written record will be maintained of each employee's/volunteer's individual orientation program. (continued on next page)

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F 0949 Level of Harm - Potential for minimal harm Residents Affected - Some	Review of facility assessment tool dated 07/29/2024 revealed facility care for 1 resident with behavioral health needs. General care requirements of patient population included mental health and behavior with specific care of Manage the medical conditions and medication-related issues causing psychiatric symptoms and behavior, identify and implement interventions to help support individuals with issues such as dealing with anxiety, care of someone with cognitive impairment, care of individuals with depression, trauma/PTSD, other psychiatric diagnoses, intellectual or developmental disabilities.