Department of Health & Human Services
Centers for Medicare & Medicaid Services

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676094	A. Building B. Wing	03/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Focused Care at Orange	4201 Fm 105 Orange, TX 77630

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30664 Based on interviews and record reviews, the facility failed to ensure the right to formulate an advance directive was provided for 3 of 3 residents reviewed for advanced directives. (Residents #26, #91, and #216) * The facility did not have a valid Out of Hospital-Do Not Resuscitate (OOH-DNR) for Residents #26, #91, and #216. This failure could place residents at risk of lifesaving procedures being performed against their wishes resulting in bruising, broken ribs, electrical shocking of the heart, having a tube placed in the throat and provided artificial breathing methods, and possibly being brought back to life in an unaware and unresponsive state. Findings included: 1. Record review of a face sheet dated [DATE] indicated Resident #26 was an [AGE] year-old male admitted on [DATE]. His diagnoses included chronic obstructive pulmonary disease (a lung disease that blocks airflow making it difficult to breathe), hypertension (condition in which the force of the blood against the artery walls is too high), and peripheral vascular disease (a blood circulation disorder that causes the blood vessels outside of the heart and brain to narrow, block, or spasm). He was designated as DNR. Record review of the current MDS assessment dated [DATE] indicated Resident #26 was alert to person, place, and time with a BIMS of 11 indicating he had moderately impaired cognition. Record review of physician orders for [DATE] indicated Resident #26 had an order dated [DATE] for DNR. Record review of the EMR for Resident #26 on [DATE] at 09:24 a.m. had a scanned OOH-DNR dated [DATE] with no date of physician signature, no printed name of physician, and no license number of physician. In the witness section there were no witnesses' signatures because there was a notary who witnessed the qualified relative's signature. Record review of an OOH-DNR provided by the DON on [DATE] at 11:24 a.m. indicated Resident #26's DNR dated [DATE] had 2 witnesses signatures in the witness section and they were dated [DATE]. (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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation and interview on [DATE] at 11:05 a.m. Resident #26 was up in his wheelchair in his room. He said he did not want CPR done. During an interview on [DATE] at 11:23 a.m. the DON said she did not know who or why 2 witness signatures were done on the form [AGE] years after the OOH-DNR was initiated by the resident and notarized. She said it was sufficient with the notary on it. She said due to the incorrectness Resident #26's DNR was not valid. She said the negative outcome would be CPR could be initiated against the resident's wishes. 2. Record review of a face sheet dated [DATE] indicated Resident #91 was a [AGE] year-old female admitted on [DATE]. Her diagnoses included cerebral infarction (lack of adequate blood supply to brain cells deprives them of oxygen and vital nutrients which can cause parts of the brain to die off), respiratory failure (a serious condition that makes it difficult to breathe on your own), kidney failure (condition where the kidney reaches advanced state of loss of function), and peripheral vascular disease (a blood circulation disorder that causes the blood vessels outside of the heart and brain to narrow, block, or spasm). She was designated as DNR. Record review of the current MDS assessment dated [DATE] indicated Resident #91 was alert to person, place, and time with a BIMS of 15 indicating she was cognitively intact. Record review of physician orders for [DATE] indicated Resident #91 had an order dated [DATE] for DNR. Record review of the EMR for Resident #91 on [DATE] at 12:16 p.m. had a scanned OOH-DNR dated [DATE] signed by the physician in the wrong section of the form, there was no date for the signature, there was no printed name of the physician, and no physician license number. Record review of an OOH-DNR provided by the DON on [DATE] at 11:24 a.m. indicated Resident #91's DNR dated [DATE] had no date physician signed the DNR, his signature under the 2-physician section was dated [DATE], and there was no physician signature in the bottom section of the form. During an observation and interview on [DATE] 11:06 AM Resident #91 was lying in bed with her oxygen on via nasal canula. She said she did not want CPR done. During an interview on [DATE] at 11:23 a.m. the DON said the date physician signed should be marked, his signature under the 2-physician section should not be dated [DATE], and the physician should have signed the bottom section. She said Resident #91's DNR was not valid. She said the negative outcome would be CPR would be initiated against the resident's wishes. 3. Record review of a face sheet dated [DATE] indicated Resident #216 was an [AGE] year-old male admitted on [DATE]. His diagnoses included cerebral infarction (lack of adequate blood supply to brain cells deprives them of oxygen and vital nutrients which can cause parts of the brain to die off), hypertension (condition in which the force of the blood against the artery walls is too high), and heart failure (a condition that develops when the heart doesn't pump enough blood for the body's needs). He was designated as DNR. Record review of a baseline care plan dated [DATE] indicated Resident #216 was designated a DNR. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of physician orders for [DATE] indicated Resident #216 had an order dated [DATE] for DNR. Record review of an OOH-DNR provided by the DON on [DATE] at 11:24 a.m. indicated Resident #216's OOH-DNR dated [DATE] had Section B with no identification marked as to who the person was initiating the DNR and no physician signature in the bottom section of the form. The bottom section of the form indicated All persons who have signed above must sign below, acknowledging that this document has been properly completed. During an observation and interview on [DATE] at 11:01 a.m. Resident #216 was propelling himself in the hallway. He said he did not think he would like someone pounding on his chest if his heart stopped. During an interview on [DATE] at 11:23 a.m. the DON said the person should have been marked as to who they were and the physician should have signed the bottom section. She said Resident #216 's DNR was not valid. She said the negative outcome would be CPR would be initiated against the resident's wishes. Record review of an Out of Hospital- Do Not Resuscitate accessed at https://www.hhs.texas.gov/regulations/forms/advance-directives/out-hospital-do-not-resuscitate-ooh-dnr-order indicated the following: * The section at the bottom of the form All persons who have signed above must sign below, acknowledging that this document has been properly completed * The INSTRUCTIONS FOR ISSUING AN OOH-DNR ORDER indicated: * Section B - If an adult person is incompetent or otherwise mentally or physically incapable of communication and has either a legal guardian, agent in a medical power of attorney, or proxy in a directive to physicians, the guardian, agent, or proxy may execute the OOH-DNR Order by signing and dating it in Section B.; * Section D - If the person is incompetent and his/her attending physician has seen evidence of the person's previously issued proper directive to physicians or observed the person competently issue an OOH-DNR Order in a nonwritten manner, the physician may execute the Order on behalf of the person by signing and dating it in Section D.; and * In addition, the OOH-DNR Order must be signed and dated by two competent adult witnesses, who have witnessed either the competent adult person making his/her signature in section A, or authorized declarant making his/her signature in either sections B, C, or E,

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30664 Based on interviews and record reviews, the facility failed to ensure an accurate MDS was completed for 1 of 13 residents (Resident #90) reviewed for MDS assessment accuracy. * The facility did not accurately code Resident #90's MDS assessment for bladder and bowel incontinence. This failure could place residents at risk for not receiving the appropriate care and services to maintain the highest level of well-being. Findings included: Record review of a face sheet dated 03/06/24 indicated Resident #90 was a [AGE] year-old female admitted on [DATE]. Her diagnoses included malignant neoplasm of cervix (cancer of the lower female reproductive system) and quadriplegia (dysfunction or loss of motor and/or sensory function in the neck area of the spinal cord). Record review of physician orders for March 2024 indicated Resident #90 had nephrostomy (an opening between the kidney and the skin) tubes and a colostomy (a surgery that creates a new opening in the belly for the colon, the organ that forms poop) with an order dated 01/03/24. Record review of the admission MDS assessment dated [DATE] indicated Resident #90 was coded 3 always incontinent of bowel and was coded 3 always incontinent of bladder. Record review of the care plan dated 01/12/24 indicated Resident #91 had nephrostomy tubes and a colostomy. During an observation and interview on 03/04/24 at 09:20 a.m. Resident #90 was in bed. She did not answer questions. She had nephrostomy tubes and a colostomy intact. During an observation 03/05/24 at 09:48 a.m. Resident #90 had nephrostomy tubes and bags w/dressings intact and a colostomy bag. During an interview on 03/06/24 at 10:56 a.m. MDS Nurse F said Resident #90's MDS assessment should have been marked Not Rated and not Always Incontinent since she had nephrostomy tubes and a colostomy. She said the negative outcome of the MDS not being correct would be resident not receiving the appropriate care and incorrect information to CMS. During an interview on 03/06/24 at 12:25 p.m. the DON said the facility followed the MDS RAI manual regarding accuracy of the MDS. She said the MDS Nurses were responsible for the accuracy of the MDS assessment. According to the MDS RAI Manual dated October 2023: H0300: Urinary Continence: (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coding Instructions o Code 0, always continent: if throughout the 7-day look-back period the resident has been continent of urine, without any episodes of incontinence. o Code 1, occasionally incontinent: if during the 7-day look-back period the resident was incontinent less than 7 episodes. This includes incontinence of any amount of urine sufficient to dampen undergarments, briefs, or pads during daytime or nighttime. o Code 2, frequently incontinent: if during the 7-day look-back period, the resident was incontinent of urine during seven or more episodes but had at least one continent void. This includes incontinence of any amount of urine, daytime and nighttime. o Code 3, always incontinent: if during the 7-day look-back period, the resident had no continent voids. o Code 9, not rated: if during the 7-day look-back period the resident had an indwelling bladder catheter, condom catheter, ostomy, or no urine output (e.g., is on chronic dialysis with no urine output) for the entire 7 days H0400: Bowel Continence: Coding Instructions o Code 0, always continent: if during the 7-day look-back period the resident has been continent of bowel on all occasions of bowel movements, without any episodes of incontinence. o Code 1, occasionally incontinent: if during the 7-day look-back period the resident was incontinent of stool once. This includes incontinence of any amount of stool day or night. o Code 2, frequently incontinent: if during the 7-day look-back period, the resident was incontinent of bowel more than once, but had at least one continent bowel movement. This includes incontinence of any amount of stool day or night. o Code 3, always incontinent: if during the 7-day look-back period, the resident was incontinent of bowel for all bowel movements and had no continent bowel movements. o Code 9, not rated: if during the 7-day look-back period the resident had an ostomy or did not have a bowel movement for the entire 7 days. (Note that these residents should be checked for fecal impaction and evaluated for constipation.)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30664 41057 Based on observation, interview and record review, the facility failed to ensure preadmission screening for individuals identified with MI, DD, or ID were evaluated for services for 2 of 21 residents reviewed for resident assessments (Residents #50 and #69). The facility did not have an accurate PASRR level 1 screening (PL1) for Residents #50 and #69 upon admission . This failure could place residents who have a diagnosis of mental disorder, developmental disability, or intellectual disability at risk for a diminished quality of life and not receiving necessary care and services in accordance with individually assessed needs. Findings included: 1. Record review of a face sheet dated 03/06/24 indicated Resident #50 was a [AGE] year-old male admitted on [DATE]. His diagnoses included recurrent depressive disorders (more than just a feeling of sad or low), major depressive disorder (mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life), and anxiety disorder (persistent and excessive worry that interferes with daily activities) on 07/31/23. Record review of a PASRR Level 1 Screening dated 03/08/23 indicated Resident #50 was negative for MI. Record review of physician orders for March 2024 indicated Resident #50 had an order dated 06/29/23 to receive fluoxetine 40 mg (antidepressant) and an order dated 07/31/23 to receive buspirone 5 mg (used to treat anxiety). Record review of a care plan dated 12/07/23 indicated Resident #50 had a care plan indicating he received an antidepressant. During an interview on 03/06/24 at 10:56 a.m. MDS nurse H said major depressive disorder and anxiety would be a trigger for a positive PL1 and a PE should be done. She said a PE was not done on Resident #50 due to his PL1 being negative. She said she was not sure what needed to be done but she would contact her PASRR person to find out. She said the negative outcome would be a person would not receive services if they qualified. During an interview via phone on 03/06/24 at 12:47 p.m. the Regional Nurse said major depressive disorder would be a triggering diagnosis for a positive PL1. She said Resident #50 should have had a positive PL1. She said a corrected PL1 should be done and sent to LMHA. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Record review of a face sheet dated 03/04/24 indicated Resident #69 was a [AGE] year-old female admitted [DATE] with diagnoses of Huntington's disease (an inherited disease that causes progressive breakdown of nerve cells in the brain.), dementia (loss of cognitive function) and anxiety disorder (a feeling of fear, dread, and uneasiness). Record review of an admission MDS dated [DATE] indicated Resident #69 was not PASSR positive and had a BIMS score of 00 indicating severely impaired cognition and had an altered level of consciousness continuously. The MDS indicated Resident #69 had a diagnosis of Huntington's disease, dementia, and anxiety. Record review of a care plan dated 01/02/24 indicated Resident #69 had a care plan indicating she had Huntington's disease and was at risk of a decline in physical mobility. Record review of physician's orders dated 03/04/24 indicated Resident #69 was prescribed tetrabenazine (a medication to treat a movement disorder caused by Huntington's disease) 50 mg three times a day with a start date of 12/22/23. Record review of a PASRR level 1 screening completed by the transferring facility dated 12/22/23 indicated Resident #69 was negative for mental illness, intellectual disability, and developmental disability and negative for dementia as the primary diagnosis. There was no PASRR Level II Screening or Form 1012 (Mental Illness/Dementia Resident Review) found in the clinical record from the resident's admission on 12/22/23 to 03/06/24. During an observation on 03/04/24 at 09:00 a.m., Resident #69 was lying in bed with no observed distress and was able to answer some questions with yes and no answers. During an interview on 03/06/24 at 11:00 a.m., MDS Nurse F said she was responsible for Resident #69's PL1 and the regional nurse double checked the PASRR forms. She said she received verbal education on PASRR by the regional nurse. MDS Nurse F said Resident #69's PL1 should have been positive. She said she was unaware the diagnosis of Huntington's was a PASRR positive diagnosis. MDS Nurse F said the risk of an incorrect PL1 was a resident may miss out on PASRR services. She said she would send in a new positive PL1 after surveyor intervention. During an interview on 03/06/24 at 12:10 p.m., the DON said the MDS nurses were responsible for PASRR forms, and the regional nurse was the backup/ double check. The DON said Resident #69's PL1 form was overlooked. She said the risk to residents with an incorrect PL1 was a delay in treatment and not receiving PASRR services. The DON said her expectation was PASRR forms to be completed accurately and timely. During an interview on 03/06/24 at 12:12 p.m., the Administrator said the MDS nurses were responsible for PASRR forms. He said his expectation was PASRR forms be completed per regulation requirements. He said the risk of an incorrect PL1 was a resident may miss out on PASRR services. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 03/06/24 at 12:48 p.m., the Regional Nurse said the MDS nurses were responsible for PASRR forms. She said she audited PASRR forms and provided training on PASRR. The Regional Nurse said Huntington's was a diagnosis that was a PASRR positive diagnosis. She said Resident #69's PL1 was overlooked, she said she did not review it. The Regional Nurse said the risk of an incorrect PL 1 was a resident may not be treated correctly and not get the extra benefit of PASRR services. She said she would reeducate the MDS nurses. Record review of the facility policy, revised 11/15/23, titled, PASRR Policy indicated, . The purpose of this policy is to ensure PASRRS are being obtained and completed timely and accurately.6. Follow Texas PASRR Policy for all mandatory meetings and care coordination including any changes that may require a change in resident's PASRR status. Record review of the October 2023 Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual titled, A1500: Preadmission Screening and Resident Review (PASRR) Item Rationale Health-related Quality of Life indicated . o All individuals who are admitted to a Medicaid certified nursing facility, regardless of the individual's payment source, must have a Level I PASRR completed to screen for possible mental illness (MI), intellectual disability (ID), developmental disability (DD), or related conditions o Individuals who have or are suspected to have MI or ID/DD or related conditions may not be admitted to a Medicaid-certified nursing facility unless approved through Level II PASRR determination. Those residents covered by Level II PASRR process may require certain care and services provided by the nursing home, and/or specialized services provided by the State.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 25779 Based on observation, interview, and record review, 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 for 2 of 21 residents. (Residents #50 and #55) The facility failed to develop a care plan for Resident #50's anxiety disorder or anxiety medication. The facility did not develop a care plan to address Resident #55's contracture of the right hand. This failure could place the residents at risk of not receiving care and services to maintain their highest level of well-being. Findings included: 1. Record review of a face sheet dated 03/06/24 indicated Resident #50 was a [AGE] year-old male admitted on [DATE]. His diagnoses included anxiety disorder (persistent and excessive worry that interferes with daily activities) on 07/31/23. Record review of a care plan dated 12/07/23 indicated Resident #50 had no care plan for anxiety or psychotropic medication related to anxiety and buspirone. Record review of the MDS assessment dated [DATE] indicated Resident #50 had an active diagnosis of anxiety disorder and he received an antianxiety medication. Record review of physician orders for March 2024 indicated Resident #50 had an order dated 07/31/23 to receive buspirone 5 mg (used to treat anxiety). During an interview on 03/06/24 at 02:00 p.m. MDS H acknowledged Resident #50 had no care plan for the anxiety or buspirone. She said the negative outcome would be residents could not receive the appropriate care. She said the MDS Nurses were responsible for the care plans. 2. Record review of physician orders dated 03/05/24 indicated Resident #55, admitted [DATE], was [AGE] years old with a diagnosis of cerebral vascular accident (an interruption of blood flow to cells in the brain causing weakness, usually to one side of the body). Record review of the most recent quarterly MDS assessment date 12/05/23 indicated Resident #55 had moderate cognitive impairment and limited ROM to upper and lower extremities on both sides. Record review of Resident #55's care plans dated 02/22/24 did not indicate Resident #55 had limited ROM. A care plan dated 02/22/24 indicated the resident had a diagnosis of cerebral vascular accident, but the care plan did not address the resident's limited ROM. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During observations, Resident #55's fingers on her right hand were stiff and contracted upward towards the bottom of the palm of the hand but not inward towards the palm of the hand. The thumb was contracted inward between the second and third fingers with the thumb protruding outside of the fingers. *on 03/04/24 at 09:27 a.m., *on 03/04/24 at 03:39 p.m., and *on 03/05/24 at 11:21 a.m. During an observations on 03/04/24 at 3:39 p.m., Resident #55 was asked if she could move her fingers and thumb. The fingers were stiff and did not bend at the knuckles. She was only able to move her fingers approximately 1 to 2 inches away from the bottom of the palm of her hand. She was able to move the thumb approximately 1/2 to 1 inch. The knuckle of the thumb was stiff and would not bend. During an interview and record review on 03/05/24 at 12:27 p.m., the DON said Resident #55's care plans did not address the resident's contractures to the right hand. She said her expectations were for the care plans to be patient centered, updated with changes at least quarterly and reviewed in the meetings. She said not updating the care plans could cause the residents to not receive the care they may need. During an interview and record review on 03/05/24 at 12:53 p.m., MDS nurse F said she did not have Resident #55 care planned for ROM and she should have been. She said she had not looked at her recently but did understand part of the assessment was laying eyes on the resident. She said the possible negative outcome of not implementing a care plan for ROM would be the resident may not receive the care she required, and the resident's contracture could possibly not be monitored and worsen. Record review of a Comprehensive Care Plan policy revised 04/25/21 indicated: . The care plan is revised every quarter, significant change of condition, annual or as the resident condition changes on an individual basis. The care plan process is an ongoing review process. Surveyor: [NAME]-[NAME], [NAME] 30664

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25779 Based on observation, interview and record review, the facility failed to ensure a resident with limited range of motion received appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion for 1 of 21 residents (Resident #55) reviewed for quality of care The facility did not ensure Resident #55 had interventions in place to prevent a decrease in ROM for the contractures of the right hand. This failure could place the residents at risk of not receiving care and services to maintain their highest level of well-being and decline. Findings included: Record review of physician orders dated 03/05/24 indicated Resident #55, admitted [DATE], was [AGE] years old with a diagnosis of cerebral vascular accident (an interruption of blood flow to cells in the brain causing weakness, usually to one side of the body). There were no orders for a hand splint to the resident's upper extremities. Record review of the most recent quarterly MDS assessment date 12/05/23 indicated Resident #55 had moderate cognitive impairment and limited ROM to upper and lower extremities on both sides. Record review of the care plans dated 02/22/24 did not indicate Resident #55 had limited ROM. A care plan dated 02/22/24 indicated the resident had a diagnosis of cerebral vascular accident, but the care plan did not address the resident's limited ROM. Record review of physical therapy notes dated 01/21/24 to 02/14 24 indicated Resident #55 received therapy to her lower extremities. However, there was no documentation to indicate the resident had therapy to her upper extremities or had a contracture to the right hand. There were no documented interventions for the right-hand contracture. The therapy goals were to improve transfer and ambulation. During the following observations, Resident #55's fingers on her right hand were stiff and contracted upward towards the bottom of the palm of the hand but not inward towards the inside palm of the hand. The thumb was contracted inward between the second and third fingers with the thumb protruding outside of the fingers. The resident did not have a hand splint in place. *on 03/04/24 at 09:27 a.m., *on 03/04/24 at 03:39 p.m., and *on 03/05/24 at 11:21 a.m. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Focused Care at Orange		STREET ADDRESS, CITY, STATE, ZIP CODE 4201 Fm 105 Orange, TX 77630	

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and interview on 03/04/24 at 3:39 p.m., Resident #55 said staff had not put a hand splint in her hand and she would like to have one put in her hand to keep it from getting worse. She said she never refused to have a handroll placed in her hand and had never thought to ask staff for one. When asked if she could move her fingers and thumb, the fingers were stiff and did not bend at the joints. She could only move her fingers about 1 to 2 inches away from the bottom of the palm of her hand. She was able to move the thumb approximately 1/2 to 1 inch. The joint of the thumb was stiff and would not bend. She was only able to move her fingers approximately 1/4 to 1/8 inch away from the palm of the hand. She was able to move the thumb approximately 1/4 to 1/2 inch with the knuckle of the thumbs stiff and would not bend. During an interview on 03/04/24 at 3:42 p.m., LVN B said Resident #55 was alert, oriented and could answer questions correctly. She said the resident was sometimes hard to understand but was oriented. She said the resident had improved cognitively since the last MDS assessment. During an interview on 03/05/24 at 11:19 a.m., LVN C said Resident #55 was seen by PT in January 2024. She said the resident did not have a hand splint in her hand and she had not seen one in her hand. She said her job was to report contractures to therapy and when she noticed the resident's hand becoming more contracted, she reported it to therapy. She said therapy was aware of the resident's contractures. She said the possible negative outcome of not having a hand splint in the resident's hand could be increased contractures and possible altered skin integrity. During an interview on 03/05/24 at 11:21 a.m., PT D said she was the therapist who evaluated and saw Resident #55 during January and February 2024. She said the resident was evaluated on 01/21/24 for services and discharged on [DATE]. As she reviewed the notes from those dates, she said she did not have the resident listed to have a contracture to her right hand but did have weakness. She said PT would have to do more functional addressing of the hand. She said the resident had tardive dyskinesia (uncontrollable movements of mild to severe jerking, shaking or twitching) movements they were focusing on and the right contracted hand got overlooked. She said the resident needed assistance with wheeling self and she was more focused on the global and gross motor skill issues. She said the right hand contracture was an oversight. She said if the resident could not move her fingers to function that was a problem. She said they could have put a palm guard in place, which had lambs wool and goes around their hand and prevents the hand from further contracture. During observation and interview on 03/05/24 at 11:37 am., PT D said Resident #55's thumb was contracted inward, as she attempted to move the resident fingers and make her hold on to the arm rest, and interventions did need to be implemented. She said it was an oversight on her part. She said the resident was admitted from a rehab facility related to a stroke. She said in reviewing the therapy notes, the resident had recently been seen for tardive dyskinesia but not specifically for the hand. She said the negative outcome of not having interventions in place could be further contractures and skin breakdown. During observation and interview on 03/05/24 at 12:47 a.m., CNA E said she thought Resident #55 had a hand splint but could not remember. The CNA entered the resident's room and began looking for a hand splint but was unable to find one. She said Resident #55's hand had been contracted for several months. She said the resident could not move her fingers and they were stiff. She said the resident had not had a hand splint for at least the last 2 months that she knows of. She said she had never been told to put a hand splint in the resident's hand. She said the possible negative outcome could be the resident would have pain with movement or would not be able to open her hand at all. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 03/06/24 at 2:01 p.m., the DON said there was not a ROM or contracture policy. She said her expectations were for the residents to receive ROM exercises to prevent a decrease in ROM. Record review of the undated Physical Therapy Job Description indicated: . Initial and interim assessment of client's level of functioning and recommends, in writing to the patient's physician, the need for a rehabilitation program, goals and discharge plans, either restorative or maintenance.

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F 0695

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Provide safe and appropriate respiratory care for a resident when needed.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 25779

Based on observation, interview, and record review, the facility failed to ensure that a resident who needed respiratory care was provided care, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences for 1 of 21 residents (Resident #37) reviewed for quality of care.

The facility did not administer Resident #37's oxygen via nasal cannula as ordered by the physician.

This failure could place the residents at risk of not receiving care and services to maintain their highest level of well-being.

Findings included:

Record review of physician orders dated 03/05/24 indicated Resident #37, admitted [DATE], was [AGE] years old with diagnoses of atrial fibrillation (an irregular, often rapid heart rate that commonly causes poor blood flow) and shortness of breath. The orders indicated the resident received oxygen 2 liters via nasal cannula.

Record review of the most recent quarterly MDS assessment dated [DATE] indicated Resident #37 received oxygen therapy.

Record review of a care plan updated 1/28/24 indicated Resident #37 was on oxygen therapy r/t Ineffective gas exchange. The interventions indicated: OXYGEN SETTINGS: O2 via nasal cannula @ 2L via nasal cannula. Humidified air.

During observations Resident #37's oxygen was in progress and was set at 3 liters via nasal cannula:

*on 03/04/24 at 8:23 a.m.,

*on 03/04/24 at 11:56 a.m.,

*on 03/04/24 at 12:40 p.m., and

*on 03/05/24 at 11:18 a.m.

During observation, interview and record review on 03/05/24 at 11:18 a.m., LVN A, upon review of the clinical record, said Resident #37's oxygen was ordered at 2 liters via nasal cannula. During observation of the resident, the LVN said the resident's oxygen was set at 3 liters and should be set at 2 liters. She said the possible negative outcome would be the resident's lungs could be affected and it could cause the resident to require a higher dose of oxygen.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 03/05/24 at 12:27 p.m., the DON said her expectations were for oxygen to be administered at the correct dose and for the LVNs to check the settings each time they went in the room. She said the possible negative outcome could be the residents' lungs would receive too much oxygen and physician orders would not be followed. Record review of a Respiratory policy dated 4/2021 indicated: It is the policy of this community to ensure all oxygen administration is conducted in a safe manner. 1. Verify there is an order for the oxygen administration to include: a. method, b. flow rate, and c. oxygen saturations parameters if indicated.

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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 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33460 Based on observation, interview, and record review, the facility failed to provide or obtain from an outside source dental services to meet the needs of 1 of 21 residents reviewed for dental services. (Resident #7) The facility did not assist Resident #7, who had missing teeth and dental decay, with a dental service consult. This failure could place the residents at risk for not receiving care and services to maintain their highest practicable mental, physical, and psychosocial well-being. Findings included: Record review of an admission record dated 03/06/24 indicated Resident #7 admitted on [DATE] was [AGE] years old with diagnoses of head injuries, stroke, and speech and language deficits. Record review of MDS annual assessment dated [DATE] indicated Resident #7 was severely impaired with cognition, had unclear speech, and ate a mechanically altered diet. She had obvious or likely cavity or broken natural teeth and inflamed or bleeding gums or loose natural teeth. Record review of the care plan dated 09/20/23 indicated Resident #7 required a pureed diet related to difficulty in chewing and swallowing. Record review of physician orders dated 03/06/24 indicated Resident #7 orders included a pureed diet. During an observation on 03/04/24 at 9:50 a.m., Resident #7 had missing teeth and she had an overgrowth on her gums . Several of her teeth were barely showing past the gums. During a family interview on 03/04/24 at 3:00 p.m., Resident #7's responsible party said the facility had spoken to her in September 2023 about an appointment with a dentist, but she had not heard anything else. During an interview on 03/05/24 at 3:15 p.m., the SW said a request was sent to the dental services, but the insurance indicated it would not pay. The SW stated the facility had not reached out to the dentist or the family. She said social services should have followed up and determined the reason. She said the last SW must had missed the needed follow-up for Resident #7. She said this failure could cause dental pain or self-esteem issues. The SW said the nurses would tell her if the resident had issues with their teeth or dentures then she would refer the resident to the dentist. She said it was the responsibility of social services to make appointments. During an interview on 03/06/24 at 8:00 a.m., RN K said Resident #7 had dental issues related to the seizure medication and thought she had been seen by the dentist. She said if the residents developed pain or dental issues, the nurse would tell the SW. (continued on next page)

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 03/06/24 at 9:45 a.m., the DON said her expectation was for the residents to receive dental services as needed. She said the nurses were to refer residents with dental concerns to the SW and she would arrange dental services. The DON said the facility did not have a policy for dental services.

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30664 Based on interview and record review, the facility failed to employ staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service for 1 of 12 dietary staff (DA J) reviewed for food and nutrition services. The facility failed to ensure DA J had a current Food Handler's Certificate while working in the facility's kitchen. This failure could place residents who consumed food prepared in the facility kitchen at risk of foodborne illness due to being served by improperly trained staff. Findings included: Record review of 12 dietary staff food handlers' certificates indicated DA J's certificate had an expiration date of [DATE]. During an interview on [DATE] at 11:47 a.m., DA J said she did not realize her food handler's certification had expired last year. She stated, I was trying to get on the computer to complete the food handler training today. During an interview on [DATE] at 11:52 a.m. the DM said she noticed the Food Handlers Certificate for DA J was expired. During an interview on [DATE] at 12:30 p.m., the Administrator said the DM had just started recently but she would be the one responsible to monitor the certificates. He said the dietary staff were to have current food handler's certification to prevent food borne illness and the food handler certification was required. Reference obtained from the Texas Food Establishment Rules dated 2015 indicated .Certified Food Protection Manager and Food Handler Requirements. (e) The food establishment shall maintain on premises a certificate of completion of the food handler training course for each food employee. The requirement to complete a food handler training course shall be effective [DATE]

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 30664 Based on observations, interviews, and record reviews the facility failed to store, prepare, distribute, and serve food under sanitary conditions in 1 of 1 preparation kitchen. * The facility did not ensure baking sheets did not have brown and/or black baked on build up. * The facility did not ensure steam table pans did not have brown and/or black baked on build up. * The facility did not ensure muffin pans did not have brown and/or black baked on build up. * The facility did not ensure skillets did not have black build up on the outer and inner surface. * The facility did not ensure staff leave their shoes in the kitchen. * The DM and Cook G did not ensure food was at a safe temperature prior to serving food to residents. These failures could place residents who eat from the kitchen at risk of foodborne illnesses. Findings included: During observations on 03/04/24 during initial tour of the kitchen at 08:36 a.m. indicated: * There were 3 large deep baking sheets, 7 large baking sheets, 3 half size baking sheets, and 5 muffin pans all with black/brown build up inside the corners and the outside edges; * There were 2 large shallow steam table pans with brown build up on the outside edges. * There was 1 large skillet on the stove being used had black build up on the outer and inner surface. During an interview on 03/04/24 at 09:00 a.m. the DM said she had only been working at the facility for 2 weeks and had not been able to do anything yet about the buildup. During observations and interviews of the lunch meal service on 03/05/24 indicated: * at 11:46 a.m. there were slide shoes under the prep table next to the steam table. * at 12:01 p.m. the DM acknowledged the slide shoes under the preparation table and said the slide shoes should not be there and removed them. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	* at 12:18 p.m. Cook G pulled two deep steam table pans with 2 turkey breasts roasts out of the oven. Cook G conducted a temperature check with the temperatures ranging from 169-171 degrees. Cook G sliced up two turkey breast roasts, placed them in a steam table pan, then placed the pan on the steam table. The other pan with 2 turkey breast roasts were left on the preparation table. * at 12:30 p.m. the DM removed the lids from the foods on the steam table. She did not check the temperatures of the food at that time. * at 12:35 p.m. the DM was pulling serving utensils and did not have all the correct ones. She said she would have to adjust how much was given with the ones she had to ensure the residents received the right amount. The temperatures of the food was not checked at that time. * at 12:38 p.m. the DM placed a turkey slice on a plate without checking the temperature. * at 12:40 p.m. the DM started to serve the a turkey slice on a plate without checking the temperature. Surveyor asked what was the temperature of turkey being served since it had been sitting out of the oven and not on the steam table. Cook G said the temperature was checked when she took them out of the oven. Surveyor asked the DM and Cook G when should the temperatures of food to be checked and the DM said when taken out of the oven and before serving. The DM checked the temperature of the turkey slices and it was 154 degrees. She then started to serve and surveyor asked what the temperatures were of the other food on the steam table. She said she did not know and started checking the temperatures. The temperatures were above the required holding temperature. According to the US Food and Drug Administration Food Code dated January 18, 2023: 2-103.11 Person in Charge. The PERSON IN CHARGE shall ensure that: (I) EMPLOYEES are properly maintaining the temperatures of TIME/TEMPERATURE CONTROL FOR SAFETY FOODS during hot and cold holding through daily oversight of the EMPLOYEES' routine monitoring of FOOD temperatures; 3-501.16 Time/Temperature Control for Safety Food, Hot and Cold Holding. (A) Except during preparation, cooking, or cooling, or when time is used as the public health control as specified under S3-501.19, and except as specified under (B) and in (C) of this section, TIME/TEMPERATURE CONTROL FOR SAFETY FOOD shall be maintained: (1) At 57 C (135 F) or above, except that roasts cooked to a temperature and for a time specified in 3-401. 11(B) or reheated as specified in 3-403.11(E) may be held at a temperature of 54oC (130oF) or above; or (2) At 5 C (41 F) or less. .4-6 Cleaning of Equipment and Utensils 4-601 Objective (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	4-601.11 Equipment, Food-Contact Surfaces, Nonfood-Contact Surfaces, and Utensils. (A) EQUIPMENT FOOD-CONTACT SURFACES and UTENSILS shall be clean to sight and touch. (B) The FOOD-CONTACT SURFACES of cooking EQUIPMENT and pans shall be kept free of encrusted grease deposits and other soil accumulations. (C) Non FOOD-CONTACT SURFACES of EQUIPMENT shall be kept free of an accumulation of dust, dirt, FOOD residue, and other debris

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Keep all essential equipment working safely. 30664 Based on observation, interview, and record review the facility failed to maintain all essential equipment in safe operating condition, for 1 of 1 food scale in the kitchen reviewed for food service. * The facility did not ensure the food scale was in working order. This failure could place residents who eat out of the kitchen at risk for inadequate food amounts, weight loss, and decreased quality of life. Findings include: Record review of the menu spread sheet for the lunch meal service for 03/05/24 indicated residents were to be served 2 ounces of roast turkey. Observations and interview on 03/05/24 during the lunch meal indicated: * at 12:18 p.m. Cook G pulled 2 deep steam table pans with 2 turkey breasts roasts uncut out of the oven. Cook G sliced up 2 of the turkey roasts. Cook G said she would slice the turkey about 1/2 inch thick. * at 12:38 p.m. the DM started to place a turkey slice on a plate without checking the portion amount. The surveyor asked how she knew the right amount was being served since Cook G sliced the turkey so it was not precut to the amount required for the meal. Cook G said she cut each slice about 1/2 inch thick. The DM obtained the food scale and tried to weigh the turkey slice. The scale would not function and weigh the turkey slice. The DM said with the food scale not working the accuracy of the meat portion could not be determined. She said they would serve a little extra to try and make sure the residents received enough meat. She said the negative outcome could be residents not receiving the right amount and possible weight loss. She said she was new and was still learning but she would eventually be During an interview on 03/06/24 at 10:22 a.m. the DM said she did not have a policy about the food scale or food portions. She said they were to follow the menu spreadsheet for the portion amount.