STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676148	A. Building B. Wing	05/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Peach Tree Place	315 W Anderson St Weatherford, TX 76086

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 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** Based on interview and record review the facility failed to develop and implement a comprehensive, person-centered care plan for each resident that included measurable objectives and time frames to meet, attain, and/or maintain the resident's highest practicable physical, mental, and psychosocial well-being for 3 of 12 (Residents # 21, #25, and #145) residents reviewed for comprehensive care plans. The facility failed to ensure Resident #21 had a care plan in place regarding hospice services. The facility failed to ensure Resident #25 had a care plan in place regarding her diagnosis of seizure disorder. The facility failed to ensure Resident #145 had a care plan in place regarding his DNR status. These failures could place residents at risk for not receiving appropriate care and supervision. Findings included: Record review of Resident #21's admission Record revealed he was a [AGE] year-old male admitted to the facility on [DATE] with a diagnosis of cerebral infarction due to thrombosis of right middle cerebral artery (a stroke caused by a blood clot in an artery that supplies oxygen and nutrients to the right side of the brain). Record Review of Resident #21's Significant Change MDS assessment dated [DATE] revealed he had a BIMS score of 4 indicating severe cognitive impairment, a diagnosis of Cerebral Vascular Attack (stroke), and that he was receiving hospice services. Record review of Resident #21's Order Summary Report dated [DATE] revealed an order to Admit to 'hospice company' for diagnosis cerebral infarction dated [DATE]. Record review of Resident #21's comprehensive care plan, most recent revision date of [DATE], revealed no care plan in place regarding the resident's hospice services. Record review of Resident #25's admission Record revealed she was a [AGE] year-old female originally admitted to the facility on [DATE] with a most recent admission date of [DATE], with diagnoses including metabolic encephalopathy (brain dysfunction resulting from metabolic imbalances or underlying conditions) and dementia. (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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #25's Quarterly MDS assessment dated [DATE] revealed she had a BIMS score of 0 indicating severe cognitive impairment and she received anticonvulsant medication. Record review of Resident #25's Comprehensive Care Plan, most recent revision date of [DATE], revealed no care plan related to her diagnosis of seizure disorder. Record review of Resident #25's Order Summary Report dated [DATE] an order for oxcarbazepine 150mg by mouth twice a day for seizures dated [DATE]. Record review of Resident #145's admission Record revealed he was an [AGE] year-old male originally admitted to the facility on [DATE] with a most recent admission date of [DATE] with diagnoses including Chronic Obstructive Pulmonary Disease (a group of lung diseases that block airflow and make it difficult to breathe), liver failure, Type 2 Diabetes mellitus, and a history of lung cancer. Record review of Resident #145's miscellaneous documents revealed an Out of Hospital Do Not Resuscitate form signed and dated [DATE]. Record review of Resident #145's Comprehensive Care Plan, most recent revision date [DATE] revealed no care plan in place regarding the resident's DNR status. In an interview on [DATE] at 9:18 am LVN B stated if she walked in a room and a resident was not breathing, she would ask another nurse or aide to go look in the chart to check the code status. She stated when nursing staff opened a resident's electronic health record, the header had the resident's code status on the front page, or they could look at the documents scanned into the resident's chart to see what was is uploaded, or in the orders, or care plan. She stated if there was conflicting information she would talk to the DON, Administrator, and/or family to get clarification and the correct documentation. She stated an adverse outcome would be breaking the wishes of the resident if he/she wanted to be a DNR, but the computer showed them to be a full code somewhere such as in the care plan. In an interview on [DATE] at 09:23 am the DON stated the chart would say on the header, and there was also a DNR book at the nurse's station. She stated that a copy of all DNR's were uploaded into chart under Miscellaneous. She stated if a nurse walked in on a resident and isn't sure, he/she would ask someone to go get the book to find code status. She stated if there was not a DNR on file or uploaded into the electronic health record, the resident was considered a full code. She stated her expectation was if the staff do not see a DNR in the book or in the scanned documents, the resident was considered a full code. The DON stated that an adverse outcome would be bringing someone back that didn't want to be brought back. The DON stated the MDS Coordinator completed the admission MDS assessment and initiated the care plan and diagnosis list on admission, and the DON added all the medications into the resident's chart. The DON stated that all nurses were responsible for putting in orders after the admission process was completed. She stated the DON reconciled medications and diagnoses on admission and if there were conflicting orders, or a medication order with a diagnosis not listed in the resident's chart, she would call the diagnosing or prescribing physician to get clarification, and then update the chart (including the care plan) accordingly. She stated an adverse outcome could be the resident receiving the wrong medication, or not receiving the medication they need, and could have adverse side effects. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on [DATE] at 9:32 am the MDS Coordinator stated completing and updating care plans was is a team effort. She stated she would look in the electronic health record on the resident's header to verify code status, and/or orders to look for a DNR. She stated there was a book at the nurse's station with a copy of all resident's DNR forms. She stated if there was conflicting information she would go to DON or Social Worker to clarify which one was right for the resident. She stated she was not sure of the expectation for care planning since I've only been doing this February. She stated that an adverse outcome for not having the correct advanced directive information care planned could be that CPR might be performed which would go against the resident's or the family's wishes, the resident could sustain CPR related injuries, and not be able to pass peacefully. The MDS Coordinator stated it was a team effort in completing the diagnosis/medications/orders/care plan for a new resident. She stated the MDS wasis updated annually, quarterly, or if there was a significant change for the resident. She stated she was not sure how the chart was corrected if a diagnosis was not in the care plan but would find out. She stated when a resident went on hospice services, an MDS significant change assessment was completed, hospice staff conducted a medication review, and sent the facility orders for any changes. She stated after receiving information related to hospice services, she would then update the care plan as per the expectation of the DON. She stated she was not sure what adverse outcomes could occur if a resident's care plan was not kept updated. In an interview on [DATE] at 10:15 am the Regional MDS Coordinator stated she found and corrected the care plan for a Resident #21 as hospice had not been added and services were started on [DATE]. She stated the expectation was the care plan should immediately be updated once hospice services start and the MDS Significant Change is done. She stated there really would not be any adverse outcomes to the resident if the care plan was not updated. In an interview on [DATE] at 2:42 pm the Administrator stated that when hospice services were started for a resident, an MDS significant change assessment was completed and an update to the care plan was done to reflect the changes by the MDS Coordinator. She stated the nursing staff collaborate with hospice for orders and care plans. She stated the staff nurses review resident's medications with diagnoses. She stated the previous DON would put in the diagnoses and reconcile them with orders. She stated the procedure was for the floor nurses to put orders in the chart when they were received. The Administrator state that during the facility's daily clinical meetings, department heads updated any information regarding care plans, went over assessments, orders, and diagnoses for each resident. She stated that nursing staff do audits on medication and diagnoses in addition to the medication regimen reviews done by the consultant pharmacist. She stated the MDS coordinator completes the initial MDS Assessment upon admission, MDS wasis updated annually, quarterly, and with any significant changes and based on changes, the RN/DON initiated and completed the care plans, and the MDS Coordinator updates the care plans quarterly and as needed. She stated she could not think of any adverse outcome that could come of the care plan not being updated. A copy of the facility's care plan policy/procedure was requested from the MDS Coordinator on [DATE] and had not been provided to the survey team by the time of exit.

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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. Based on observation, interview, and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety in 1 of 1 kitchen, by failing to ensure: A. The food fryer was left in an unsanitary condition, food fryer had not been cleaned after use, food crumbs dried to fryer baskets (2) and inside fryer walls. B. Bottom shelf of food prep table was not clean and hads food crumbs on shelf and food crumbs on container lids containing flour, sugar and powder milk that wasis stored on shelf. These failures could place residents at risk for decline in nutritional health status and foodborne illness. The findings include: On 5/13/25 at 9:34am during the observation of dietary kitchen, the fryer was not clean, there were had food scraps on the baskets and fryer. Bottom shelf on prep table had , food crumbs on bottom shelf and containers lids of flour, sugar and powered milk lids covered with food crumbs. On 5/13/25 at 10:50am interview with the Dietary Manager, the Dietary Manager stated that the fryer was last used on 5/11/25 for the dinner meal, chicken tenders were fried using the fryer. The Dietary Manager stated that fryer and fryer baskets should have been cleaned after dinner on 5/11/25. The Dietary Manager stated that bottom prep table should be cleaned daily, and container lids should not have food particles on lids. The Dietary Manager stated that there wasis a cleaning schedule that staff wereare to follow, Dietary Manager stated that equipment should be cleaned and sanitized after each use to prevent food borne illness, and the kitchen should be cleaned daily, and no food scraps or particles should be left out as to not attract pests. 5/15/25 at 2:00 PM, in an interview with the Administrator, stated it was her expectation for the kitchen to be cleaned daily, food particles wereare not to be left on food containers or shelves,d,, it should be cleaned up daily, and food equipment should be cleaned and sanitized after use, failure to do so has the potential for infection and pests. A record review of the facility policy Cleaning and Disinfection of Environmental Surfaces, dated as revised September 2020, revealed the following [in part]: 9. Housekeeping surfaces (e.g., floors, tabletops) will be cleaned on a regular basis, when spills occur, and when these surfaces are visibly soiled. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Food and Drug Administration Food Code, dated 2017, specified [in part]: 4-601.11 Equipment, Food-Contact Surfaces, Nonfood-Contact Surfaces, and Utensils. (C) Nonfood-contact surfaces of equipment shall be kept free of an accumulation of dust, dirt, food residue, and other debris.

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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. Based on observation, interview and record review, the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment to help prevent the development and transmission of communicable disease and infections for one (LVN A) of three staff reviewed for infection control practices. LVN A did not perform any hand hygiene before or after medication administration for Resident #26, Resident #4, or Resident #8. LVN A did not sanitize reusable electronic wrist blood pressure cuff before or after use during medication administration for Resident #4 or Resident #8. These failures could place residents at risk of the spread of infections. Findings included: During an observation on 05/14/25 at 07:09 AM, LVN A prepared Resident #26's medication without performing any hand hygiene beforehand. LVN A provided Resident #26 with their medication and the resident had a bit of a coughing spell. LVN A provided the resident with additional water and watched resident until she was fine. LVN A then left room, went back to the medication cart, and charted the medication administration via electronic MAR. LVN A did not perform hand hygiene after administering Resident #26's medication. During an observation on 05/14/25 at 07:25 AM, LVN A proceeded to pick up the reusable electronic wrist blood pressure cuff off the medication cart and took blood pressure and pulse of Resident #4. LVN A did not sanitize the electronic reusable wrist blood pressure cuff before or after use and did not perform any hand hygiene before or after taking the measurement. LVN A then went back to the medication cart and began preparing medication for Resident #4. LVN A did not perform any hand hygiene before he began the preparation of the medication. LVN A provided Resident #4 with their medication then left room, went back to the medication cart, and charted the medication administration via electronic MAR. LVN A went to the Medication room and retrieved an over the counter vitamin for Resident #4 that had not been in the medication cart. LVN A, then prepared the vitamin for Resident #4 and went back into the resident room and administered the vitamin to Resident #4. During the time LVN A went to the medication room and prepared the vitamin, he did not perform any hand hygiene. LVN A then pushed the medication cart down the hall to another resident. LVN A did not perform any hand hygiene after he provided Resident #4 with their medication. During an observation on 05/14/25 at 07:39 AM, LVN A picked up the reusable electronic wrist blood pressure cuff off of the top of the medication cart and went into Resident #8's room and obtained a blood pressure and pulse. LVN A did not perform any hand hygiene before or after obtaining the readings. LVN A did not sanitize the reusable electronic wrist blood pressure cuff before or after use for Resident #8. LVN A then preceded to prepare medication for Resident #8. LVN A then provided Resident #8 with their medication and then left the room and charted the medication administration via electronic MAR. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 05/14/25 at 07:44 AM with LVN A, he stated that he did not perform hand hygiene between each resident medication administration. LVN A said he did not sanitize the reusable electronic wrist blood pressure cuff between each resident use. LVN A said his failure to perform hand hygiene or sanitize the equipment could cause resident infections. LVN A said he just did not have ABHR on his medication cart or in his pocket to sanitize his hands. He did state that the facility had ample supply of ABHR for staff to utilize, but he just simply did not have one at the time of his medication administration. LVN A produced the equipment sanitizer wipes from the bottom drawer of the medication cart and said that the wipes were supposed to be used to wipe down the equipment used for residents before it was used and then again after it was used. During an interview on 05/14/25 at 01:39 PM the RCRN stated that hand hygiene was supposed to be performed between each time a nurse prepared and administered medications to a resident and to sanitize the equipment between each use. During an interview on 05/15/25 at 03:06 PM the DON and RCRN stated that they expected that hands were washed or sanitized before preparing a resident medication and again after administering medication. Then when staff finished administering the medication, they were to sanitize their hands again either by handwashing with soap and water or using ABHR. The RCRN said it was expected that the equipment like a blood pressure cuff would be sanitized before it was used and then after it was used, that way it was ready for the next resident. The DON and RCRN said that they did not have a policy that was for sanitizing equipment such as the reusable electronic wrist blood pressure cuff, but did have a policy regarding sanitizing of the blood glucose monitor for resident use. It was not provided for review. Record Review of LVN A's personnel file revealed a hire date of 11/27/24. LVN A had Infection Control training during orientation dated 12/17/24. Record Review of facility policy labeled Fundamentals of Infection Control Precautions updated 3/24 revealed: Hand hygiene continues to be the primary means of preventing the transmission of infection. The following is a list of some situations that require hand hygiene: Before and after direct resident contact; . Upon and after coming in contact with a resident's intact skin, (e.g., when taking a pulse or blood pressure, and lifting a resident); . After contact with a resident's mucous membranes and body fluids or excretions; . After handling soiled equipment or utensils; . Consistent use by staff of proper hygienic practices and techniques is critical to preventing the spread of infections . Except for situations where hand washing is specifically required, antimicrobial agents such as ABHR are also appropriate for cleaning hands and can be used for direct resident care.