STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676165	A. Building B. Wing	12/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Park Manor of Tomball	250 School Street Tomball, TX 77375

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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 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** 47479 Based on interview and record review, the facility failed to ensure all Pre Admission Screening and Resident Review (PASRR) Level I residents with mental illness were provided with a PASRR Level II assessment for 1 of 2 residents reviewed for a mental illness, intellectual disability or developmental disability. (Resident #64) Resident #64 was admitted to the facility with a pre-admission screening reflecting no indicators of a mental illness when the resident had a diagnosis of Bipolar Disorder. This failure could place residents with mental illness, intellectual disability or developmental disability at risk for not receiving needed care and services to meet their needs or decreased quality of life. Findings included: Record review of Resident #64's face sheet revealed a [AGE] year-old female who was admitted into the facility on [DATE] and was diagnosed with disorder of the autonomic nervous system, history of transient ischemic attack, hemiplegia, and hemiparesis (partial paralysis of extremities), following cerebral infarction affecting left dominant side, bipolar disorder and mood disorder. Record Review of Resident #64's MDS, dated [DATE], reflected resident had a score of 14 indicating resident's cognition was intact. It also reflected resident was documented to have bipolar disorder. Record review of Resident #64's care plan, dated 12/11/24, revealed resident had a potential psychological well-being problem related to bipolar disorder. Record review of Resident #64 PASRR level 1 screening, dated 07/14/2023, reflected resident was marked no for having, . evidence or an indicator this is an individual with a mental illness . Record review of Resident #64's electronic health chart, on 12/11/24, revealed resident had no other PASRR evaluations performed. (continued on next page)

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

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview with the MDS coordinator on 12/12/24 at 12:33PM, she stated she started her job in July 2024. She said she only worked with all new admissions since that time to revise any PASRR level one screens that needed to be corrected. She stated she did not go back to audit any possibly incorrect PASRR assessments. She stated she is the only one responsible for submitting positive screenings and setting up meetings with a local authority. She also said her corporate staff was the only person who could audit her work but had not received an audit related to PASRR screenings since she started working with this facility. She stated the risk to a resident like Resident #64, who was found to have a mental illness diagnosis, is the risk of losing out on extra services that she could be eligible for. In an interview with the DON, on 12/12/2024 at 12:39PM, she stated she was not responsible for performing audits and the MDS Nurse was responsible for auditing her own work. She stated the risk Resident #64 faced was possibly missing services that she could be eligible for and that shows the importance of ensuring accurate PASRR level one screenings are performed and revised when needed. Record review of the facility's policy titled, PASRR Clinical Policy, dated May 2014, reflected, . The PASRR level 1 (PL1) Screening Form is designed to identify persons who are suspected of having Mental Illness (MI), Intellectual Disability (ID) of a Developmental Disability (DD) also referred to as Related Conditions. The PASRR Evaluation (PE) is designed to confirm the suspicion of MI, ID or DD/RC and ensure the individual is placed in the most integrated residential setting receiving the specialized services needed to improve and maintain the individual's level of functioning. If documentation entered on the PL1 Indicates MI/ID/DD, a PE must be completed Section C; PASRR Screen (Screener) INTENT: This section to be completed for resident's suspected of having Mental Illness. 2. Identify diagnoses: Review the medical record, if available, for diagnoses. Medical record sources can include but are not limited to: verbal interview with the resident or LAR, observation, progress notes, Annual Physical Exam, the most recent History and Physical, hospital discharge summaries or diagnosis list. 3. If the answers to C0100=No, Co200=No, one nursing facility choice must be entered in section D. If the PL1 is being submitted on to the LTC Online Portal by an LA, the evaluation is complete. 4. These are required fields. 5. C0100. Mental Illness - Select whether or not this resident demonstrates evidence of a Mental Illness. 0 = No, 1 = Yes 6. A mental disorder is defined as the following: a schizophrenic, mood, paranoid, panic or other severe anxiety disorder, somatoform disorder; personality disorder; other psychotic disorder; or another mental disorder that may lead to a chronic disability. Dementia including Alzheimer's disease or a related disorder, is a neurologically driven disease that through evaluation is not indicative of a mental illness, it is a medical condition. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	7. If Alzheimer/Dementia is the primary diagnosis and there is MI diagnosis no PE is needed. 8. If Alzheimer/Dementia is the primary diagnosis and there is ID/DD diagnosis PE is needed. 9. If Alzheimer/Dementia is not the primary diagnosis and there is MI diagnosis PE is needed .

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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** 41469 Based on observation, interview, and record review, the facility failed to ensure 1 of 2 residents (Resident #96) reviewed for pressure ulcers received necessary treatment and services, consistent with professional standards of practice, to promote healing, in that: Resident #96 was observed to not be repositioned off of sacral wound for a span of 4 hours. This failure could place residents at risk for skin breakdown or failure for ulcers to heal. Findings included: Record review of Resident #96's face sheet, dated 12/12/2024, reflected a [AGE] year-old male resident who was admitted to the facility on [DATE] with diagnoses including diagnosed with end stage renal disease and stage 4 pressure ulcer on the sacrum. Record review of Resident #96's MDS, dated [DATE], reflected the resident was at risk for pressure ulcers, he had a BIMS score of 10 indicating resident's cognition was moderately impaired and he needed substantial/maximal assistance for bed mobility. Record review of Resident #96's care plan, dated 08/09/2024, reflected, . [Resident #96] has potential for further skin breakdown r/t: a cognitive impairment, hx of pressure injuries, impaired mobility, incontinence, nutritional deficit STAGE 4 SACRUM . The goal was for the pressure to show signs of healing and remain free from infection. Interventions listed included assisting resident with turning/repositioning during rounds and wound vac therapy. Record review of Resident #96's wound evaluation, dated 12/05/2024, revealed the resident had a stage IV sacral pressure ulcer measuring 8 x 6 x 1.5 cm with a surface area of 48 cm2. The pressure ulcer wound progress at this time was noted to have improved . Record review of Resident #96's wound evaluation, dated 12/09/2024, revealed the resident's sacral pressure ulcer was still measuring 8 x 6 x 1.5 cm with a surface area of 48 cm2. The pressure ulcer wound progress at this time was noted to be not at goal. Record review of Resident #96's active physician's orders, dated 12/12/2024, included: - Starting 12/07/2024: . every day shift every Tue, Thu, Sat Clean with normal saline pat dry, apply Collagen Powder then apply Negative Pressure Wound Therapy @ 125 MM/HG AND every 24 hours as needed Treatment order: CLEANSE WITH NORMAL SALINE, PAT DRY, APPLY NEGATIVE PRESSURE WOUND THERAPY @ 125 MM/HG . Observation of Resident #96 on 12/11/2024 at 10:20AM, revealed Resident #96 was observed sleeping in bed while lying flat on his back with wound vac to sacrum in place. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation and interview with Resident #96 on 12/11/2024 at 11:57AM, revealed Resident #96 sitting with back against the bed eating a grilled cheese sandwich. When asked if the nursing staff offer to reposition him, he stated, they never tried that with me. He stated he had never been offered to be repositioned or turned from side to side. Observation of Resident #96 on 12/11/2024 at 12:40PM, revealed the Resident #96 was sleeping again still flat on his back. Observation of Resident #96 on 12/11/2024 at 1:55PM, revealed the resident was observed sleeping still on his back. In an interview with Family Member #1 on 12/11/2024 at 1:56PM, she stated she visited Resident #96 every other day and finds the resident lying flat on his back every time. She stated she has never seen any nursing staff come in to offer to reposition the resident or prop him off of his sacral wound. In an interview with CNA B on 12/11/2024 at 2:00PM, she stated she was in charge of caring for Resident #96 during her shift from 6AM - 2PM. When asked if the resident was repositioned during her shift today, she said in the past, she generally has offered to reposition him before but the resident would refuse. She stated residents are supposed to be repositioned every two hours and not repositioning a resident could cause the resident to have increased risk of skin breakdown. In an interview with LVN B on 12/11/2024 at 2:36 PM, he stated aides should be repositioning residents with wounds and reporting any issues related to the wound vac to him. He stated he had never rounded on and checked patients to ensure CNA B was repositioning them and she has never reported any issues to him about Resident #96. He stated he should not have to check if the aide was repositioning Resident #96 because she should have known what to do. He stated not offloading wounds could cause aggravation of the wound and an increase of pain. In an interview with Wound Care Nurse A on 12/11/2024 at 3:28PM, she stated there were multiple factors contributing to wound aggravation including weight loss and infrequent repositioning. She said she did not audit or monitor and nursing staff and was unaware of who was rounding to ensure repositioning was being done. She stated she believed she was told Resident #96 had refused repositioning, but all refusals needed to be reported and documented and repositioning should have still been offered. In an interview with the DON on 12/11/2024 3:32PM, she stated the aides were expected to reposition their bed bound residents every two hours. She stated in the case where the resident often refused, repositioning should have still continually be offered and all refusals for repositioning should be reported to the nurse and documented as well. She stated not repositioning residents with sacral wounds could prevent wounds from healing. In a phone interview with the Wound Physician on 12/12/2024 at 1:04PM, she stated there was no decline or improvement seen in the wound from her assessments on 12/05/2024 to 12/09/2024. She stated repositioning is important for wound healing. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the facility's policy and procedure, Turning a Resident on His/Her Side Away from You, dated March 2004, reflected, . The purposes of this procedure are to provide comfort to the resident, to prevent skin irritation and breakdown, and to promote good body alignment The following information should be recorded in the resident's medical record:1. The date and time that care was given. 2. The name and title of the individual(s) who assisted with the care. 3. The position in which the resident was placed. 4. The reason for changing the resident's position. 5. If and how the resident participated in the procedure or any changes in the resident's ability to participate in the procedure. 6. Any problems or complaints made by the resident related to the procedure. 7. If the resident refused the treatment, the reason(s) why and the intervention taken. 8. The signature and title of the person recording the data .

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44591 Based on observation, interview, and record review the facility failed to ensure that the medication error rate was not five percent or greater. The facility had a medication error rate of 6.9 % based on 2 errors out of 29 opportunities, which involved 2 of 8 residents (Resident #15 and Resident #96) reviewed for medication errors in that:. - LVN L failed to administered medication as ordered to Resident #96 by administering Multivitamins w/ Minerals instead of plain Multivitamins as ordered. - LVN M failed to administer medications as ordered to Resident #15 by administering eye drops with Tetrahydrozoline Hydrochloride 0.05% instead of eye drops with Carboxymethylcellulose Sodium as ordered. These failures could place residents receiving medication at risk of inadequate therapeutic outcomes. Resident #96 Record review of Resident #96's Face Sheet dated 12/11/2024 revealed, a [AGE] year-old male who admitted to the facility on [DATE] with diagnoses of: end stage kidney disease (kidney reaches advanced state of loss of function), muscle weakness, high potassium and high sodium. Record review of Resident #96's MDS dated [DATE] revealed, moderately impaired cognition as indicated by a BIMS score of 10 out of 15, needs extensive assistance with bed mobility, transfers, and requires tube feeding. Record review of Resident #96's Care Plan revealed, focus- requires tube feeding related to dysphagia (difficulty swallowing); interventions- give medications per order. Record review of Resident #96's Physicians Order dated 11/14/2024 revealed, multivitamin oral tablet, give 1 tablet via G-tube one time a day. Observation on 12/11/24 at 7:00 am, revealed LVN L provided Resident #96 morning medications to include Multivitamin with minerals one tab. The physician ordered multivitamin one tab. Resident #15 Record review of Resident #15's Face Sheet dated 12/11/24 revealed, a [AGE] year-old male who admitted to the facility on [DATE] with diagnoses of: diabetes type 2 with mild non-proliferative diabetic retinopathy (tiny blood vessels in the retina leak, causing swelling). Record review of Resident #15's MDS dated [DATE] revealed, moderately impaired cognition as indicated by a BIMS score of 12 out of 15, is dependent with eating, hygiene, dressing and is always incontinent of bowel and bladder. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #15's Care Plan revealed, focus- resident has impaired cognitive function/impaired thought processed related to dementia, resident forgetful at time. Intervention: no changes to medication. Record review of Resident #15's Physician Order dated 10/14/2024 revealed, Artificial Tears Ophthalmic solution 1% (Carboxymethylcellulose Sodium) ordered. Observation on 12/11/24 at 7:20 am revealed LVN M provided Resident # 15 morning eye drops which contained Tetrahydrazoline Hydrochloride a decongestant used to relieve redness in the eyes. The physician ordered Carboxymethylcellulose Sodium a lubricant to treat dry eyes. In an interview with LVN L on 12/11/24 at 11:32 am, he stated he didn't think giving a Multivitamin with minerals when a multivitamin was ordered was a medication error. He stated he should only give medications ordered by the doctor. He stated if resident is given the wrong medicine, resident may have unwanted consequences. In an interview with LVN M on 12/11/24 at 11:37 am, she stated she should only give medications ordered by the doctor. She stated she thought she had given moisturizing eye drops and stated she gave the wrong eye drops. She stated if resident received the wrong medicine, resident may not be treated correctly. In an interview with the DON on 12/11/24 at 1:45 pm. The DON stated nurses and med aides should only give medications ordered by doctor. Medications should be verified prior to administration to residents. She stated giving the wrong medication to a resident could cause an allergic reaction and possible hospitalization due to the reaction. Record review of the facility policy titled Administering Medications revised 12/2012 revealed, Policy Statement: Medications shall be administered in a safe and timely manner, and as prescribed. Policy interpretation and implementation: 3. Medications must be administered in accordance with the orders, including any required time frame. 7. The individual administering the medication must check the label to verify the right resident, right medication, right dosage, right time and right method (route) of administration before giving the medication.