STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676183	A. Building B. Wing	05/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Huntington Health Care & Rehabilitation Center	220 E Ash Street Huntington, TX 75949

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 49017 Based on observations, interviews, and record review the facility failed to treat each resident with respect and dignity and care in a manner and in an environment that promoted resident independence and dignity while dining for one (1) of 24 residents reviewed for meal service. (Resident #53). LVN B stood beside Resident #53 while she assisted the residents to eat. This failure could place residents who need assistance with eating at risk for weight loss and a decreased quality of life. Findings included: Review of the Face Sheet for Resident #53 indicated she was an [AGE] year-old female admitted on [DATE]. She had the following diagnoses: Hyperthyroidism (when the thyroid gland makes too much thyroid hormone), Alzheimer's disease (A type of brain disorder that causes problems with memory, thinking, and behavior), Anxiety disorder (mental illnesses that cause constant fear and worry), Chronic Kidney Disease (a condition where the kidneys gradually lose their ability to properly filter waste), and Hypertension (high pressure in the vessels that carry blood from the heart to the rest of the body). Review of the MDS with assessment reference date of 5/14/2024 indicated that the resident had a BIMS score of 5, which indicated severely impaired cognition. Resident #53 also required partial to moderate assistance with meals. Review of care plan for Resident #53 dated 5/1/2024 reflected t hat she required moderate assistance of 1 person for ADLs. Resident was on a regular consistency diet. During an observation on 05/29/2024 at 12:42 PM, LVN B stood beside Resident #53 during mealtime to feed her. All other staff were assisting residents in the restorative dining room. LVN B would walk in the dining room to observe other residents and returned to Resident #53 three times and fed her while standing by her wheelchair. (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 - Few	In an interview on 05/29/2024 at 3:09 PM LVN B stated she should have been at eye level with the resident when she was assisting her with her meal. She said that standing over the resident could have a negative effect by making the resident feel like the employee was rushing and that standing over the resident was a dignity issue. She said that next time she would assist the resident to the restorative dining room if she required assistance with meals. In an interview on 05/30/2024 at 09:18 AM the DON stated that the staff was expected to sit at eye level with residents when assisting them with meals. She said that standing up while providing assistance was unacceptable. She said that it was a dignity issue and that the residents could feel rushed or uncomfortable with staff standing over them. She said that she plans to in-service staff on providing meal assistance with dignity and respect and that staff will be monitored. In an interview on 05/30/2024 at 9:41 AM, the administrator said that he expected staff to assist residents with meals with dignity and respect. He said that staff should be at eye level with residents when assisting residents with meals. He said that he expected the staff to treat residents with dignity and respect at all times and during meals to be at eye level when assisting residents with eating. He said that standing over the residents could have a negative emotional effect on the residents. Review of policy titled Dignity from Nursing Services Policy and Procedure Manual for Long Term Care revised February 2021 stated that when assisting with care residents are provided with a dignified dining experience.

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46273 Based on interviews, and record review, the facility failed to ensure that the resident was free from physical or chemical restraints imposed for purposes of discipline or convenience and that were not required to treat the resident's medical symptoms for 1 of 10 residents (Resident #54) reviewed for physical restraints. The facility failed to obtain physician order and informed consent for Resident #54 before implementing a position change alarm. This failure could place residents in the facility at risk of decreased quality of life, injury and being subjected to restraints for purposes of convenience or discipline. Findings included: Record review of a facility face sheet dated 5/29/24 for Resident #54 indicated that she was an [AGE] year-old female admitted to the facility on [DATE] with diagnoses including: hypertension (high blood pressure), dementia, and kidney failure. Record review of a quarterly MDS assessment dated [DATE] for Resident #54 indicated that she had a BIMS score of 6, which indicated that she had severe cognitive impairment. Section P (Restraints) indicated that she had not used a chair alarm (position change alarm) during the previous 14 days. Record review of a comprehensive care plan dated 1/26/24 for Resident #54 did not indicate that she was currently using a position change alarm. Record review of a physician order report dated 5/29/24 for Resident #54 reflected that she did not have a current physician order for a position change alarm. Record review of electronic medical record for Resident #54 indicated that she did not have a signed informed consent for a position change alarm. During an observation on 5/28/24 at 12:18 pm Resident #54 observed sitting up in the dining room in a wheelchair with what appeared to be a chair alarm (position change alarm). During an observation and interview on 5/29/24 at 8:15 am Resident #54 was observed in her room lying in bed. Her wheelchair was next to the bed with a position change alarm observed on the back of her wheelchair. CNA J and LVN H were both in the hallway right outside Resident #54's room and both said that it was a body alarm that was to be used when she was up in the wheelchair, and it would alarm if she tried to stand up. During a joint interview on 5/29/24 at 9:00 am the DON and LVN H could not locate the physician order for a chair alarm. The DON said there must be an order in place to be able to use the alarm and said she would call the doctor and get it corrected. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/30/24 at 10:50 am the Administrator said that the DON was responsible for ensuring all orders and consents for restraints were in place. He said that the floor nurses should also be checking and monitoring the physician orders as well. He said it could affect resident's dignity and could cause them to not be able to get up. He said going forward he would expect that all orders were properly in place and followed appropriately. During an interview on 5/20/24 at 11:01 am the DON said floor nurses were responsible for getting orders and consents before using any type of restraint. She said it could be a dignity issue and make resident's feel bad. She said going forward, she would expect her staff to ensure orders and consents were in place before using any restraints. She said she would be implementing angel rounds (rounds made by administrative staff to observe residents and help identify issues). Record review of a facility policy titled Use of Restraints dated 2001, and revised April 2017 read .Restraints shall only be used upon the written order of a physician and after obtaining consent from the resident and/or representative (sponsor) .

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43994 Based on interviews and record review, the facility failed to refer all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change of condition for 1 of 6 Residents (Resident #32) reviewed for PASSAR (Preadmission Screening and Resident Review Services). The facility failed to ensure Resident #32 had a new level 1 PASSAR completed with a new diagnosis of Post-Traumatic Stress Disorder (a mental health condition that develops following a traumatic event characterized by intrusive thoughts about the incident, recurrent distress/anxiety, flashback, and avoidance of similar situations) and major depressive disorder (persistent feeling of sadness and loss of interest that interferes with daily life). These failures could place residents at risk of not receiving the needed PASSAR services to meet their individual needs and could result in a decreased quality of life. The findings were: Record review of a face sheet dated 5/29/2024 for Resident #32 indicated he admitted to the facility on [DATE] and was [AGE] years old with diagnosis of PVD (causes decreased blood flow to the legs), PTSD, major depressive disorder (persistent feeling of sadness and loss of interest), and hypertension. Record review of a Quarterly MDS assessment dated [DATE] for Resident #32 indicated he was unable to complete the interview with a BIMS score of 99. He had active diagnosis in the 7 day look back period for depression and PTSD. There was not a referral made to the Local Contact Agency. Record review of a care plan for Resident #32 did not indicate he was PASSR positive. During an interview on 5/30/2024 at 9:35 AM, the DON said she had been employed at the facility for 1 year. She said she was also responsible for completing PASSR for all the residents in the facility. She said she was aware that Resident #32 had a diagnosis of mental illness that was dated in 2022 but that was prior to her working at the facility and being responsible for PASSR. She said she completed a new Level 1 for Resident #32 on 5/29/2024 and had contacted the Local Authority about doing an evaluation. She said when a resident had a new diagnosis of mental illness or if they went to a behavioral hospital, a new PASSR form should be completed for the Local Authority to come and conduct an evaluation. She said residents could be at risk of not receiving needed services that PASSR offers. Record review of a PASSR Level1 Screening dated 5/29/2024 for Resident #32 (after surveyor questioned) indicated he was positive for mental illness. (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/30/2024 at 10:30 AM, the Administrator said the DON was responsible for PASSR. He said he was made aware of Resident #32 having new diagnosis of mental illness but those were added prior to the DON working at the facility. He said there was a risk of residents not receiving proper services if new mental illnesses diagnosis were added. He said the DON completed a new Level 1 on yesterday. Record review of a facility policy titled Behavioral Assessment, Intervention, and Monitoring revised March 2019 indicated, .The facility will provide, and residents will receive behavioral health services as needed to attain or maintain the highest practicable physical, mental, and psychosocial well-being in accordance with the comprehensive assessment and plan of care. Assessment: 5. New onset or changes in behavior that indicate newly evident or possible serious mental disorder, intellectual disability, or a related disorder will be referred for a PASARR Level 2 evaluation .

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46273 46436 Based on interviews and record review the facility failed to develop and implement a baseline care plan for each resident that included the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care for 2 of 8 residents (Resident #48 and #64) reviewed for baseline care plans. The facility failed to complete a baseline care plan within 48 hours of admission on Resident # 48 and provide a care plan summary to the resident or representative. The facility failed to complete a baseline care plan within 48 hours of admission on Resident # 64 and provide a care plan summary to the resident or representative. These failures could place residents at risk of not receiving correct and/or necessary care or treatment. Findings included: 1. Record review of a facility face sheet indicated Resident # 48 was a [AGE] year-old male and admitted to the facility on [DATE] with diagnosis of end stage heart failure. Record review of a quarterly MDS assessment dated [DATE] indicated Resident #48 had a BIMS score of 15 indicating intact cognition, required setup assistance with ADL's, and required hospice services and oxygen therapy. Record review of the facility's electronic health record indicated no baseline care plan was completed on admission. 2. Record review of a facility face sheet dated [DATE] for Resident #64 indicated that she was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses including: macular degeneration (an eye disease that can blur your central vision), dementia, and cerebral infarction (stroke). Record review of electronic medical record for Resident #64 included a comprehensive care plan that was not initiated until [DATE], after resident expired in facility on [DATE]. During an interview on [DATE] at 2:25 pm the DON said she could not locate a baseline care plan for Resident #64 and said that it was not done. During an interview on [DATE] at 10:08 am Resident #48 said he did not recall any nurse discussing with him on admission about his care plan nor was he given a summary of his plan of care. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on [DATE] at 3:13 pm LVN B said she had been an LVN 3 years and that she had received training on completing baseline care plans on admission. She said the nurses had a checklist that they followed, and all assessments and baseline care plans should be completed before the end of shift. She said she was not aware that a summary of the care plan was to be given to the resident or representative. She said a negative outcome could occur if the baseline care plan was not completed . During an interview on [DATE] at 3:15 PM the MDS nurse said she was responsible for overseeing that admission assessments were completed. She said on day 8 following admission, she would review the admission documentation, and if something was missing, she would tell the admitting nurse. She said she was not aware that the baseline care plan had to be completed within 48 hours or that the resident or representative was to receive a copy of the summary. She said if the baseline care plan was not done it could cause a delay in resident care. During an interview on [DATE] at 3:24 PM the DON said that the MDS nurse was responsible for ensuring the baseline care plan and summary were done. She said there had been training and expected the regulation to be followed . She said that resident care could be affected if the baseline care plan was not completed. During an interview on [DATE] at 9:33 AM the Administrator said the admitting nurse should be completing the baseline care plan and providing a summary to the resident or representative and then reviewed by the MDS nurse within 48 hours. If not done, a negative outcome could occur. He said he expected the baseline care plan and summary to be completed per the regulation. Record review of an undated and untitled facility tool used for admissions indicated the nurse was to complete the baseline care plan on admission. Record review of a facility policy dated [DATE] titled Care Plans - Baseline indicated, .a baseline care plan to meet the resident's immediate needs shall be developed for each resident within 48hours of admission; the resident and their representative will be provided a summary of the baseline care plan .

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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** 46273 Based on observations, interviews, and record review, the facility failed to ensure the residents' environment remained as free of accident hazards as possible for 3 of 12 residents reviewed for quality of care. (Resident #3, #33, and #38) The facility failed to remove worn and damaged mechanical lift slings from service. This deficient practice could result in a loss of quality of life due to injuries. Findings included: Record review of a facility face sheet dated 5/29/24 for Resident #3 indicated that he was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses including: dysphagia, muscle weakness, and dementia. Record review of a quarterly MDS assessment dated [DATE] for Resident #3 indicated that he had a BIMS score of 15 which indicated that he was cognitively intact Section GG (Functional Abilities and Goals) indicated that he required substantial/maximal assist for transfers. Record review of a comprehensive care plan dated 12/30/23 for Resident #3 indicated that he required assistance with transfers and required a mechanical lift at times. Record review of physician orders dated 5/29/23 for Resident #3 indicated that he had the following physician order dated 1/31/24: Patient transfer in least restrictive fashion with variable level of independence due to patient inconsistency with fatigue/participation. Variable transfer needed to promote patient self-function mobility while maintaining safety. Transfers may vary from 1-person to Hoyer lift (mechanical lift) with Hoyer lift pad in wheelchair at all times. Record review of a facility face sheet dated 5/29/24 for Resident #33 indicated that she was an [AGE] year-old female admitted to the facility on [DATE] with diagnoses including: hypertension (high blood pressure), hyperlipidemia (high cholesterol), and Alzheimer's disease. Record review of a quarterly MDS assessment dated [DATE] for Resident #33 indicated that she had a BIMS score of 99 which indicated that she was unable to complete the interview for mental assessment. Section GG (Functional Abilities and Goals) indicated that she required substantial/maximal assist for transfers. Record review of a comprehensive care plan dated 1/16/24 for Resident #33 indicated that she required a Hoyer lift transfer X 2. Record review of a physician order report dated 5/29/24 for Resident #33 indicated that she had the following physician order dated 2/28/24: Hoyer lift for all transfer X 2 staff members. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of a facility face sheet dated 5/29/24 for Resident #38 indicated that she was an [AGE] year-old female admitted to the facility on [DATE] with diagnoses including: dysphagia, pneumonia, and asthma. Record review of a quarterly MDS assessment dated [DATE] for Resident #38 indicated that the BIMS score could not be conducted due to resident being rarely/never understood. Section GG (Functional Abilities and Goals) indicated that she was dependent with transfers. Record review of a comprehensive care plan dated 5/15/24 for Resident #38 indicated that she required a Hoyer lift for transfers. Record review of a physician order report dated 5/29/24 for Resident #38 indicated that she had the following physician order dated 5/17/24: may be transferred using Hoyer lift. During an observation on 5/28/24 at 9:09 am Resident #33 was observed in her room sitting up in a chair with a Hoyer sling observed underneath her. The colors of the sling were faded, and loose strings were observed along the edging seam. It was a blue mesh sling, unable to find the label. During an observation on 5/28/24 at 9:50 am Residents #3 and #38 were both observed up in the common area of the facility with Hoyer slings underneath them. Resident #38's pad had faded straps and loose strings. Resident #3's blue mesh sling was observed with faded straps and multiple loose strings observed along the edging of the sling. During an interview on 05/28/24 at 10:02 AM the DON said CNAs were responsible for inspecting pads before use and residents could be at risk for falls, if worn pads were used. She said the pad could break during use and the resident could fall. During an interview on 5/30/24 at 10:50 am the Administrator said CNA's were responsible for checking lift pads for safety before using them on a resident. He said residents could be at risk for injury if an aide used a lift pad that was worn. Going forward he expected that any equipment that was not in appropriate working condition be reported and replaced. During an interview on 5/20/24 at 11:01 am the DON said CNAs and nurses were responsible for checking the lift pads before using. She said residents could be at risk for potential harm from pad ripping and causing a fall. Going forward she expected staff to inspect pads before use and if label was not legible, or if there were any frays or discoloration, not to use the pad. Record review of a facility policy titled Mechanical Lift dated 8/2022 read .It is the policy of this home to utilize the Hoyer (or similar) lift when it is necessary to safely transfer a resident due to body weight or physical condition . Record review of manufacture guidelines Full Body Slings - Instructions for use accessed at www.medline.com on 5/29/24 read .Always inspect slings prior to each use. Signs of rips, tears, or frays indicate sling wear which is unsafe and could result in injury. Signs of color fading, bleached areas, or permanent wrinkles on the straps indicate improper laundering which is unsafe and could result in injury. Any slings with signs of wear or improper laundering should be immediately removed from use . and .Do not remove sling labels. If sling labels are removed or no longer legible, sling must be immediately removed from use .

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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** 43994 Based on observations, interviews, and record review the facility failed to ensure that residents requiring respiratory care are provided care, consistent with professional standards of practices for 3 of 7 residents reviewed for respiratory care (Residents #15, #29, and #1). The facility failed to ensure the external filters of Resident's #15, #29, and #1 oxygen concentrators were free of dust buildup on 5/28/2024. These failures could place residents who require respiratory care at risk for respiratory infections, breathing in dust and allergens, decreased effectiveness of oxygen concentrators, and exacerbation of respiratory distress. Findings included: 1.Record review of a face sheet dated 5/29/2024 for Resident #15 indicated he admitted to the facility on [DATE] and was [AGE] years old with diagnoses of acute respiratory failure (lungs cannot release enough oxygen into the blood), Parkinson's disease (a chronic disorder that causes difficulty moving, tremors, and stiffness), COPD (a group of lung disease that cause difficulty breathing), and Type 2 diabetes. Record review of a Quarterly MDS assessment dated [DATE] for Resident #15 indicated he did not have any impairment in thinking with a BIMS score of 15. He had special treatments, procedures, and programs while a resident that included oxygen therapy during the 14 day look back period. Record review of a care plan dated 2/23/2024 for Resident #15 indicated he suffered from COPD and had the potential for impaired gas exchange. Interventions included oxygen as ordered with protocol. Record review of active physician orders for Resident #15 undated indicated an order for oxygen at 3 Liters per minute via (through) nasal cannula (tubing with prongs that go into the nostrils) prn, and to change oxygen tubing every week on Sunday at bedtime with a start date of 1/29/2024. During an observation on 5/28/2024 at 9:02 AM, in the room of Resident #15 who was not present, had an oxygen concentrator with an external filter that had a large amount of white dust buildup. 2. Record review of a face sheet dated 5/29/2024 for Resident #29 indicated he admitted to the facility on [DATE] and was [AGE] years old with diagnosis of schizoaffective disorder bipolar type (a mental illness that has both a mood disorder and manic episodes), COPD, and hypertension. Record review of an Annual MDS Assessment for Resident #29 dated 5/21/2024 indicated he did not have any impairment in thinking with a BIMS score of 15. He had special treatments, procedures, and programs and was on oxygen therapy while a resident during the 14 day look back period. Record review of a care plan for Resident #29 dated 12/19/2022 indicated he received oxygen therapy with interventions to administer oxygen therapy as ordered. (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 active physician orders for Resident #29 undated indicated an order to change oxygen tubing and wash filter every week on Sunday dated 10/26/2022. Record review of a TAR for Resident #29 dated May 2024 indicated an order to change oxygen tubing and wash filter every week on Sunday that started on 10/30/2022 was administered as indicated by a check mark on May 26, 2024, by LVN D. During an observation and interview on 5/28/2024 at 9:02 AM, Resident #29 was present in his room and said he had been a resident at the facility for 4 years. He was on oxygen via nasal cannula at 3 Liters/min and the external filter had a large amount of white dust buildup. He said he did not remember the last time the filter was cleaned. 3. Record review of a face sheet dated 5/29/2024 for Resident #1 indicated she admitted to the facility on [DATE] and was [AGE] years old with diagnosis of pneumonia (lung infection), acute and chronic respiratory failure (lungs cannot release enough oxygen into the blood), and COPD. Record review of a TAR for Resident #1 dated May 2024 indicated an order to change oxygen tubing, nebulizer tubing, and mask, and wash oxygen filter every week on Sunday with a start date of 10/18/2023. It was administered on May 26, 2024, by LVN D as indicated by a check mark. Record review of active physician orders for Resident #1 undated indicated an order to change oxygen tubing and wash oxygen filter every week on Sunday dated 10/18/2023. Record review of a Quarterly MDS Assessment for Resident #1 dated 4/15/2024 indicated she did not have any impairment in thinking with a BIMS score of 15. Special treatments, procedures, and programs indicated she had oxygen therapy while a resident during the 14 day look back period. During an observation and interview on 5/28/2024 at 9:53 AM, Resident #1 was in bed awake on oxygen at 3 Liters/min via nasal cannula with the tubing dated 5/26 and the external filter had a large amount of dust. She said she had been a resident at the facility for [AGE] years and did not remember the last time they cleaned the filter. During an interview on 5/29/2024 at 7:50 AM, LVN B said the charge nurses were responsible for cleaning the oxygen filters every Sunday on the night shift from 6pm-6am. She said if a resident was on continuous oxygen there was an order on the TAR to clean the filters but not if a resident only used oxygen prn. Attempted a phone interview on 5/29/2024 at 7:44 AM with LVN D who worked Sunday night 5/26/2024 and no return call was received. During an interview on 5/30/2024 at 9:35 AM, the DON said she had been employed at the facility for 1 year. She said the night shift nurses on Sunday night were responsible for cleaning the filters on the oxygen concentrators. She said there should be orders on the resident's TAR with oxygen orders to clean them weekly. She said if the filters were not cleaned it could cause an exacerbation of disease processes that they had. She said she cleaned the filters of Resident #1 and #29 on 5/29/2024 but did not clean Resident #15's but would. She said going forward she would check all orders to ensure residents who had oxygen concentrators had orders to clean the filters. She said she expected the filters to be cleaned, when they were supposed to be cleaned every 7 days. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 5/30/2024 at 10:30 AM, the Administrator said the night nurses were responsible for cleaning the filters on the oxygen concentrators and they should be cleaned once a week. He said there was a risk for infections and the machine may not work properly if they were not cleaned. Record review of a facility policy titled Respiratory Therapy Equipment dated 8/2022 indicated, .It is the policy of this home that residents on respiratory therapy will have appropriate treatment. Oxygen Administration: 9. Wash filters from oxygen concentrator every 7 days in soapy water. Rinse and squeeze dry .

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46436 Based on observation, interview, and record review, the facility failed to provide pharmaceutical services, including procedures that assures the accurate acquiring, receiving, dispensing, and administering of medications for 1 of 1 medication rooms reviewed for medication administration. The facility failed to dispose of expired medications from the medication storage room. These failures could place residents who receive medications at risk of not receiving the intended therapeutic benefit of the medications, decreased quality of life, and hospitalization . Findings included: During an observation in the medication room on 5/29/2024 at 12:10 PM with MA C revealed the following: * 2 bottles of enteric coated aspirin with an expiration date of 4/24. During an interview on 5/29/2024 at 12:20 PM, MA C said she had been employed at the facility for [AGE] years. She said all nursing staff and medication aides were responsible for checking the medications and ensuring there were no expired medications stored in the medication room. She said she checked the medication room when she could. She said medications could be harmful or less effective if residents were given medications past their expiration. During an interview on 5/29/2024 at 12:24 PM, the DON said she was ultimately responsible for checking for expired medications in the medication room. She said she was not aware that there were 2 bottles of aspirin that were expired. During an interview on 5/30/2024 at 9:35 AM, the DON said she had been employed at the facility for a year and was the IP and the ADON was her back up. She said the nurses and medication aides put up medications when they arrived at the facility. She said the MDS Nurse ordered the OTC medications and put them in the medication room when they arrived. She said she was ultimately responsible for removing expired medications. She said residents could be at risk of harmful side effects or the medication being ineffective if given past the expiration dates. During an interview on 5/30/2024 at 10:30 AM, the Administrator said the DON was responsible for ensuring the medication room did not have expired medications. He said they did not want residents receiving out of date medications as they could be ineffective. Record review of a facility policy titled Medication Storage dated 9/2022 indicated, .It is the policy of this home that medications will be store appropriately as to be secure from tampering, exposure or misuse. 11. Outdated, contaminated, or deteriorated medications and those in containers that are cracked, soiled, or without secure closures are immediately removed from stock, disposed of per procedures for medications destruction, and reordered from the pharmacy, if a current order exists .

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 49017 Based on observations and interviews the facility failed to provide food that was palatable, and at a safe and appetizing temperature for residents interviewed for food temperature and taste. (Resident #168) The facility failed to serve hot and palatable foods. Resident #168 complained the food was served cold and did not taste good. These failures could place residents at risk for weight loss, altered nutritional status, and diminished quality of life. Findings included: During an interview on 05/28/2024 at 09:24 AM, Resident #168 said the food was served cold. Resident #168 eats in his room . During an observation on 05/29/2024, of the last meal cart for the residents that dine in their room left the kitchen at 12:55 PM and the test tray was served at 1:01 PM. The regular tray consisted of fettuccine alfredo with chicken, green beans, and mashed potatoes with gravy. The foods were bland and cool. The pork roast was cool and had small amount of chicken present. The green beans and mashed potatoes were cool. All food items were served cool. The dietary manager was present and sampled the test tray and stated, That's cold! During an interview on 5/29/2024 at 1:04 PM with the dietary manager she stated that she expected the food to be hot when served to the residents in their room. She said that she had heated carts available but was not sure if they were operational. She also stated that she had plate warmers available for use but did not use them. She said that she would be reviewing the process of preparing the trays and keeping them hot while on the hall carts. She said that the residents could possibly not eat as much of their meal and weight loss could occur if foods were not served hot. During an interview on 5/30/2024 at 10:03 AM the administrator said that he was not aware that the residents that eat in their room were not receiving meals hot. He stated that there were 2 warming carts available and warming plates available. He said that he was going to make sure that the warming carts were operational. He said that he expected the dietary staff to use the warming plates and warming carts to ensure that meals were delivered hot to the residents on the hall. He said that not serving warm foods can result in weight loss and possible foodborne illnesses .

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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. 49017 Based on observations, interviews, and record review, the facility failed to store, prepare, distribute, and serve food under sanitary conditions in the only kitchen. Temperature logs for the dishwasher, refrigerator 1, refrigerator 2, freezer 1, and freezer 2 were missing recorded temperatures. This failure could place residents who ate from the kitchen at risk of foodborne illness. Findings included: During an observation on 5/28/2024 at 9:20 AM, temperature log located at the dishwashing station with May 2024 on top of page had temperature checks missing from 05/20/2024 thru 05/27/2024. Temperature logs with May 2024 at heading for freezer 1 had recorded temperatures missing for 05/13/2024 thru 05/25/204, freezer 2 missing recorded temperatures for 05/14/2024 thru 05/25/2024, refrigerator 1 recorded temperatures missing for 05/14/2024 thru 05/25/2024, and refrigerator 2 recorded temperatures missing for 05/14/2024 thru 05/27/2024. During a record review of temperature logs dating from January 2024 thru April 2024, no missing recorded temperatures noted. During an interview on 5/29/2024 at 8:45 AM, the dietary manager said that the morning shift was responsible for checking the temperatures of the freezers and the refrigerators. She said that the temperature of the dish washer was checked three times a day. She said that the dietary aide filled the temperature log out. She said that she expected the staff to complete the temperature logs. She said that she has not had any mechanical issues with any of her equipment. She said that the temperatures were monitored daily, but that the staff does not always remember to fill the temperature log in. She said that she expected the logs to be completed daily. She said that not monitoring temperatures can result in food not being stored at the correct temperature resulting in foodborne illnesses that could cause residents to become ill. In an interview with the administrator on 5/30/2024 at 9:41 AM, the administrator said that he expected the temperature logs in the kitchen to be completed daily. He said that the dietary manager was responsible for monitoring compliance with monitoring temperatures of the refrigerator, freezer, and dishwasher. He said that he expected the dietary manager to check the log daily. He said that not monitoring the temperature of the appliances used could result in food spoilage and foodborne illness that can result in making the residents ill. Review of policy titled Storage Refrigerators from Dietary Services Policy and Procedure Manual 2006 stated Storage refrigerators shall have thermometers frequently monitored throughout the day. Temps are recorded on the Refrigerator/Freezer temperature log. (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 policy titles Dishwashing Preparation and Dishwashing from Dietary Services Policy and Procedure Manual 2006 stated .Minimum temperature of 120 degrees F.the dish machine should be tested for proper temperature and PPM (parts per million) of sanitizing solution. Facilities shall use an approved test kit to measure the parts per million of the chemical solutions . on a daily basis. Any abnormal test results shall be reported to the Dietary Service Manager.

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F 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Inform resident or representatives choice to enter into binding arbitration agreement and right to refuse. 46436 Based on record review and interviews the facility failed to ensure the arbitration agreement contained all the required elements for 1 of 1 facility reviewed for Arbitration Agreements. The facility did not ensure the arbitration agreement granted the resident or his/her representative the right to rescind the agreement within 30 calendar days of signing. The facility did not ensure the arbitration agreement allowed the resident or anyone else (e.g., resident's representative) to communicate with federal, state, or local officials such as federal and state surveyors, other federal or state health department employees, and representative of the Office of the State Long Term Care Ombudsman. This failure could place the residents or the residents' responsible parties in binding agreements not fully understood, have a loss of their legal rights, and cause negative psychological issues. Findings included: Record review of an undated Admission Agreement page 9 titled Arbitration and page 18 titled Dispute Resolution Plan indicated the agreement did not grant the resident or his/her representative the right to rescind the agreement within 30 calendar days of signing, and did not allow the resident or anyone else (e.g., resident's representative) to communicate with federal, state, or local officials such as federal and state surveyors, other federal or state health department employees, and representative of the Office of the State Long Term Care Ombudsman. During an interview on 05/29/24 at 9:17 AM the Administrator said that he was responsible for the admission agreements and was not aware of the requirements of the arbitration agreement. He said no resident has entered a binding arbitration and he was completing the paperwork that was supplied by corporate office. He said if the arbitration agreement was not per the regulation, it could affect the resolution and he expected that the arbitration agreement followed the regulation. The administrator said the facility did not have a policy regarding binding arbitrations and followed the admission agreement.

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F 0848 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide a neutral and fair arbitration process and agree to arbitrator and venue. 46436 Based on record review and interviews the facility failed to ensure the Arbitration Agreement contained all the required elements for 1 of 1 facility reviewed for Arbitration Agreements. The facility failed to ensure the arbitration agreement included provision of a neutral arbitrator. The facility failed to ensure the arbitration agreement contained a section indicating the provision of a convenient venue. These failures could place the residents or the residents' responsible parties in binding agreements not fully understood, have a loss of their legal rights, and cause negative psychological issues. Findings included: Record review of an undated Admission Agreement page 9 titled Arbitration and page 18 titled Dispute Resolution Plan indicated the agreement did not ensure the provision of a neutral arbitrator and did not ensure the Arbitration Agreement contained a section indicating the provision of a convenient venue. During an interview on 05/29/24 at 9:17 AM the administrator said that he was responsible for the admission agreements and was not aware of the requirements of the arbitration agreement. He said no resident has entered a binding arbitration and he was completing the paperwork that was supplied by corporate office. He said if the arbitration agreement was not per the regulation, it could affect the resolution and he expected that the arbitration agreement followed the regulation. The administrator said the facility did not have a policy regarding binding arbitrations and followed the admission agreement.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43994 46436 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 1 of 4 residents (Resident #116) and 3 of 8 staff (MDS nurse, CNA E, and CNA F) reviewed for infection control. MDS nurse failed to perform hand hygiene between residents during noon meal service on 5/28/2024. CNA E and CNA F failed to follow enhanced barrier precautions (EBP) when they provided foley catheter (a tube inserted into the bladder) care and incontinent care to Resident #116 on 5/28/2024. These failures could place residents at risk of exposure to communicable diseases and infections. Findings included: 1.During an observation on 05/28/24 at 12:15 PM the MDS nurse was observed passing lunch trays in the main dining room. She was observed handling resident wheelchairs and other items in the dining room and did not wash or sanitize her hands between residents when serving meal trays. During an interview on 05/28/24 at 12:18 PM, the MDS nurse said she had worked at the facility for 7 years and had received training on hand hygiene. She said she should have sanitized her hands between residents and after handling resident equipment. She said by not doing so could cause spread of bacteria and infections. 2. Record review of a face sheet for Resident #116 dated 5/29/2024 indicated he admitted to the facility on [DATE] and was [AGE] years old with diagnosis of retention of urine (condition when the bladder does not empty all the way), acute kidney failure (when the kidneys stop working suddenly), and dementia. Record review of a Discharge-Return Anticipated MDS assessment dated [DATE] for Resident #116 indicated he had a foley catheter. He had severe impairment in thinking with a BIMS score of 00. He was dependent of staff for ADL's. Record review of a baseline care plan dated 5/15/2024 for Resident #116 indicated he had a foley catheter in place and was incontinent of bowel/bladder. Record review of a 5 Day MDS assessment dated [DATE] for Resident #116 indicated he was unable to complete the interview with a BIMS score of 99. He did not have a foley catheter and was always incontinent of bowel/bladder. Record review of active orders undated for Resident #116 indicated an order dated 5/22/2024 for foley catheter care every shift and prn. (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 observation on 5/28/2024 at 4:00 PM, CNA E and CNA F were in the room of Resident #116 to provide incontinent and foley catheter care. Both CNA E and CNA F only wore gloves during the care provided and did not wear gowns. There were no issues with hand hygiene during the care provided. During an interview on 5/28/2024 at 4:30 PM, the ADON/Treatment nurse said she was not the IP in the facility and was taking some classes for it. She said she was not aware that residents who had foley catheters were to be placed on EBP but knew about residents that had wounds and staff had to wear a gown and gloves while providing care to them. During an interview on 5/29/2024 at 2:31 PM, LVN B said she was not aware of staff that needed to wear gown and gloves until that morning for residents that had feeding tubes, indwelling catheters, and wounds. She said they had an in-service that morning and was instructed on enhanced barrier precautions. She said before that day she was only aware to wear PPE that consisted of gown and gloves for residents with wounds. During an interview on 05/29/24 at 4:05 PM, the DON said she was also the infection prevention nurse and all staff had been trained on hand hygiene. She said the MDS nurse had been properly trained on performing hand hygiene during meal service and should have performed hand hygiene after handling a resident and between each meal tray served. She said if hands were not washed it could lead to the spread of infections and expected all staff to follow proper infection control measures during meal service. During an interview on 5/30/2024 at 9:35 AM, the DON said she had been employed at the facility for a year. She said she was the IP and the ADON was the backup. She said prior to 5/28/2024 she was aware of the new EBP, and the facility did receive the QSO memo from CMS. She said when she received it, she did not read through it thoroughly about residents with indwelling catheters needing EBP. She said the staff would not have known about EBP prior to 5/28/2024 because they did not get an in-service training on it. She said EBP were for residents who had indwelling catheters and chronic wounds and staff should wear a gown and gloves when they provided patient care. She said going forward she started an in-service with the staff on EBP on 5/28/2024. She said there was a risk for spreading infections and diseases if staff did not follow EBP. During an interview on 5/30/2024 at 9:44 AM, the Administrator said the infection prevention nurse and the DON were responsible for ensuring all staff now when to perform hand hygiene. He said there had been training on hand hygiene and would ensure it was specific to meal service. He said if hand hygiene was not performed it could cause spread of germs. He said he expected all staff to follow proper procedure for hand hygiene. During an interview on 5/30/2024 at 10:30 AM, the Administrator said the IP/DON was responsible for training staff on infection control. He said he was aware of the new EBP guidance, and the facility liaison sent him a copy of the QSO memo from CMS for EBP and gave it to the DON. He said the facility did not have an in-service with staff when they were made aware of EBP so his staff would not have known to follow EBP. He said he expected that all infection control policies would be followed. He said there was a risk of spreading infections in the facility if staff were not aware. Record review of an in-service titled Foley, G-tube (feeding tubes), and central lines dated 5/28/2024 conducted by the DON to staff indicated that anyone with an indwelling device/wound you have to use enhanced barrier precautions. Gloves and gown when providing care. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of a QSO (Quality, Safety and Oversight) Memo dated 3/20/2024 from CMS (Centers for Medicare and Medicaid Services) titled Enhanced Barrier Precautions in Nursing Homes indicated, .CMS is issuing new guidance for State Survey Agencies and long-term care (LTC) facilities on the use of enhanced barrier precautions (EBP) to align with nationally accepted standards. EBP recommendations now include use of EBP for residents with chronic wounds or indwelling medical devices during high-contact resident care activities regardless of their multidrug-resistant organism status. Guidance: EBP's refer to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and gown use during high contact resident contact activities. Record review of a facility policy dated 8/2022 titled Hand Hygiene indicated, hand hygiene is the primary means to prevent the spread of infection; employees must wash their hands before and after assisting a resident with meals .

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46273 Based on observations, interviews, and record review, the facility failed to be equipped to allow residents to call for staff through a communication system which relayed the call directly to a centralized staff work area for 2 of 12 residents reviewed for call lights. (Residents #44 & #55). The facility failed to ensure Resident #44's and Resident #55's emergency call lights in the bathroom were reachable from the floor. This failure could place residents at risk of injury, pain, hospitalization , and a diminished quality of life. Findings included: Record review of a facility face sheet dated 5/29/24 for Resident #44 indicated that she was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses including dementia and history of falling. Record review of a quarterly MDS assessment dated [DATE] fore Resident #44 indicated that she had a BIMS score of 9 which indicated that she had moderate cognitive impairment. Section GG (Functional Abilities and Goals) indicated that she required supervision or touching assistance with toilet transfers. Section H (Bowel and Bladder) indicated that she was always continent of bowel and bladder. Record review of a comprehensive care plan dated 8/11/23 for Resident #44 indicated that she was at risk of falls and interventions included to keep the call light within reach. Record review of a facility face sheet dated 5/29/24 for Resident #55 indicated that she was an [AGE] year-old female admitted to the facility on [DATE] with diagnoses including: hyperlipidemia (high cholesterol) and Alzheimer's disease. Record review of a quarterly MDS assessment dated [DATE] for Resident #55 indicated that she had a BIMS score of 10 which indicated that she had moderate cognitive impairment. Section GG (Functional Abilities and Goals) indicated that she required supervision or touching assistance with toilet transfers. Section H (Bowel and Bladder indicated that she was always continent of bowel and bladder. Record review of a comprehensive care plan dated 5/14/24 for Resident #55 indicated that she was at risk for falls and interventions included to keep the call light within reach. During an observation on 5/28/24 at 9:33 am Resident #44 was observed lying in her bed asleep. There was a rolling walker observed beside her bed. The call light in her bathroom was observed to have a red cord coming from the white box. The cord was tied and was approximately 3 to 4 inches from the white panel box. During an observation and interview on 5/28/24 at 9:35 am Resident #55 was observed ambulating. She said she was going to play Bingo. Her bathroom call light was observed to be wrapped around the grab bar. (continued on next page)

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	676183	A. Building B. Wing	05/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Huntington Health Care & Rehabilitation Center	220 E Ash Street Huntington, TX 75949

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 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/39/24 at 10:50 am the Administrator said that the CNAs were responsible for ensuring that all call lights were in place and in working order. He said that residents may not be able to call for help when needed if they can't reach their call light. Going forward, he would expect that all call lights be in place and functioning. During an interview on 5/30/24 at 11:01 am the DON said all staff members were responsible for ensuring call lights were in place. Residents could be at risk of not being able to call for help in an emergency, such as falls. Going forward, she would expect call lights to be checked every shift to make sure they are not tied up. Record review of a facility policy titled Call light - use of dated 8/2022 read .it is the policy of this home to ensure residents have a call light within reach and that they are physically able to access and that they have been instructed on its use .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0926 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have policies on smoking. 46436 Based on observations, interviews, and record review, the facility failed to follow established policy regarding smoking areas, and smoking safety for 1 of 1 smoking area reviewed. The facility failed to empty ash trays and keep trash out of the ash trays in the designated smoking area on 5/29/2024. This failure could place residents who smoke at risk of physical harm and lead to an unsafe smoking environment. The findings included: During an observation on 05/29/24 at 8:25 AM the designated smoking area had 2 ash trays present. One ash tray was overflowing with cigarette butts and the other ash tray had a paper towel that had presence of burn marks . During an interview on 05/29/24 at 8:29 AM HSK A said the maintenance director was responsible for maintaining the smoking area and she would empty the trash. She said that in her training she was taught that residents were to be supervised during the smoke break to ensure they did not put their cigarettes in the trash can or keep a lighter. She said that paper in the ash trays and excessive butts could cause a fire. During an interview on 05/29/24 at 8:31 am the maintenance supervisor said the housekeeping department and the staff supervising the smokers were responsible for maintaining the area in a safe manner. He said he did clean up any butts on the ground and spray for pest as needed but the daily cleaning and emptying of the ash trays were the responsibility of the housekeepers. He said if trash and paper were placed in the ash trays, or the ash trays were not emptied regularly it could cause a fire . During an interview on 05/29/24 at 8:40 am the administrator said the housekeeping department was responsible for maintaining the smoking area in a clean and safe manner. He said the staff that assist the smokers were also responsible and had been taught to ensure the ash trays were emptied and no trash was in the ash trays, but that training had been a while ago. He said if the ash trays contained excessive butts and trash, it could cause a fire. He said he expected the smoking area to be maintained with each smoke break. Record review of a facility policy dated 11/2022 titled Smoking indicated, .All ashtrays and trash will be checked on a regular basis by the staff monitoring smoke breaks to ensure compliance with HHSC regulations, no trash or other foreign debris is allowed to be put in ash trays .