

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676184	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/08/2024
NAME OF PROVIDER OR SUPPLIER Providence Park Rehabilitation and Skilled Nursing		STREET ADDRESS, CITY, STATE, ZIP CODE 5505 New Copeland Rd Tyler, TX 75703	

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)
<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>37495</p> <p>Based on observations, record reviews, and interviews the facility failed to provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior and clean bed linens that were in good conditions for 4 of 8 residents (Residents #5, #42, #44, and #58) reviewed for a safe environment.</p> <p>The facility failed to provide clean and adequate linens for Residents #5, #42, #44, and #58.</p> <p>This failure could place residents at risk for a diminished quality of life and a decreased feeling of self-worth.</p> <p>Findings included:</p> <p>During an observation and interview on 05/06/24 at 10:38 a.m., revealed Resident #5 was in his room lying bed with a flat sheet and blanket that was covering him. Resident #5 had a fitted sheet on his bed. Resident #5 said they may not have enough linens because they seem to run out of them at times. Resident #5 said when they ran out of linens he had to wait until they brought more to get his sheets changed and his bed made.</p> <p>During an observation on 05/06/24 at 11:53 a.m., revealed CNA F entered Resident #58's room and was asked by the resident to make his bed. CNA F informed Resident #58 they had no clean linens available, and she would make his bed once laundry was finished washing them.</p> <p>During an interview on 05/06/24 at 11:56 a.m., CNA F said she could not make Resident #58's bed because there were no clean linens in the linen supply room. CNA F said they ran out of clean linens frequently about 2-3 times a week when she worked. CNA F said she worked 4-5 days a week. CNA F said they had a shortage of linens.</p> <p>During an observation and interview on 05/06/24 at 12:09 p.m., revealed Resident #58 was in his room sitting in a wheelchair next to his bed. There was no fitted sheet, flat sheet or blanket on Resident #58's bed. Resident #58 said they did not have any clean sheets to make his bed right now and he would have to wait until they brought more. Resident #58 said they must have a shortage of linens because they run out of them at times.</p> <p>(continued on next page)</p>

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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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an observation and interview on 05/06/24 at 12:23 p.m., revealed Resident #42 was in her room sitting in a wheelchair next to her bed. There was no fitted sheet, flat sheet or blanket on Resident #42's bed. Resident #42 said they had no clean sheets to make her bed which happened 2-3 times a week. Resident #42 said she could not get into her bed now if she wanted to because she would have to wait until it was made. Resident #42 said it made her feel forgotten like they didn't care about her.</p> <p>During an observation on 05/06/24 at 12:23 p.m., revealed there were no fitted or flat sheets in the Linen Closet on the 500/600 Hall.</p> <p>During an interview in the dining room on 05/06/24 at 12:42 p.m., Resident #44's family member said she was at the facility on 05/05/24 to visit him during lunch. She said she took him back to his room after he was finished with lunch and noticed he had no sheets on his bed, so she went to the linen closet on the 200/400 Hall. She said she could not make his bed because there were no sheets in the linen closet. She said she placed a throw blanket on the mattress and assisted him into bed before she left the facility. She said they had run out of linens and would make his bed when they got some back from laundry.</p> <p>During an observation of Resident #44's room on 05/06/24 at 1:00 p.m., revealed there was no fitted sheet, flat sheet or blanket on his bed.</p> <p>During an interview on 05/06/24 at 1:23 p.m., CNA G said she worked the 6 a.m.-2 p.m. shift on 05/05/24 and provided care to Resident #44. CNA G said she stripped his sheets off his bed before lunch, but was unable to make his bed because there were no clean linens available. CNA G said she made rounds after lunch and Resident #44 was in bed lying on his own personal blanket. CNA G said there were no sheets in the 200/400 Hall linen closet, and she was unable to make his bed before the end of her shift. CNA G said when she made her rounds this morning Resident #44 was in bed and lying on a blanket. CNA G said it was the same blanket Resident #44 was lying on at the end of her shift on 05/05/24. CNA G said they ran out of clean linens 2-3 times a week when she worked. CNA G said she worked 4-5 days a week. CNA G said they had a shortage of linens.</p> <p>During an observation on 05/06/24 at 4:50 p.m., a hand count was conducted by the Laundry Supervisor of the fitted sheets and flat sheets in the facility. The locations and counts revealed:</p> <ul style="list-style-type: none"> *Laundry Room (clean side)- 15 flat sheets, 8 fitted sheets *Laundry Room (dirty side)- 31 flat sheets, 10 fitted sheets * Linen Closet 200/400 Hall- 12 flat sheets, 6 fitted sheets *Linen Closet 500/600 Hall - 10 flat sheets, 7 fitted sheets *Resident Rooms- 102 flat sheets, 102 fitted sheets *The total number of flat sheets in the facility- 170 * The total number of fitted sheets in the facility- 133 <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 05/06/24 at 5:25 p.m., the Laundry Supervisor said they had a total of 170 flat sheets and 133 fitted sheets in the facility. The Laundry Supervisor said they should have at least 300 flat and 300 fitted sheets on hand to keep both linen closets stocked up to ensure they had enough linens for bed changes throughout the day while they washed the dirty linens. The Laundry Supervisor said she was unaware they did not have enough linens. The Laundry Supervisor said she was responsible for ordering linens and needed to order more.</p> <p>During an interview on 05/06/24 at 5:25 p.m., the Administrator said he was unaware they had 170 flat sheets and 133 fitted sheets in the facility. The Administrator said he expected to have enough linens in the facility and told when they needed more so he could order more. The Administrator said they should have at least 300 fitted and flat sheets each to ensure they had enough for bed changes. The Administrator said he would order more.</p> <p>Record review of an undated copy of the facility's Statement of Resident Rights indicated, .You, the resident, do not give up any rights when you enter a nursing facility .You have a right to: (1) all care necessary for you to have the highest possible level of health; (2) safe, decent and clean conditions .</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42190</p> <p>Based on interview and record review, the facility failed to ensure a resident who is unable to carry out activities of daily living received the necessary services to maintain grooming and personal hygiene for 1 of 21 residents reviewed for ADL care. (Resident #62)</p> <p>The facility failed to ensure Resident #62 received scheduled showers/baths and did not accurately document bed baths. Resident #62 did not receive 9 showers since her admission and inaccurately documented bed baths for Resident #62 when she was not a resident in the facility.</p> <p>This failure could cause residents to feel socially isolated and have a loss of dignity and self-worth.</p> <p>Findings included:</p> <p>Review of Resident #62's Face Sheet, dated 05/08/24, revealed a [AGE] year-old female who readmitted to the facility on [DATE]. Resident #62, again, discharged from the facility due to a change of condition and readmitted on [DATE] with diagnoses to include: anal abscess, muscle weakness, low back pain unspecified, other reduced mobility, anxiety disorder, not elsewhere classified, diabetes mellitus without complications and Crohn's disease of both small and large intestine with fistula (chronic inflammatory bowel disease).</p> <p>Review of Resident # 62's ADL Plan of Care, dated 05/08/2024, revealed she had a history of paraplegic (inability to voluntarily move the lower parts of the body) , she has impaired physical mobility, right lower extremity weakness, and left lower extremity weakness. She required partial to moderate assistance with showers/bath .</p> <p>Record review of Resident #62's ADL flow record indicated she did not receive a shower/bath on 04/15/24, 04/17/24, 04/19/24, 04/22/24, 04/24/24, 04/26/24, 04/29/24, 05/03/24, and 05/07/24.</p> <p>Record review of Resident #62's skin assessment-shower, completed by CNA O, indicated Resident #62 received a bed bath on 04/10/24 and 04/12/24 .</p> <p>During an interview on 05/08/24 at 2:53 PM, CNA - O said the signature on Resident #62's Skin Assessment -Shower logs dated 04/10/24 and 04/12/24, were her signature and she did give Resident #62 a bed bath on both days. She said she would not have signed the form if Resident #62 was not here and she had not given her a bed bath.</p> <p>During an interview on 05/08/24 at 3:00 PM, ADON - H viewed Resident #62's skin assessment-shower sheet for 04/10/24 and 04/12/24. When asked what Resident #62's admitted was, ADON - H said 4/13/24. She also said, She can't get a bath if she not here. She said the signature on the shower sheet dated 04/10/24 and 04/12/24 were completed by an agency staff and evidentially the agency staff was not paying attention. ADON H reviewed Resident #62's ADL Flow Record sheet, ADON and said Resident #62 only received 1 shower since her admission on 04/13/24. She said Resident #62 was scheduled for showers/baths every Monday, Wednesday, and Friday.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 05/08/24 at 3:07 PM, the DON was asked to review and explain Resident #62's skin assessment-shower sheet, for 04/10/24 and 04/12/24, the DON said, The only thing I can say is her admitted was 04/13/24. The DON reviewed Resident #62's ADL Flow Record sheet and said it indicated Resident #62 received 1 shower/bed bath since her admission.</p> <p>Review of the Facility's Policy, Titled: Bathing (Not Partial or Completed Bed Bath), revised January 20, 2023. Policy: Staff will provide bathing services for residents within standard practice guidelines.</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47204</p> <p>Based on observation, interview, and record review the facility failed to ensure that residents requiring respiratory care were provided such care, consistent with professional standards of practice for 1 of 3 resident (Resident #73) reviewed for respiratory care.</p> <p>The facility failed to ensure Resident #73 had physician orders for oxygen therapy.</p> <p>This failure could place residents who receive respiratory care at risk for developing respiratory complications and a decreased quality of care.</p> <p>The findings included:</p> <p>Record review of Resident #73's face sheet, dated 05/07/2024, indicated she was an [AGE] year-old female who was admitted to the facility on [DATE] with diagnoses which included chronic obstructive pulmonary disease (group of diseases that block airflow and impairs breathing), acute and chronic respiratory failures, shortness of breath, pneumonia (infection of the lungs), and cognitive deficit (impaired ability to remember, think, or make a decision).</p> <p>Record review of Resident #73's MDS assessment dated [DATE], indicated Resident #73 usually understood and was usually understood by others. Resident #73's BIMS score was 12, which indicated her cognition was moderately impaired. The MDS indicated Resident #73 had active diagnoses which included chronic obstructive pulmonary disease, acute and chronic respiratory failure, and pneumonia. The MDS indicated Resident #73 was not receiving oxygen therapy during the assessment period.</p> <p>Record review of Resident #73's care plan dated 04/19/2024 indicated Resident #73 had a concern for breathing and an intervention to Administer medications, respiratory treatments, and oxygen as ordered.</p> <p>Record review of Resident #73's physician orders dated 05/07/2024 did not indicate any orders for oxygen therapy.</p> <p>During observations on 05/06/2024 at 11:21 AM and 01:30 PM and on 05/07/2024 at 07:48 AM, Resident #73 was noted to be lying in bed with the head of the bed elevated and receiving oxygen at 2 LPM via nasal cannula.</p> <p>During an interview with Resident #73 at 11:21 on 05/06/2024, she said she had to have oxygen to breathe. She said she was receiving oxygen at 3 LPM at her home before she went to the hospital.</p> <p>During an interview with LVN B on 05/07/2024 at 12:40 PM, she said Resident #73 was receiving oxygen at 2 LPM for respiratory issues. She said Resident #73 had been receiving oxygen every day since the Resident's admission. LVN B said the oxygen was supposed to be applied as needed but the resident used it continuously. LVN B said she could not find an order for oxygen therapy in the physician's orders.</p> <p>(continued on next page)</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview with ADON E on 05/07/2024 at 12:48 PM, she said she could not find an order for Resident #73 to receive oxygen therapy. She said she did not know why there was not an order for Resident #73 to have oxygen therapy. She said an order for oxygen use with instructions for method of oxygen delivery and a prescribed flow rate was important to prevent potential respiratory issues.</p> <p>A review of the facility's policy titled Applying An Oxygen Delivery Device included the following instructions:</p> <p>Validate physician's orders. Verify setting on flowmeter and oxygen source and the prescribed flow rate.</p>		

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<p>F 0732</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Many</p>	<p>Post nurse staffing information every day.</p> <p>37495</p> <p>Based on observation, interview, and record review the facility failed to post Nursing Staffing Data information daily as required on a daily basis for 3 of 3 days (05/06/24, 05/07/24 and 05/08/24) for May 2024 and maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater for 4 of 4 months (February 2024, March 2024, April 2024, and May 2024) reviewed for nursing staffing.</p> <p>The facility failed to post the required staffing information for 05/06/24, 05/07/24 and 05/08/24.</p> <p>The facility failed to retain the nursing staffing data for February 2024, March 2024, April 2024, and May 2024</p> <p>These failure could cause residents, families, and visitors to be unaware of the facility daily staffing requirements.</p> <p>Findings included:</p> <p>During an observation on 05/06/24 at 10:33 a.m., revealed the daily nursing staffing data was not posted.</p> <p>During an observation on 05/07/24 at 8:45 a.m., revealed the daily nursing staffing data was not posted.</p> <p>During an observation on 05/07/24 at 5:34 p.m., revealed the daily nursing staffing data was not posted.</p> <p>During an observation on 05/08/24 at 8:44 a.m., revealed the daily nursing staffing data was not posted.</p> <p>During an observation on 05/08/24 at 12:15 p.m., revealed the daily nursing staffing data was not posted.</p> <p>During an interview on 05/08/24 at 12:30 p.m., ADON H said the staffing coordinator was responsible for posting the daily staffing sheets. ADON H said she was responsible for the posting the daily staffing and took over the responsibilities when their staffing coordinator left the facility back in February 2024. ADON H said she did not have the daily staffing sheets for February 2024, March 2024, April 2024, and May 2024 because she had not posted any since she took over in February 2024. ADON H said she has not had the time to post them because she has been busy working shifts as a charge nurse and taking care of her responsibilities as the ADON.</p> <p>Record review of the facility's undated Staffing Coordinator Job Description indicated, .The role of the staffing coordinator is to ensure adequate and appropriate staffing of the facility nursing department to meet the needs of the residents .Complete and post work sheets and time schedules .All care and services will be provided in accordance with: Federal and State Rules and Regulations .</p>

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure medication error rates are not 5 percent or greater.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47204</p> <p>Based on observation, interview, and record review, the facility failed to ensure medication error rate was not 5 percent or greater for 2 of 2 residents reviewed for medication administration. (Resident #53 and #104)</p> <p>MA A failed to administer one scheduled medication, Vitamin B12 1000 mcg SL tablet (to treat vitamin deficiency) to Resident #104 as ordered by the physician and;</p> <p>MA A failed to administer a physician ordered multivitamin with minerals (to treat vitamin deficiency) to Resident #53, resulting in a 7 percent medication error with 2 errors out of 26 opportunities.</p> <p>These failures could place residents at risk of inadequate therapeutic outcomes.</p> <p>Findings included:</p> <p>Resident #104:</p> <p>Record review of a face sheet dated 05/07/2024 indicated Resident #104 was an [AGE] year-old female who admitted to the facility on [DATE] with diagnoses which included vitamin deficiency.</p> <p>Record review of the physician orders dated 05/07/2024 indicated Resident #104 was to receive Vitamin B-12 1000 mcg SL daily.</p> <p>During an observation of medication administration and interview on 05/07/2024 at 07:58 AM, MA A said she could not give Resident #104 her dose of Vitamin B-12 1000 mcg SL because she did not have it on the cart and there was none in the facility.</p> <p>Resident #53</p> <p>Record review of a face sheet dated 05/07/2024 indicated Resident #53 was a [AGE] year-old male who admitted to the facility on [DATE] with diagnoses which included vitamin deficiency.</p> <p>Record review of the physician orders dated 05/07/2024 indicated Resident #53 was to receive one multivitamin with minerals tablet daily.</p> <p>During observation of medication administration and interview on 05/07/2024 at 08:27 AM, MA A said she could not give Resident #53 his physician ordered dose of Centrum Silver (a multivitamin with minerals) because she did not have any in the medication cart. She said she would let the nurse know. At 02:28 PM, MA A approached this surveyor and said she had obtained a bottle from the supply room and had given Resident #53 his vitamin. MA A presented a bottle to this surveyor and said this was the vitamin she gave. The label on the bottle said Multivitamin. When asked if she had given a multivitamin or a multivitamin with minerals, MA A said she gave resident #53 a multivitamin.</p> <p>(continued on next page)</p>		

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview with the DON on 05/07/2024 at 01:55 PM, she said the expectation was that if a medication is not available for administration, the medication aides were to let the charge nurse know. She said if a medication could not be located, then the facility would obtain over-the-counter medications from a local pharmacy or retailer that carried house stock medications.</p> <p>Record review of the website Centrum.com on 05/21/2024 indicated Centrum Silver contained the following minrals: manganese,zinc, selenium, copper, chromium, molybdenum, chloride, potassium, phosphorus, iodine, and magnesium.</p> <p>Review of the facility's policy titled Medication - Administration dated 08-2020 indicated the following:</p> <p>Policy: It is the policy of this home that medications will be administered and documented as ordered by the physician</p> <p>and in accordance with state regulations.</p> <p>Record review of the facility's medication administration procedures: .4. Current medications and dosage schedules, except topical used for treatments, are listed on the resident's medication record (MAR) 7. Supplies and equipment, which are needed during a medication pass, are to be placed on the medication cart. The following equipment and materials are needed for the medication pass: Routine medications needed, including house stock medications.</p>

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<p>F 0809</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure meals and snacks are served at times in accordance with resident's needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37495</p> <p>Based on observation, interview, and record review, the facility failed to provide at least three meals daily, at regular times comparable to normal meal times in the community or in accordance with resident needs for 2 of 3 residents reviewed for meals. (Residents #7 and #97).</p> <p>Residents #7 did not receive a sack lunch on 05/06/24 when she left for hemodialysis at 10:50a.m.</p> <p>Residents #97 did not receive a sack lunch on 05/07/24 when he left for hemodialysis at 5:30a.m.</p> <p>This failure could place dialysis residents, at risk of not receiving adequate therapeutic nutritional status to maintain the highest practicable level of well-being, and not having their nutritional needs met.</p> <p>Finding included:</p> <p>Resident #7</p> <p>Record review of Resident #7's face sheet indicated she was a [AGE] year-old female who admitted to the facility on [DATE] with a diagnoses which included, respiratory failure (a condition that makes it difficult to breath on your own), congestive heart failure (a condition in which the heart does not pump blood as efficiently as it should), generalized muscle weakness, diabetes, dialysis (a process of removing excess water, and toxins from the blood in people whose kidneys do not function), and failure to thrive.</p> <p>Record review of an admission Minimum Data Set assessment, dated 2/7/2024, indicated Resident #7 had a BIMS assessment score was fifteen indicating she was cognitively intact.</p> <p>Record review of a dialysis pre/post communication report dated 5/06/2024 indicated no documentation of a sack lunch was provided for Resident #7 to take to the dialysis unit.</p> <p>During an observation and interview on 05/07/2024 at 8:55 a.m., Resident #7 was in her room eating breakfast. Resident #7 said on dialysis days the facility did not send a sack lunch on Monday 05/06/2024.</p> <p>During an interview on 05/07/24 at 02:23 p.m., Resident #7 said on dialysis days the facility did not send a sack lunch on Monday, or any scheduled dialysis days since her admission. The resident said by the time she returned to the facility from her off-site dialysis unit on Mondays, Wednesdays, and Fridays, which was usually after 5:15 p.m. she was very hungry.</p> <p>During an interview on 05/07/2024 at 4:00p.m. ADON H said, the facility did not send a sack lunch with Resident #7 on 05/06/2024. ADON H said, Resident #7 was given a breakfast on 05/06/2024 and was given dinner after the resident returned from dialysis around 5:30p.m.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676184	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/08/2024
NAME OF PROVIDER OR SUPPLIER Providence Park Rehabilitation and Skilled Nursing		STREET ADDRESS, CITY, STATE, ZIP CODE 5505 New Copeland Rd Tyler, TX 75703	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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<p>F 0809</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Record review of Resident #7's consolidated doctor's orders dated 05/08/2024 indicated a start date 02/10/2024 for a Renal 80 grams diet, and start date 02/07/2024 for HS snack, and a start date 03/27/2024 for dialysis on Monday, Wednesday, and Friday.</p> <p>Record review of Resident #7's consolidated doctor's orders dated 05/08/2024 indicated a start date 05/08/2024 for a snack Monday, Wednesday and Friday on day shift nurse to ensure snack is provided to resident to take to dialysis.</p> <p>During an interview on 05/08/2024 at 8:15 a.m., the Facility Transportation, said no sack lunches were sent with the residents before being transported to the dialysis unit on Monday 5/6/2024 or since he was hired at this facility. He said he was hired as the facility transportation on 05/04/2024. He said, Resident #7 was scheduled for dialysis pick-up today at 10:45 a.m.</p> <p>During an observation and interview on 05/08/24 at 8:20 a.m., CNA (J) was in the Resident #7's room assisting with breakfast setup. She said the charge nurse informed her Resident #7 was scheduled to go to the dialysis unit today and to have her fed and dressed by 10 a.m. She said there was no mention of picking up a sack lunch from dietary to send with the resident to the dialysis unit.</p> <p>During an interview on 05/08/24 at 9:53 a.m., LVN (L) charge nurse said, she assumed it was the nurses' responsibility to notify the CNAs to pick-up sack lunches from the kitchen for residents going to dialysis on their days of scheduled dialysis sessions. She said on Monday 5/6/2024 the facility did not send a sack lunch with Resident #7 to the dialysis unit.</p> <p>Resident #97</p> <p>Record review of Resident #97's facesheet indicated he was a [AGE] year-old male who admitted to the facility on [DATE] with diagnosis to include, hemiplegia and hemiparesis, affecting right dominate side, diastolic heart failure (a condition in which your heart's main pumping chamber becomes stiff and unable to fill properly), hypertension, renal dialysis (a process of removing excess water, and toxins from the blood in people whose kidneys do not function), chronic obstructive pulmonary disease (a group of lung diseases that block airflow and make it difficult to breathe).</p> <p>Record review of Resident #97's physician orders dated 05/08/2024 indicated he had a physician order for snack Tuesday, Thursday, Saturday - on 1 time per day - Nurse to ensure snack is provided to resident to take to dialysis.</p> <p>During an interview on 05/08/2024 at 2:45 p.m. Resident #97 said he went to dialysis on 05/07/24. He said he did not receive breakfast before he left the facility for dialysis, and he never had. When asked if he was hungry when he left the facility, he said yes, but he has gotten used to not getting breakfast. He said he did not receive a snack or anything when gone for dialysis. He said he was hungry when he returned to the facility on [DATE]. He said he was always hungry after returning from dialysis.</p> <p>During an interview on 05/08/24 at 8:33 a.m., MA (K) said, the nurses were responsible for letting the CNAs know what was needed for residents to take with them on scheduled dialysis days.</p> <p>(continued on next page)</p>		

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<p>F 0809</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 05/08/24 at 8:40a.m., the Receptionist, said she printed out the transport list daily for the van driver and placed it in his communication box every morning so he would know when residents needed to be at their appointments. She provided lists for transportation dated 05/07/24 and 05/08/24 with the times and destinations indicated.</p> <p>During an observation in the kitchen on 05/08/24 at 8:45 a.m., a sheet of paper secured to the door of the 2-door cooler indicated Dialysis Lunch and listed Resident (#7) for Monday, Wednesday, and Friday dialysis and Resident (#97) for Tuesday, Thursday, and Saturday dialysis. No times of departure were noted, only the types of foods the dietary could have included in the sack lunch and foods to avoid for the sack lunch.</p> <p>During an interview on 05/08/24 at 8:47a.m., Dietary Cook M said, the dietary aides were the ones to prepare the sack lunches or snacks.</p> <p>During an interview on 05/08/24 at 8:50 a.m., Dietary Aide N said, he had worked at the facility for about 2 months but had worked some last year also. He said the van driver, or the nurse needed to ask for a sack lunch or snack when they needed it. He said he did not know anything about a posting on the cooler in the prep area. He said that was all new to me about the list but that the driver or the nurse had not come and asked for a sack lunch or snack to go. He said he did not have a permanent dietary manager to remind them a snack needed to be prepared. He said the list on the cooler must had just been put up because he had not seen it the day before. He said it did not indicate any specific times the snacks or sack lunches were to be prepared only the days they were needed, so the driver or nurse would still need to come and pick it up.</p> <p>During an interview on 05/08/24 at 9:00a.m. the RD said she put the dialysis lunch list on the cooler last week. She said the early morning dialysis residents on Tuesday, Thursday, and Saturday should have a sack or snack lunch prepared because they left before their breakfast meal. She said Resident #7 has a good breakfast before she must leave for her dialysis but would be gone during the lunch meal and should have a snack or sack lunch prepared. She said at other facilities the CNAs or nurses came to the kitchen and picked up the snacks prepared for their dialysis residents.</p> <p>A record review of a transport list dated 05/08/2024, indicated on Monday, Wednesday, and Friday Resident #7's, chair appointment time 11:45a.m. and on Tuesday, Thursday, and Saturday, Resident #97's, chair appointment time was 6:00a.m.</p> <p>During an interview on 05/08/2024 at 2:45p.m. the DON said, sack lunches were not sent out with the dialysis residents, and she presented an external email form dated 5/08/2024 from the dialysis (kidney) care unit stated, it is recommended to not eat while on the dialysis machine.</p>		

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<p>F 0919</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Make sure that a working call system is available in each resident's bathroom and bathing area.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42190</p> <p>Based on observation, interview, and record review, the facility failed to be adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a centralized staff work area, for 1 of 21 residents (Resident #09) reviewed.</p> <p>Resident #09's call light was inoperative and failed to light and sound at the centralized call light panel, located at the only nurse station near hall 400.</p> <p>This failure could place residents who rely on the call light system to have delayed response to meet their needs.</p> <p>Findings included:</p> <p>Record review of Resident #09's face revealed an admitted [DATE] with diagnoses that include: other diseases of stomach and duodenum (the first part of the small intestine) , muscle weakness, dysphagia (difficulty swallowing) , cognitive communication deficit, unsteadiness on feet, (lung disease that causes restricted airflow, unspecified, type 2 diabetes mellitus with diabetic neuropathy (weakness, numbness and pain from nerve damage, usually in the hand and feet), specified, morbid (severe) obesity due to excess calories and chronic kidney disease.</p> <p>During observation and interview on 05/06/2024 at 10:38 AM, Resident #09 stated she need someone to help her put batteries in her hearing aids, but no one had been answering her call light. When asked to depress her call light, it was observed that the wall panel did not illuminate and the white light, in the corridor, above Resident #09's door, did not illuminate. She said the last time she remembered someone answering her call light was 3-4 days ago.</p> <p>During interview and observation on 05/06/2024 at 12:48 AM, CNA - O said to her knowledge all call lights were working. She entered Resident #09's room and depressed the call light button. She observed that the wall plate light did not illuminate and said, It didn't come on. I thought it was working. CNA - O observed the light, in the corridor, above Resident #09's door, was not illuminated.</p> <p>On 05/06/2024 at 12:48 AM, the call light panel, at the nurse station near hall 400, was observed to not be illuminated or sounding, after Resident #9's call light had been depressed. LVN - L observed the call light panel and said, it's not showing a call light is on. When informed that Resident #09's call light had been depressed, LVN - L entered resident #09's room and depressed the call light button. She observed the light on the wall plate had not illuminated. She also observed the light, in the corridor, above resident #09's door was not illuminated. During the test of resident #09's call light, ADON - H entered resident #09's room at 1:13 PM. LVN - L informed ADON H of her findings. ADON H replaced resident #09's call light cord with another call light cord. After replacement of the call light cord, resident #09's call light was observed to be operating properly; wall light panel illuminated, light in the corridor, above resident #09's door, was illuminated and the call light panel, at the nurse's station near the 400 hall, was sounding.</p> <p>(continued on next page)</p>		

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<p>F 0919</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of facility's Policy, with a revised date of January 19, 2023, Titled: Call Light Answering: Staff will provide an environment that helps meet the resident's needs by answering call lights appropriately. The policy did not address the functionality of call lights.</p>		