STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676209	A. Building B. Wing	02/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Decatur Medical Lodge	701 W Bennett Rd Decatur, TX 76234

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48122 Based on observations, interviews, and record review the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights for 2 of 4 residents (Resident #4 and Resident #19) reviewed for care plans in that: The facility failed to ensure that Resident #4 and Resident #19 use of bed rails/grab bars/mobility bars/transfer bars were documented in their care plans. The facility's failure placed residents requiring care at risk of not having their individual needs met, not receiving necessary care and services, and a failure to ensure continuity of care. Findings included: Record Review of Resident #4's Face Sheet reflected a [AGE] year-old male who initially admitted to the facility on [DATE]. Resident #4 had relevant diagnoses of Parkinson's Disease (progressive neurodegenerative disorder that affects movement, balance, and coordination) with dyskinesia (involuntary, uncontrolled movements), with fluctuations; Alzheimer's Disease (progressive neurodegenerative disorder that affects memory, thinking, and behavior); unspecified dementia (condition in which a person loses the ability to think, remember, learn, make decisions, and solve problems), unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety; cerebral infarction (condition where blood flow to the brain is interrupted, causing brain tissue to die; also known as an ischemic stroke); depression; anxiety disorder; insomnia; dizziness and giddiness; other reduced mobility; Type 2 Diabetes Mellitus with diabetic nephropathy (disease that occurs when the body does not respond properly to insulin leading to high blood sugar levels); unsteadiness on feet. Record Review of Resident #4's Quarterly MDS, dated [DATE], reflected a BIMS score of 12 indicating moderate cognitive impairment. Resident #4's functional limitations in range of motion were listed as impairment for lower extremities on both sides of the body. Resident #4 was noted to use a manual wheelchair for mobility. Resident #4 was noted to need substantial/maximal assistance for self-care categories of oral hygiene, toileting, shower/bathing, upper and lower body dressing, putting on/taking off footwear, and personal hygiene. Resident #4 was noted to need substantial/maximal assistance in the mobility categories of roll left and right and tub/shower transfer. Resident #4 was reflected to need partial/moderate assistance for sit to lying, lying to sitting on side of the bed, sit to stand, chair/bed-to-chair transfer and toilet transfer. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #4's Care Plan, last updated on 2/05/2025, reflected focus areas of an ADL Self Care Performance Deficit with interventions of encourage the resident to use bell to call for assistance; Bed Mobility, Toilet Use, Transferring all requires Extensive assistance. Resident #4 had a focus area of potential for pressure ulcer development with interventions of educate the resident/family/caregivers as to causes of skin breakdown; including: transfer/positioning requirements; importance of taking care during ambulating/mobility, good nutrition and frequent repositioning, and Low air loss mattress to bed. There was no mention of bed rails/grab bars as a focus area or intervention in the care plan. Observation of Resident #4's room and bed on 2/04/2025 at 11:57 AM revealed grab/mobility bar on the left side of the bed raised, the right side of the bed against the wall; resident was not in the room. Observation on 2/05/2025 at 8:08 AM of Resident #4's room area and bed revealed the resident had been moved to another room; left side grab/mobility bar remained raised and right side of bed against wall; resident was sleeping soundly at time of observation and did not wake to his name being spoken. Resident not able to be interviewed. Record review of Resident #19's Face Sheet reflected a [AGE] year-old male who initially admitted to the facility on [DATE]. Resident #19 had relevant diagnoses of Hemiplegia And Hemiparesis Following Cerebral Infarction Affecting Right Dominant Side (paralysis or severe weakness on one side of the body caused by a stroke), Chronic Obstructive Pulmonary Disease With (Acute) Exacerbation (chronic lung disease that makes it difficult to breathe caused by damage that narrows airways making it harder to move air in and out of the lungs), Acute And Chronic Respiratory Failure With Hypoxia (when lungs are unable to exchange gases properly with blood), Obstructive (condition where urine flow is blocked within the urinary tract, causing urine to back up) And Reflux (where urine flows backwards from the bladder into the ureters typically due to a faulty valve mechanism) Uropathy (conditions that can potentially damage the kidneys), Need For Assistance With Personal Care, Cognitive Communication Deficit, Unspecified Lack Of Coordination, Other Reduced Mobility, Occlusion And Stenosis Of Unspecified Carotid Artery (narrowing or complete blockage of blood flow in one of the carotid arteries in the neck), Acute Kidney Failure, Unsteadiness On Feet, History Of Falling, Weakness, Right Hand Contracture, Muscle Weakness (Generalized), Other Lack Of Coordination. Record review of Resident #19's Quarterly MDS, dated [DATE], reflected a BIMS score of 12, which indicated a moderate cognitive impairment. The Quarterly MDS also showed that Resident #19 had impairment to bilateral lower body and too the right side of the upper body. Resident #19 was noted to have utilized a motorized wheelchair for mobility; required substantial/maximal assistance for oral hygiene, toileting hygiene, showering/bathing, upper and lower body dressing, putting on/taking off footwear, personal hygiene, sit to lying, rolling right and left, tub/shower/toiler transfers, lying to sitting on side of bed, sit to stand, and chair/bed-to-chair transfers. Observation on 2/04/2025 at 3:04 PM of Resident #19 room area and bed revealed that the bed had a floor and ceiling tension mounted grab/transfer bar next to the left-hand side of the bed with the right-hand side of the bed against the wall. The resident was not in the room at the time. Observation on 2/05/2025 at 8:10 AM of Resident #19's room area and bed revealed the grab/transfer bar in the same location. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 2/05/2024 at 1:25 PM with Resident #19 stated that he used the grab/transfer bar during personal care by aides, to help roll and for repositioning while in bed. Record review of Resident #19's Care Plan, last updated on 12/07/2024, reflected that Resident had ADL self-care performance deficit r/t hemiplegia and required interventions of BED MOBILITY: EXTENSIVE assistance X2 Staff, EATING: SUPERVISION and SET-UP assistance, TOILET USE: EXTENSIVE assistance X2 Staff, TRANSFERRING: EXTENSIVE assistance X2 Staff. Resident #19 had limited physical mobility r/t Right Hemiplegia with Right hand contracture with splint to knees and required interventions of NON-WEIGHT BEARING, ACTIVITIES: Invite to activity programs that encourage physical activity, physical mobility, such as exercise group, walking activities to promote mobility, Monitor/document/report PRN any s/sx of immobility: contractures forming or worsening, thrombus formation, skin-breakdown, fall related injury, Provide gentle range of motion as tolerated with daily care The Care Plan had no mention of grab/transfer bar as an intervention or focus for Resident #19. Interview on 2/06/2025 at 12:10 PM with CNA D revealed that if a resident had grab/transfer bars raised on or installed next to their bed, a conversation would happen with the resident about what they used the bars for, then they would have made sure the resident had approval for the bars on the Kardex, an electronic nursing worksheet that shows resident information such as medications, care schedules, and follow-ups based on a resident's care plan, and would have also checked with the charge nurse why the grab/transfer bars were on the resident bed. CNA D stated that the nurses are responsible for updating the care plan that shows in the Kardex they review for resident care information. Interview on 2/06/2025 at 12:11 PM with the DON revealed that usually either the DON, an ADON, a MDS nurse, or the admission nurse would have completed the assessments at admission including the bed rail/grab bar assessment for each new or returning resident and if the resident were assessed to be safe using grab/transfer bars then there would be a need to obtain signed consent or notify the resident's responsible party for verbal consent. The use of the grab/transfer bars would be documented in the resident's care plan. If a staff member sees a resident with a bed that had grab/transfer bars on it that was not care planned, the care plan should be updated by either the MDS nurse or done by the staff member who had possibly completed the assessment; the care plan may also be updated by an ADON or DON based on who is available. The DON also stated that if a resident were assessed to not be safe using grab/transfer bars and has the grab/transfer bars on the bed then nursing should have picked up on that during the multiple daily rounds. The DON stated that if a resident were not assessed as safe, there were no consent, and the grab/transfer bar use was not in care plan there could be a risk to the resident that would be considered small, a minor risk to injury, but the grab/transfer bars should not be on the bed as the resident assessment said they were not safe. When asked about the lack of care planning of the grab/transfer bar for Resident #4 and Resident #19, The DON stated she would have to look into the records of the residents to see what happened and would then correct any missing information for the residents. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 2/06/2025 at 12:53 PM with LVN F revealed that resident care plans were updated quarterly and annually by the MDS nurses. The MDS nurses were to make sure all resident triggers were documented along with all diagnoses, high risk medications, and equipment/items used such as grab/transfer bars. LVN F stated that for grab/transfer bars the process included the safety assessment, obtaining a consent signature or documenting verbal consent from a responsible party, and documenting in the care plan why the grab/transfer bars were needed. LVN F stated if a staff member noticed there were grab/transfer bars on a resident bed, that staff member should make sure all documentation was up to date and if not to bring it up in the weekly IDT meeting. LVN F stated that if a staff member asked a nurse why a resident had grad/transfer bars on their bed the nurse would go to the resident's chart and look for the care plan item to provide the information. Record Review of the facility's Care Plans, Comprehensive Person-Centered, 2001 MED-PASS, Inc. (Revised January 2025), policy statement was A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. The policy interpretation and implementation stated: 1. The interdisciplinary team (IDT), in conjunction with the resident and his/her family or legal representative, develops and implements a comprehensive, person-centered care plan for each resident . 3. The care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment. 7. The comprehensive, person-centered care plan: a. includes measurable objectives and timeframes; . 9. Care plan interventions are chosen only after data gathering, proper sequencing of events, careful consideration of the relationship between the resident's problem areas and their causes, and relevant clinical decision making. 10. When possible, interventions address the underlying source(s) of the problem area(s), not just symptoms or triggers. 11. Assessments of residents are ongoing and care plans are revised as information about the residents and the residents' conditions change. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record Review of the facility's Proper Use of Side Rails policy states the purpose is To ensure the safe use of side rails as resident mobility aids and to prohibit the use of side rails as restraints unless necessary to treat a resident's medical symptoms. Relevant sections include: Definition: Physical restraints are defined by the Centers for Medicare and Medicaid Services (CMS) as any manual method or physical or mechanical device, material, or equipment attached or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body. (Note: The definition of restraints is based on the functional status of the resident and not on the device, therefore any device that has the effect on the resident of restricting freedom of movement or normal access to one's body could be considered a restraint.) General Guidelines: 1. Side rails are considered a restraint when they are used to limit the resident's freedom of movement (prevent the resident from leaving his/her bed). (Note: the side rails may have the effect of restraining one individual but not another, depending on the individual resident's condition and circumstances. 2. Side rails are only permissible if they are used to treat a resident's medical symptoms and/or to assist with mobility and transfer of residents. 3. Upon admission, readmission, with routine quarterly or significant change MDS and PRN, therapy/designee will complete the Side Rail Utilization Assessment, or equivalent form to determine the resident's symptoms, risk of entrapment and rationales for using side rails prior to implementation. When used for mobility or transfer, the assessment will include a review of the resident's: (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	a. Bed mobility; b. Ability to change positions, transfer to side of bed and from bed or chair, and to stand and toilet; c. Risk of entrapment from the use of side rails . 4. Consent for use of side rail will be obtained from the resident or legal representative, after presenting potential benefits and risks. 5. The resident's care plan will reflect the use of side rails and updated as necessary . 7. Least Restrictive devices will be reviewed and recommendations if indicated will be attempted prior to use of siderails 8. Once least restrictive alternatives to bed rails have been determined to not meet the resident's needs, if a bed rail is necessary, the resident assessment should be considered in determining proper side rail placement.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48520 Based on observation, interview, and record review, the facility failed to ensure residents fed by enteral means received the appropriate treatment and services to prevent complications for 1 (Resident #81) of 4 residents reviewed for enteral nutrition in that: 1.LVN B failed to obtain physician orders for water to flush Resident #81's G-tube before medication administration and after medication administration via the G-tube. 2. LVN B failed to hold tube feeding for 30 minutes after medication administration for Resident #81 per facility policy. 3. LVN B pushed all medication and water with a syringe and plunger instead of using gravity gentle flow (this is a method used by attaching a feeding syringe without the plunger to allow water, medications and food to enter the stomach vis G-tube gently without force of pushing) to administer medications and water via G-tube for Resident #81. These deficiency practices could affect residents who receive tube feedings by not receiving the appropriate nutrition/ hydration and causing complications. The findings included: Review of Resident #81's face sheet dated 02/06/25 revealed a [AGE] year-old female who was admitted to the facility on [DATE]. Her diagnoses included sequelae of cerebral infarction (this is a condition of depression and anxiety after a stroke), difficulty speaking after stroke, difficulty swallowing, and gastrostomy malfunction. Review of Resident #81's admission MDS assessment dated [DATE], revealed the resident's BIMS score was 0, indicating she was unable to be assessed. The MDS Assessment reflected Resident #81 was usually unable to be understood by others. Further review revealed Resident #81 was dependent on staff for all ADLs and required a feeding tube to obtain 51 % or more nutrition. MDS reflected Resident #81 was dependent on staff for all upper and lower bed mobility including turning and repositioning in bed. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #81's Care plan initiated 12/04/24 revealed Resident #81 had required a feeding tube due to dysphagia (difficulty swallowing). The goal was for Resident #81 to remain free of side effects or complications related to tube feeding through the review date. The interventions included; The resident needs the HOB elevated 30-45 degrees during and thirty minutes after tube feed, Check for tube placement and gastric contents/residual volume per facility protocol and record, Observe/document/report as needed any s/sx of: Aspiration- fever, SOB , Tube dislodged, Infection at tube site, Self-extubating (pulling out g-tube), Tube dysfunction or malfunction, Abnormal breath/lung sounds, Abnormal lab values, Abdominal pain, distension, tenderness, Constipation or fecal impaction, Diarrhea, Nausea/vomiting, Dehydration, Provide local care to G-Tube site as ordered and monitor for s/sx of infection, Registered Dietician to evaluate quarterly and PRN. Monitor caloric intake, estimate needs. Make recommendations for changes to tube feeding as needed, Speech therapist evaluation and treatment as ordered. Review of Resident #81's order summary for February 2025 reflected the following: - Gabapentin Oral Capsule (Gabapentin) Give 100 mg via G-Tube three times a day related to unspecified sequelae of cerebral infarction - Docusate Sodium Oral Tablet 100 MG (Docusate Sodium) Give 1 tablet via G-Tube two times a day for Constipation - Hydrocodone-Acetaminophen Tablet 7.5-325 MG Give 1 tablet by mouth every 6 hours for Pain Crush and administer via g-tube. - Enteral Feed Order two times a day Enteral: Enteral Nutrition [brand name] 1.5 at 65 ml per hour for (20) hours via pump. Start infusion at 2pm and continue until 10 am for a total of 20 hours. Set [brand name] pump water flushes at 150 ml every 4 hours. - Enteral Feed Order every shift Enteral: Crush or open capsules and dilute each medication with 5 to 10 ml of water if indicated. Observation on 02/04/25 at 2:35 PM revealed LVN B picked a feeding syringe with plunger attached and drew 30 cc of water into the feeding syringe attached it to Resident #81's G-tube and she pushed the 30 cc of water into the G-tube to flush Resident #81's G-tube before medication administered. She then unattached the feeding syringe and drew up one of the medications into the feeding syringe and re attached it to Resident #81's G-tube and pushed the medication. She removed the feeding syringe from the G-tube and drew up 10 cc of water into the feeding syringe and reattached it back to Resident # 81's G-tube and pushed the 10 cc of water into the G-tube. LVN B continued to attach and reattach and push all three medications and the 10 cc of water in between the medication and another 30 cc of water after medication administration via the G-tube of Resident #81. LVN B did not use the gravity gentle flow to administer medications and water via G-tube for Resident #81. LVN B attached the feeding right after medication administration. LVN B did not hold tube feeding for 30 minutes after medication administration. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 02/04/25 at 2:55 PM, LVN B stated she was a travel nurse and that she had been trained to use the syringe and plunger attached to help push the medication and water inside the G-tube. She stated this is how she had always done it. LVN B stated the ADON had given her a G-tube facility check off list this afternoon prior to her administering Resident #81's afternoon medications and restarting the feeding. LVN B stated she thought she saw the orders for water flush of 30 cc before medication and 30 cc after medication but when she was asked to show surveyor the order she stated I only see the 5-10cc. LVN B stated she would not be coming back to the facility, and she would call in the following day because she did not feel well prepared to have been watched. LVN B stated she was a travel nurse and only came to the facility occasionally, she had not been given any G-tube in-services. In an interview with ADON on 02/05/25 at 08:55 AM, ADON stated LVN B was an agency nurse, and she had been in serviced before working on the floor about many things including G-tube and infection control. She stated LVN B had verbalized understanding and the ADON had gone over G-tube Medication Administration-Skills assessment before she worked with the residents. ADON stated LVN B should not have used the plunger to push medication and water into the G-tube and should have let it free flow by gravity. ADON stated I was taught Never to push as it can damage the bulb of the G-tube. The ADON stated the expectations for all nurses, was that if there were no orders to do something to reach out to the NP and get orders. The ADON stated she may have been nervous and forgot because she was being watched. The ADON stated the expectation was that all staff including agency staff follow the G-tube medication administration and infection control policy. In an interview with the NP on 02/05/25 at 08:39 AM she stated with the G-tube you mainly push air when checking for placement by pushing 10 cc of air and when checking for residual and returning the residual. She stated you could push a small amount of water as needed when there was a clog as G-tubes tend to become clogged easily. She stated all G-tube should have water flush orders and she would look into the resident's order to make sure it was ordered. In an interview with the DON on 02/05/25 at 09:12 AM, it was revealed that LVN B's competencies were done by the agency she worked for, and it was the agency's responsibility to verify them before employment. The DON stated, it is not fair for you [surveyor] to write deficiency practice of G-tube when our own nurses do a great job, she [LVN B] is agency. The DON stated that the ADON went over EBP, G-tube, and medication safety. She was agency, she stated LVN B froze up because she was nervous. The DON stated ADON went over EBP, she (LVN B) was educated before she did any procedure, and she said that she was ready. The DON stated there was nothing LVN B couldn't do skill wise as a nurse. The DON stated the expectation was to follow EBP protocol and to follow all infection control. The DON stated LVN B did a lot of things wrong and she was pulled off the floor and sent home. Record review order summary for Resident #81 on 02/05/25 at 12:37 PM reflected Enteral Feed Order every shift Enteral: Flush feeding tube with 30 to 60 ml of water before and after each medication administration ordered by NP. Active 02/05/2025. Record review of facility policy titled Enteral nutrition revised 2/13/2007 reflected, We will provide nutritionally complete enteral or parenteral feedings as ordered by the physician for the nourishment of residents who are unable to eat by mouth. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of facility policy titled Administering Medication through an Enteral Tube revision date July 5, 2019, reflected .read in part . Verify that there is a physician's medication order for this procedure, restarted at least 30 minutes after medication administration as indicated by the Physician 9.Consult the physician if there are any questions regarding compatibility, or if going this time period without feedings may compromise the resident 13.When correct tube placement and acceptable GRV have been verified, flush tubing with 15-30 mL water (or prescribed amount) Reattach syringe (without plunger) to the end of the tubing. 18. Administer medication by gravity flow. a. Pour diluted medication into the barrel of the syringe while holding the tubing slightly above the level of insertion. b. Open the clamp and deliver medication slowly. c. Clamp tubing (or begin flush) before the tubing drains completely. 19. If administering more than one medication, flush with 15 mL (or prescribed amount) water between medications. 20. When the last of the medication begins to drain from the tubing, flush the tubing with 15 mL of tap water (or prescribed amount .

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48122 Based on observations, interviews, and record review the facility failed to assess the risks and benefits of bed rails and grab bars with the resident or resident representative or obtain informed consent prior to installation for one (Resident #4) of four resident rooms observed and reviewed for bed rails/enabler bars. The facility failed to have evidence of informed consent and assessment of the resident for risk of entrapment for bed rails or grab bars for Resident #4. This failure could place residents who used bed rails/grab bars at risk of the resident not being assessed for bed rails or grab bars, resident/responsible party not being aware of the risks, and informed consent not being obtained from the resident or responsible party. Findings included: Record Review of Resident #4's Face Sheet reflected a [AGE] year-old male who initially admitted to the facility on [DATE]. Resident #4 had relevant diagnoses of Parkinson's Disease (progressive neurodegenerative disorder that affects movement, balance, and coordination) with dyskinesia (involuntary, uncontrolled movements), with fluctuations; Alzheimer's Disease (progressive neurodegenerative disorder that affects memory, thinking, and behavior); unspecified dementia (condition in which a person loses the ability to think, remember, learn, make decisions, and solve problems), unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety; cerebral infarction (condition where blood flow to the brain is interrupted, causing brain tissue to die; also known as an ischemic stroke); depression; anxiety disorder; insomnia; dizziness and giddiness; other reduced mobility; Type 2 Diabetes Mellitus with diabetic nephropathy (disease that occurs when the body does not respond properly to insulin leading to high blood sugar levels); unsteadiness on feet. Record Review of Resident #4's Quarterly MDS, dated [DATE], reflected a BIMS score of 12 indicating moderate cognitive impairment. Resident #4's functional limitations in range of motion were listed as impairment for lower extremities on both sides of the body. Resident #4 was noted to use a manual wheelchair for mobility. Resident #4 was noted to need substantial/maximal assistance for self-care categories of oral hygiene, toileting, shower/bathing, upper and lower body dressing, putting on/taking off footwear, and personal hygiene. Resident #4 was noted to need substantial/maximal assistance in the mobility categories of roll left and right and tub/shower transfer. Resident #4 was reflected to need partial/moderate assistance for sit to lying, lying to sitting on side of the bed, sit to stand, chair/bed-to-chair transfer and toilet transfer. (continued on next page)

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	676209	A. Building B. Wing	02/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Decatur Medical Lodge	701 W Bennett Rd Decatur, TX 76234

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #4's Care Plan, last updated on 2/05/2025, reflected focus areas of an ADL Self Care Performance Deficit with interventions of encourage the resident to use bell to call for assistance; Bed Mobility, Toilet Use, Transferring all requires Extensive assistance. Resident #4 had a focus area of potential for pressure ulcer development with interventions of educate the resident/family/caregivers as to causes of skin breakdown; including: transfer/positioning requirements; importance of taking care during ambulating/mobility, good nutrition and frequent repositioning, and Low air loss mattress to bed. Resident #4 had a focus area of Skin Tear/potential for skin tear with interventions of identify potential causative factors and eliminate/resolve when possible, and use caution during transfers and bed mobility to prevent striking arms, legs, and hands against any sharp or hard surface. Review of Medical Record of Resident #4 revealed no signed bed rail/grab bar consent form signed by the resident or resident's responsible party or noted to have verbal permission for the enabler bars. Observation of Resident #4's room and bed on 2/04/2025 at 11:57 AM revealed grab/mobility bar on the left side of the bed raised, the right side of the bed against the wall; resident was not in the room. Observation on 2/05/2025 at 8:08 AM of Resident #4's room area and bed revealed Resident #4 had been moved to another room and the left side grab/mobility bar remained raised and right side of bed against wall; resident was sleeping soundly at time of observation and did not wake to his name being spoken. Resident not able to be interviewed. Interview on 2/06/2025 at 12:10 PM with CNA D revealed that if a resident had grab/transfer bars raised on or installed next to their bed, a conversation would happen with the resident about what they used the bars for, then they would have made sure the resident had approval for the bars on the Kardex, an electronic nursing worksheet that shows resident information such as medications, care schedules, and follow-ups based on a resident's care plan, and would have also checked with the charge nurse why the grab/transfer bars were on the resident bed. Interview on 2/06/2025 at 12:20 PM with the LVN E revealed that it was important to check a resident's chart for orders for bed rails/grab/transfer bars because if there was no order then the resident should not have them on or next to their bed. LVN E stated grab/transfer bars were only used for resident positioning, bed rails were not used as they would have been considered a restraint. LVN E stated that if a resident were assessed not appropriate for grab/transfer bars or did not have consent and the resident had a bed with grab bars on it, the grab bars should have been reported in the TELS system for maintenance to remove them as well as calling maintenance to request the removal. LVN E stated as part of the process conferring with other staff on why the grab/transfer bars were on the bed would also be conducted to see if the resident needed new evaluations and to obtain consent. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 2/06/2025 at 12:41 PM with the DON revealed that usually either the DON, an ADON, a MDS nurse, or the admission nurse would have completed the assessments at admission including the bed rail/grab bar assessment and obtaining consent for each new or returning resident and if the resident were assessed to be safe using grab/transfer bars then there would be a need to obtain signed consent or notify the resident's responsible party for verbal consent. The use of the grab/transfer bars would be documented in the resident's care plan. If a staff member sees a resident with a bed that had grab/transfer bars on it that was not care planned, the care plan should be updated by either the MDS nurse or done by the staff member who had possibly completed the assessment; the care plan may also be updated by an ADON or DON based on who is available after verifying the consent was obtained. The DON also stated that if a resident were assessed to not be safe using grab/transfer bars and has the grab/transfer bars on the bed then nursing should have picked up on that during the multiple daily rounds. The DON stated that if a resident were not assessed as safe, there were no consent, and the grab/transfer bar use was not in care plan there could be a risk to the resident that would be considered small, a minor risk to injury, but the grab/transfer bars should not be on the bed as the resident assessment said they were not safe. When asked about Resident #4 not having informed consent, the DON stated she would have to look into that and would address any missing items related to bed tails/grab bars immediately. Interview on 2/06/2025 at 12:53 PM with LVN F revealed that resident care plans were updated quarterly and annually by the MDS nurses. The MDS nurses were to make sure all resident triggers were documented along with all diagnoses, high risk medications, and equipment/items used such as grab/transfer bars. LVN F stated that for grab/transfer bars the process included the safety assessment, obtaining a consent signature or documenting verbal consent from a responsible party, and documenting in the care plan why the grab/transfer bars were needed. LVN F stated if a staff member noticed there were grab/transfer bars on a resident bed, that staff member should make sure all documentation was up to date and if not to bring it up in the weekly IDT meeting. LVN F stated that if a staff member asked a nurse why a resident had grad/transfer bars on their bed the nurse would go to the resident's chart and look for the care plan item to provide the information. Record Review of the facility's Care Plans, Comprehensive Person-Centered, 2001 MED-PASS, Inc. (Revised January 2025), policy statement was A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. The policy interpretation and implementation stated: 1. The interdisciplinary team (IDT), in conjunction with the resident and his/her family or legal representative, develops and implements a comprehensive, person-centered care plan for each resident . 3. The care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment. 7. The comprehensive, person-centered care plan: a. includes measurable objectives and timeframes; . (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	9. Care plan interventions are chosen only after data gathering, proper sequencing of events, careful consideration of the relationship between the resident's problem areas and their causes, and relevant clinical decision making. 10. When possible, interventions address the underlying source(s) of the problem area(s), not just symptoms or triggers. 11. Assessments of residents are ongoing and care plans are revised as information about the residents and the residents' conditions change. Record Review of the facility's Proper Use of Side Rails policy states the purpose is To ensure the safe use of side rails as resident mobility aids and to prohibit the use of side rails as restraints unless necessary to treat a resident's medical symptoms. Relevant sections include: Definition: Physical restraints are defined by the Centers for Medicare and Medicaid Services (CMS) as any manual method or physical or mechanical device, material, or equipment attached or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body. (Note: The definition of restraints is based on the functional status of the resident and not on the device, therefore any device that has the effect on the resident of restricting freedom of movement or normal access to one's body could be considered a restraint.) General Guidelines: 1. Side rails are considered a restraint when they are used to limit the resident's freedom of movement (prevent the resident from leaving his/her bed). (Note: the side rails may have the effect of restraining one (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	individual but not another, depending on the individual resident's condition and circumstances. 2. Side rails are only permissible if they are used to treat a resident's medical symptoms and/or to assist with mobility and transfer of residents. 3. Upon admission, readmission, with routine quarterly or significant change MDS and PRN, therapy/designee will complete the Side Rail Utilization Assessment, or equivalent form to determine the resident's symptoms, risk of entrapment and rationales for using side rails prior to implementation. When used for mobility or transfer, the assessment will include a review of the resident's: a. Bed mobility; b. Ability to change positions, transfer to side of bed and from bed or chair, and to stand and toilet; c. Risk of entrapment from the use of side rails . 4. Consent for use of side rail will be obtained from the resident or legal representative, after presenting potential benefits and risks. 5. The resident's care plan will reflect the use of side rails and updated as necessary . 7. Least Restrictive devices will be reviewed and recommendations if indicated will be attempted prior to use of siderails 8. Once least restrictive alternatives to bed rails have been determined to not meet the resident's needs, if a bed rail is necessary, the resident assessment should be considered in determining proper side rail placement.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48520 Based on observation, interview, and record review the facility failed to ensure all drugs and biologicals were stored in locked compartments for one of eight medication carts (Nurse med cart #1) in that: The facility's nurse medication cart (Nurse med cart #1) was left unlocked, unattended, and out of LVN B's view outside room [ROOM NUMBER] on 02/04/25. This failure placed residents at risk of their medications being stolen or misused and health complications related to accidental ingestion of drugs and/or biologicals, including hospitalization and death, Findings included: During an observation in 300 hallways on 02/04/25 from 2:39 PM to 2:50 PM, the Nurse medication cart (Med cart #1) was unlocked, with drawers able to be opened. There were insulins (medications that can lower blood sugars), prescription medications pills, over the counter medications, and breathing treatments inhalers containing albuterol, (a medication that causes nervousness, shakiness, throat/nasal irritation, muscle aches, and trembling). Three staff members were observed walking past the unlocked and unattended Nurse Med cart #1 at 2:40 PM, 2:48 PM and at 2:50 PM. During an interview on 02/04/25 at 2:55 PM, LVN B stated she forgot to lock the nurse med cart#1 when it was unattended and out of her view. She stated, I forgot to lock it. LVN B stated the medication carts should never be left unlocked when unattended because anyone could walk up and get into the medications on the cart. LVN B stated the expectation was the medication cart was always locked when no one was using it. In an interview with ADON on 02/05/25 at 08:55 AM, ADON stated LVN B was an agency nurse, and she had been in serviced before working on the floor about many things including medication safety and storage of medication. The ADON stated LVN B verbalized understanding. The ADON stated the medication carts should always be locked to decrease the risk of residents, especially residents with dementia, getting into the cart and accessing medications or treatment items. During an interview on 02/05/25 at 09:12AM, the DON stated the expectation was all the medication carts were locked when not in use and unattended to decrease the risk of residents and unauthorized persons getting into the cart and accessing medications. Record review of the facility's policy titled Storage of Medications, with a revision date of April 2019, reflected, in part, The facility stores all drugs and biologicals in a safe, secure, and orderly manner ., Unlocked medication carts are not left unattended.

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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** 48520 51047 Based on observation, interview and record review, the facility failed to maintain an infection prevention and control measure designed to provide a safe, sanitary environment to help prevent the development and transmission of communicable diseases and infections for 2 of 4 residents (Resident #3 and Resident #81) reviewed for infection control in that: 1.CNA A failed to put on Personal Protective Equipment (PPE) while providing perineal care to Resident #3, who is on EBP. 2. LVN B failed to put on PPE while administering medications and tube feeding via G-tube for Resident #81 who was on EBP for G-tube (a g-tube is a feeding tube that is placed through the abdominal cavity area into the stomach for nutritional purpose and medication for individual who have difficulty swallowing). These deficient practices could place residents and nursing staff at risk of transmission of communicable diseases and infections. Findings include: 1.Review of Resident #3 face sheet, dated 2/4/2025, revealed that Resident #3 is a [AGE] year-old male admitted on [DATE] with diagnosis of Alzheimer's disease, hemiplegia (paralysis that affects one side of body) following a stroke, protein-calorie malnutrition. Review of Resident #3 care plan, dated 12/3/2024, revealed that Resident #3 is at increased risk of multidrug-resistant organism (MDRO) due to having a foley catheter. His care plan stated that EBP care should be maintained for Resident #3 until his foley catheter is no longer needed. Review of Resident #3 order, dated 4/2/2024, revealed that Resident #3 is on EBP for urinary catheter and gown & gloves should be worn during high- contact care. Observation on 2/4/2025 at 09:49 AM, CNA A answered Resident #3 call light. CNA A performed hand hygiene before entering Resident #3 room. Resident #3 door had EBP sign posted. Resident #3 asked CNA to change his soiled brief because he had a bowel movement. CNA A did not put on gown and proceeded to provide perineal care for Resident #3. CNA used gloves, and hand hygiene was performed by CNA A while she provided care for Resident #3. Resident #3 has a foley catheter. In an interview on 2/4/2025 at 10:00 AM, CNA stated that she has worked at the facility for 4 years. She admitted that after she provided care for Resident #3, she realized that he is on EBP, and she forgot to put on a gown. She stated she understands during high-contact care; she should put on gown and gloves. She stated the risk of not donning PPE would be the spread of infection. She has had in-service on EBP last month provided by the DON. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 02/06/25 at 09:31 AM with DON, she stated CNA A came to her on 2/4/2025 after she provided care for Resident #3 without putting on PPE. DON provided 1:1 in-service to CNA A on the same day. The DON stated that staff should put on PPE when providing care for wounds, indwelling devices, port access, IV line, any high-contact care. She also stated that staff is encouraged to ask any of the facility nurses or the ADON and DON if they are unsure about putting on PPE. She stated that the risk of staff not following the precaution is the spread of infection. She provides in-service on infection control quarterly as required, and any time an issue or concern arises. She stated that everyone was in charge of reminding each other to practice infection control. The ADON and DON are responsible for making sure staff follow infection control protocol. 2. Review of Resident #81's face sheet dated 02/06/25 revealed a [AGE] year-old female who was admitted to the facility on [DATE]. Her diagnoses included sequelae of cerebral infarction (this is a condition of depression and anxiety after a stroke), difficulty speaking after stroke, difficulty swallowing, and gastrostomy malfunction (this is a feeding tube that is placed through the abdominal cavity area into the stomach for nutritional purpose and medication for individual who have a difficulty swallowing). Review of Resident #81's admission MDS assessment dated [DATE], revealed the resident's BIMS score was 0, indicating she was unable to be assessed. The MDS Assessment reflected Resident #81 was usually unable to be understood by others. Further review revealed Resident #81 was dependent on staff for all ADLs and required a feeding tube to obtain 51 % or more nutrition. MDS reflected Resident #81 was dependent on staff for all upper and lower bed mobility including turning and repositioning in bed. Review of Resident #81's care plan initiated 10/02/24, revealed Resident #81 was on EBP related to patients that were indicated for the following residents who are: Known to be colonized or infected with a multidrug-resistant organism. (MDRO) when Contact Precautions do not otherwise apply at increased risk of MDRO acquisition - G-Tube. The goal was EBP care should be maintained for Resident #81's entire stay or until wounds have healed or indwelling medical device is no longer needed. The interventions included making sure PPE was available immediately outside the room, provide patient standard precautions using gowns and gloves during dressing, bathing, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device care or use and wound care. Review of Resident #81's February physician orders on 02/04/25 reflected: -Gabapentin Oral Capsule (Gabapentin) Give 100 mg via G-Tube three times a day related to unspecified sequelae of cerebral infarction. - Nursing intervention: implement and maintain enhanced barrier precautions when performing high contact care activities. Resident is on EBP for G-tube. Every shift for EBP. Observation on 02/04/25 at 2:35 PM revealed LVN B did not put on her gown for EBP while administering medications to Resident #81 via G-tube. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview with LVN B on 02/04/25 at 2:55 PM, she stated she was nervous being watched, that was why she forgot to wear the gown for enhance barrier precaution. She stated the expectation was to follow infection control precautions of hand hygiene and [NAME] PPE for residents on EBP. She stated the risk to the resident was contamination of the medication she took with her bare hands, and she also risked exposing the resident to infection for not wearing PPE for EBP. In an interview with ADON on 02/05/25 at 08:55 AM, ADON stated LVN B was an agency nurse, and she had been in- serviced before working on the floor about many things including G-tube and infection control. She stated LVN B had verbalized understanding and the ADON had gone over G-tube Medication Administration-Skills assessment before she worked with the residents. The ADON stated the expectation was that all staff including agency staff follow the infection control policy. In an interview with the DON on 02/05/25 at 09:12 AM, it was revealed that LVN B's competencies were done by the agency, and it was the agency's responsibility to verify them before employment. She stated LVN B froze up because she was nervous. DON stated that the ADON went over EBP, she (LVN B) was educated before she did any procedure until she confirmed she was ready to perform them. DON stated there was nothing they felt LVN B could not have done competent wise as a nurse even when she had worked in the past. DON stated its expectation was to follow EBP protocol and to follow all infection control. DON stated LVN B did a lot of things wrong and she was pulled off the floor and sent home. Record review of facility's Infection Prevention and Control Program, dated August 2016, revealed that those with potential direct exposure to blood or body fluids are trained in and required to use appropriate precautions and personal protective equipment. Record review of facility's Enhanced Barrier Precaution policy, dated March 2024, revealed that one example of EBP resident include those with indwelling medical devices - include central lines, urinary catheters, feeding tubes, and tracheostomies/vents. EBP policy also stated that EBP are indicated during dressing, bathing/showering in a shared common shower room, transferring, providing hygiene, changing briefs or assisting with toileting . The policy also stated that gowns and gloves are used during high-contact sessions.