STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676221	A. Building B. Wing	11/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Heritage Park of Katy Nursing and Rehabilitation	6001 George Bush Dr Katy, TX 77493

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46678 Based on interview and record review, the facility failed to ensure that Pre-Admission Screening and Resident Review (PASRR) Level 1 Residents with a positive trigger for mental illness were provided with a PASRR Level II assessment for 1 (Resident #79) of 5 residents reviewed for mental illness. The facility did not correctly identify Resident #79 as having mental illness in her PASRR Level 1 Screening. This failure could place five residents with psychiatric diagnoses to trigger a positive PASRR Level I evaluation at risk for not receiving a PASRR Level II screening and receiving needed care and services to meet their needs. Findings included: Record review of Resident #79's face sheet dated 11/5/24, revealed a [AGE] year-old female admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses of rhabdomyolysis (a breakdown of muscle tissue that releases a damaging protein into the blood), unspecified psychosis, major depressive disorder (a mental health disorder characterized by persistently depressed mood or loss of interest in activities), and unspecified mood disorder. Record review of the physician orders dated 10/4/24 revealed Resident #79 was prescribed Remeron 15 mg once daily for depression. Record review of quarterly MDS dated [DATE] indicated Resident #79 had a BIMS of 3, active diagnoses of depression and psychotic disorder and was taking an antidepressant. Record review of Resident #79's care plan dated 11/5/24 indicated Resident #79 had potential psychosocial well-being problems related to loss of independence, loss of home, depression, and little interest in doing favorite activities. Interventions included: assist, encourage, and support the resident to set realistic goals and encourage participation from resident who depends on others to make own decisions. Further review of care plan indicated Resident #79 was presented with sadness and feelings of grief related to losing her sister. Interventions included: assisting resident, family, and caregivers to identify strengths and positive coping skills; monitor, document, and report to MD PRN acute episode or feelings of sadness, signs and symptoms of depression, anxiety, and sad mood as per facility behavior monitoring protocols. (continued on next page)

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

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the PASRR level 1 screening dated 11/1/22 indicated Resident #79 was negative for mental illness, intellectual disability, and developmental disability. Interview with the MDS Coordinator on 11/7/24 at 12:38 pm, he said he had worked at the facility for 2 and half years. The MDS Coordinator said he was responsible for conducting the PASRR screenings. He said Resident #79's PASRR was missed because the hospital she came from had marked no under the mental illness section. The MDS Coordinator said he did not think there was a risk to the resident because he never had a patient accept the mental illness services. He said residents would have to leave facility, and it would cost them to get a psych evaluation because that department does not offer transportation. The MDS Coordinator said the facility offered psych services there. Record review of the Resident Assessment-Coordination with PASRR Program policy dated 3/1/24 read in part . all applicants to this facility will be screened for serious mental disorders or intellectual disabilities and related conditions in accordance with the state's Medicaid rules for screening .

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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** 45581 Based on interviews and records reviews, the facility failed to develop and implement a baseline care plan within 48 hours for each resident that included the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality of care for 1 (Resident #26) of 31 residents reviewed for base-line care plans. The facility failed to ensure (Resident #26) had a baseline care plan developed within 48-hours after admission with goals based on admission orders and interventions, PASRR recommendations, Physician's orders, therapy services, dietary orders, and social services. This failure could place newly admitted residents at risks of not receiving the proper care and continuity of services. Findings included: Record review of Resident #26's Face Sheet (undated) revealed, an [AGE] year-old female who admitted to the facility on [DATE] and with diagnoses which included: unspecified dementia, unspecified severity, with other behavioral, Alzheimer's disease (a brain disorder that gradually worsens over time, causing memory loss, confusion, and behavior changes), unspecified, chronic kidney disease, stage 2 (mild), and generalized anxiety disorder. Record review of Resident #26's MDS assessment dated [DATE] revealed a BIMS score of 2 indicating she was significantly cognitively impaired. She exhibited wandering behavior 4-6 days per week, required substantial/maximal assistance with shower/bathe self, Lower body dressing, and putting on/taking off footwear. She required Partial/moderate assistance with bed to chair, toilet, tub/shower transfers. Record review of Resident #26's chart did not find a document titled Base Line Care Plan. The document the facility substituted for the Baseline Care Plan dated 10/23/2024 was incomplete. Record review of Resident #26's Initial Nursing Evaluation dated 09/29/2024 read in part .2. Sit to lying: The ability to move from sitting on side of bed to lying flat on the bed. - Admission Performance- 03. Partial/moderate assistance. 3. Lying to sitting on side of bed: The ability to move from lying on the back to sitting on the side of the bed with feet flat on the floor, and with no back support. - Admission Performance- 04. Supervision or touching assistance. 4. Sit to stand: The ability to come to a standing position from sitting in a chair, wheelchair, or on the side of the bed. - Admission Performance- 06. Independent. 5. Chair/bed-to-chair transfer: The ability to transfer to and from a bed to a chair (or wheelchair). - Admission Performance- 04. Supervision or touching assistance. 6. Toilet transfer: The ability to get on and off a toilet or commode. - Admission Performance- 03. Partial/moderate assistance . The Initial Nursing Evaluation did not contain PASRR recommendations, Dietary orders, Physician's orders, or notate whether the resident had therapy services. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 11/06/2024 at 3:24PM with the MDS Coordinator said the facility did not do a Baseline Care Plan, they wrote a Comprehensive Care Plan. He said the Comprehensive Care Plan was done within 72 hours of the resident's admission. Interview on 11/07/2024 at 12:19 PM with the MDS Coordinator said the Baseline Care was done within 48 hours and the Comprehensive Care plan within 21 days. He said there were no exceptions for the time to get them completed. He said yesterday he made a mistake saying 72 hours for the Base Line Care plan. When reviewing Resident #26's Comprehensive Care Plan he said 10/09/2024 was the date listed on the Focus part of the Care Plan. He said 10/09/2024 was not within 48 hours of the resident's admission. He said the Comprehensive Care Plan could not be used as the resident's Base Line Care Plan. He said he had worked at the facility a total of 2.5 years. He was the MDS Coordinator, and he worked Monday through Friday 8 AM- 5 PM. He was familiar with Resident #26. He said he routinely worked on the MDS assessments and assisted the DON with unit managers. He said Base Line Care Plans were supposed to be completed within 48 hours. He said the purpose of the Base Line Care Plan was to communicate the resident's needs to the staff working with that resident. He reviewed the Comprehensive Care Plan and saw Resident #26's ADLS and saw they were dated 10/09/2024. He observed her admitted [DATE]. He said those dates were not within 48 hours of each other. He said the Base Line Care plan may be located somewhere else in the system. After looking in the system he said it did not look like she had her Base Line Care Plan. He continued looking through the resident's online chart and said he found the Base Line Care plan in the Initial Nursing Evaluation- V3 dated 09/29/2024. He said they use the Initial Nursing Evaluation so there were not so many assessments. He said the Initial Nursing Evaluation incorporated all the necessary assessments. Interview on 11/07/2024 at 1:16PM with the MDS Coordinator said the required information on the Initial Nursing Evaluation had information for the care for the resident, how to do the ADLS, their code status, and incontinent status. He said the physician orders were not in the Initial Nursing Evaluation. He showed that the Dietary order was on the Eval. He said if a resident were on therapy, it would be on a Skilled Nursing Note. He said Resident #26 was not in therapy the first couple of days while at the facility. He said therapy services was not on the Initial Nursing Evaluation. He said the social worker did their own evaluation on the resident and was not a part of the Initial Nursing Evaluation. He said if the resident were PASRR positive, they would not know within 48 hours. He said the resident's goals and interventions were not listed on the Initial Nursing Evaluation. When asked what happened today with their version of the Base Line Care Plan missing information, he said he said he would have to talk with the person that helped set up the assessments to determine why the Physician's orders and therapy were not listed on the Initial Nursing Evaluation. He said a month and a half ago he had training on Base line care plans. He said he and the nursing team were responsible for ensuring all information was on the Base Line Care Plan. He said he could not answer the question of risk to residents if information was missing from the Base Line Care Plan or if staff did not follow procedure/policy regarding information on the Base Line Care Plan. When asked if there was missing information from the Base Line Care plan how would staff care for the resident, he responded with staff would not care for them in those areas. He did not answer what could happen to a resident if staff did not follow policy/protocol regarding completing the Base Line Care Plan. He said the nursing team, ADON, DON, Administrator were involved regarding meeting with the family and discussing the plan for the resident. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 11/07/2024 at 1:30 PM with the ADON, she said the Base line care plan was done upon admission. She said it had to be done within 48 hours. She said the MDS nurse, DON or the admitting nurse wrote it. She said the Base Line Care Plan had the resident's code status, initial care plan which included the resident's ADLs, diagnosis, immunizations, TB skin, Braden scale (a tool used to predict the risk of pressure ulcers in patients). She said she was not sure if physician's orders were a part of the Base Line Care plan. She said therapy and dietary services should be on the Base Line Care plan. She said everything you needed to care for the resident was on the Base Line Care plan. She said every resident should have a Base line care plan. She said she had worked at the facility for 2 years and she was the ADON. She said she worked Monday through Friday 8 AM- 5 PM. She said her routine work duties were as staffing coordinator, worked on infection control and as unit manager of the 100 Hall. She said the policy or procedure for the Base Line Care plan was they needed to be complete and done within 48 hours. She said she did not know about Resident #26's Base Line Care plan. She said she did not recall when she last had in-service on Base Line Care plan. She said the ADONs, and the DON were responsible for ensuring policy/procedure was followed that the Base Line Care Plan was complete and had all necessary information. She said the risk to residents when policy/procedure for the Base Line Care Plan was not done or complete was staff potentially miss information pertinent to their care. She said it needed to be complete, so staff knew exactly know how to care for the residents. She said the worst thing that could happen to residents when proper protocols were not practiced was if there were things missing from the Base Line Care Plan then things for the resident could be missed like medications, or diagnosis that were pertinent to their care. Interview on 11/07/2024 at 1:40 PM with the DON she said the Base Line Care Plan was done upon admission and there was a time limit of 48 hours. She said the Base Line Care Plan was generated with the nursing evaluation and when the nurse did their assessment, the information was on that assessment. She said the required information on the Base Line Care Plan was what there on the Initial Nursing Evaluation V3 like the resident's ADLs, vital signs, basic information for the resident and asked if the resident had any issues with medications. She said she was the DON and had worked at the facility since the end of May 2024. She said as the DON she oversaw the education of staff, oversaw the nursing department, oversaw patient care, pharmacy, infection control, nutrition, and incidents and accidents. She said she was familiar with the resident. She said the resident should have a Base Line Care Plan. She said the Initial Nursing Evaluation was the Base Line Care Plan and had all the information it required. She said the Physician's orders were separate from the Initial Nursing Evaluation and was entered by the nurse. She said orders were entered on the patients Medication Administration Record. She said the resident's therapy services were in section B and section M of the Initial Nursing Evaluation V3. She said PASRR recommendations was not on the Initial Nursing Evaluation V3. She said the policy/procedure for Base Line Care Plan was that needed to be done within 48 hours and the assessments on the Initial Nursing Evaluation needed to be done. When asked what happened regarding missing required information, the DON said the Initial Nursing Evaluation was the form the facility used and there was nothing missing from that form. She said she was not sure when she was last trained on Base Line Care Plan. She said she could not answer a hypothetical regarding the risk to residents when staff did not follow policy/protocol and the Base Line Care Plan was incomplete or not done. She said for her, the Base Line Care Plan had all things completed and there was nothing missing. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 11/07/2024 at 1:59 PM with the Administrator he said the Base Line Care Plan was done within 48 hours. He said nursing, any of the nurse managers could do the Base Line Care plan. He said information on the Base Line Care Plan had the resident's demographics, functional abilities, skin, general health, code status, and analyses which were under Initial Nursing Evaluation Sections A- O. He said he had worked at the facility since early [DATE] as Administrator, and he oversaw the operations of the facility. He said he did things like rounds, checked on patients, checked the facility's environment, checked with staff for their plans, established goals for staff, followed up on staff goals, spot checked areas of the facility, and was responsible for the financial part of the facility and ensured the bills were paid. He said he normally worked 6:30 AM- 4:30 PM to 5 PM, Monday- Friday. He said he made it a point to come in on the weekends too. He said he was familiar with the res and said she had the Initial Nursing Eval dated 09/29/2024. He said he was not sure where the PASRR recommendations was. He said he was not familiar with the Initial Nursing Evaluation and did not know where the dietary and therapy services were on there. He said the policy/procedure for Base Line Care Plan was for it to complete and done in 48 hours of the resident's admission. He said he did not complete the evaluation and did not know why there was missing information like PASRR recommendations and therapy services, dietary orders. He said he saw her dietary orders and it was on the Initial Nursing Evaluation. He said there was no risk to the resident when the Base Line Care Plan was incomplete because the information was duplicated elsewhere in the resident's chart. He said it the additional information was not necessarily obtained after the 48 hours of the resident's admission. He said he was ultimately responsible for ensuring policy/procedure was followed. Interview on 11/07/2024 at 2:28 PM- the Administrator, DON and MDS Nurse regarding risk to the residents when the Base Line Care Plan was incomplete and staff did not follow policy/protocol, the Administrator said all other information not included in the Base line Care plan could be found elsewhere. The DON said she was not saying the resident's health or safety could not be affected, she said the Initial Nursing Evaluation was complete and that was their Base Line Care Plan. The MDS Nurse said he was not necessarily saying that resident health and safety was not affected but felt like the initial evaluation had the same information as the Base Line Care Plan. Record review of the facility's Base Line Care Plan policy dated 03/01/2024 read in part . 1. The baseline care plan will: B. Include the minimum healthcare information necessary to properly care for a resident including, but not limited to: vii. Therapy services, if applicable. viii. PASRR recommendation, if applicable. 2. A supervising nurse shall verify within 48 hours that a baseline care plan has been developed. 5. The MDS nurse shall gather information from the admission physical assessment, hospital transfer information, physician orders, and discussion with the resident and resident representative, if applicable. a. Once gathered, initial goals shall be established that reflect the resident's stated goals and objectives. 11. Any identified needs for supervision, behavioral interventions, and assistance with activities of daily living .

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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** 27846 Based on observation, interviews, and record review the facility failed to ensure all drugs and biologicals were stored securely for one (100 Hall Nurse Medication Cart) of four medication carts reviewed for storage of medications. The Nurse Medication Cart for 100 Hall had a torn protective seal on the back of Resident #211's Tramadol HCL 50mg (a narcotic used to treat moderately severe pain) medication blister pill card (a type of medication packaging, with multiple small, sealed compartments that hold individual doses of medication) found in the locked narcotic drawer during review of medication carts. This failure could place all residents at risk of not receiving the therapeutic benefit of medications, adverse reactions to medications, infection, and drug diversion. Findings included: Record review of Resident #211's face sheet undated reflected a [AGE] year-old female first admitted to the facility on [DATE] and readmitted on [DATE]. Her diagnoses included heart failure (the heart is not pumping adequate blood throughout the body), Cellulitis (bacterial infection of the skin), fractured leg, and pain. Record review of Resident #211's care plan dated 07/08/2023 reflected: Focus: Resident #211 had acute and chronic pain related to previous injuries and fractures. Goal: Resident #211 will not have an interruption in normal activities related to pain. Interventions: Administer analgesia (pain) medications as ordered. Record review of Resident #211's quarterly MDS dated [DATE], reflected her BIMS score was 09 which indicated moderated cognitive impairment. Resident #211 required supervision and touch assistance from staff for transfers and showers. She received scheduled pain medication in the last 5 days. Resident #211 was identified as having medically complete conditions. Record review of Resident #211's active physician orders as of 11/01/2024 reflected an order for Tramadol HCL 50mg, two tablet by mouth every 12 hours as needed for chronic pain, start date 05/20/2024. Record review of Resident #211's MAR for 11/01/2024-11/30/2024 reflected Tramadol HCL 50mg Give two tablets every 12 hours as needed for chronic pain. Review with the MAR revealed no administration of Tramadol HCL 50mg. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation and interview on 11/07/2024 at 1:53 PM during a random cart check revealed the narcotic storage of Resident #211's Tramadol HCL 50mg tablet #40 out of 60 tablets in the blister pill card, had a torn protective seal. The nurse assigned to the nurse cart for 100 Hall was LVN Q. LVN Q stated once a blister pack back was torn it was to be given to the DON. The DON would follow up with the pharmacy. The pharmacy would pick up the medication. LVN Q stated the risk of the torn back was possible contamination of the pill. The pill could have been taken out. LVN Q stated she did not know how this could have happened. LVN Q stated the backs were to be checked when the medications were counted. LVN Q stated this did not always happen. In an interview on 11/07/2024 at 2:05 PM the DON stated the staff were informed to check the carts to ensure the carts were clean. The DON stated the staff was to check for damage to the bubble packs. The DON continued and stated the staff was to check for expired medications. The DON stated the ADONs check the medication carts twice a week. The DON stated the risk was the pill could fall out and lead to a drug diversion. The DON stated to help prevent this from occurring in the futured no one could have long nails or [NAME] items near the medications due to the risk of puncture. In a phone interview on 11/07/2024 at 2:10 PM with the facility pharmacist, she stated the bubble packs were not to have torn backs. The backs were to be secured. The pharmacist stated the medication was to be wasted. The pharmacist stated there was risk of contamination and drug diversion. The pharmacist stated it was important the medication was kept secured. In an interview on 11/07/2024 at 3:11 PM with the administrator, he stated the backs should not be torn because the pull could be tampered with. The administrator stated the medications were to be checked during the shift changes. The administrator stated to prevent this again we will educate staff on what to do if the backs were torn. Record review of the facility policy titled Storage of Medications, revision dated 07/2015, read in part: Purpose: The purpose of this procedure is to make sure that medications are stored in a safe, secure, and orderly manner .

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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. 46678 Based on observations, interviews, and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety for 1 of 1 kitchen in that: -Five dented cans were stored with other cans used for resident meals in the dry storage room. -Food items were not sealed and not dated in the dry storage room. These failures could place residents who received meals from the kitchen at risk for food borne illness. Findings included: Observation on 11/5/24 at 9:00 am of the dry storage room revealed the following: -One 111 oz can of tomato paste with a large dent in the middle of the can -One 106 oz can of spaghetti sauce with a large dent at the top of the seam -One 112 oz can of banana pudding with a small dent at the bottom of the seam -One 112 oz can of vanilla pudding with a small dent at the bottom of the seam -One 108 oz can of sweet potatoes in syrup with a large dent in the middle of the can -One 25 lb bag of light brown sugar not sealed and not dated -One 5 lb bag of grits not sealed and not dated Interview with the Dietary Manager on 11/6/24 at 1:30 pm, she said she had worked at the facility since 7/1/24. The Dietary Manger said the dented cans were supposed to be kept in her office. She said all kitchen staff were responsible for dating and sealing food items and were supposed to check for dented cans. The Dietary Manager did not know why these items were missed. She said when food items that were not sealed could cause cross-contamination. She said the dented cans could have particles that could get loose and contaminate the food. The Dietary Manager said the risk to the resident was they could get sick from the cross contamination. Interview with [NAME] A on 11/6/24 at 1:38 pm, she said she had worked at the facility for 5 years. [NAME] A said the morning cooks were supposed to check if food items were sealed and dated. [NAME] A said the night shift were supposed to check for dented cans and put them in the Dietary Manager's office. She said if food items were not sealed the food could get contaminated and make the residents sick. [NAME] A did not know the risk of keeping dented cans in the dry storage room. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with [NAME] B on 11/6/24 at 1:45 pm, he said he had worked at the facility for 6 months and he worked the night shift. He said everyone in the kitchen helped with dating and sealing food items and checked for dented cans. He said if food items were not sealed it could cause cross-contamination and residents could get sick. [NAME] B did not know the risk of keeping dented cans in the dry storage room. Record review of the Dry Food Storage Policy, not dated, read in part . store opened and bulk items in tightly covered containers, all containers must be labeled and dated. When packages of cans are opened staff are to inspect for dents, or abnormalities, if any are found the cans are to be removed immediately and stored in the designated area .