

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676257	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/18/2024
NAME OF PROVIDER OR SUPPLIER Trucare Living Centers		STREET ADDRESS, CITY, STATE, ZIP CODE 2265 S Sycamore St Palestine, TX 75801	

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 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure each resident receives an accurate assessment.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40124</p> <p>43994</p> <p>46273</p> <p>Based on observations, interviews and record reviews, the facility failed to ensure an accurate MDS was completed for 6 of 15 residents (Residents #40, #53, #70, #74, #17, and #7) reviewed for MDS assessment accuracy.</p> <p>1.The facility incorrectly coded Resident #40 as having received Insulin in previous 14 days while a resident on his MDS Assessment.</p> <p>2.The facility failed to accurately code on the MDS assessments for Resident's #53 on 8/10/2024, #70 on 7/20/2024, #74 on 8/29/2024 and #7 on 8/7/2024 who had side rails on their bed.</p> <p>This failure could place residents at risk for not receiving the appropriate care and services to maintain the highest level of well-being.</p> <p>Findings included:</p> <p>1. Record review of the facility face sheet dated 9/17/2024 for Resident #40 reflected that he was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses including: Type 2 diabetes mellitus (insufficient production of insulin, causing high blood sugar), reduced mobility and muscle weakness.</p> <p>Record review of a Quarterly MDS dated [DATE] for Resident #40 indicated that he had a BIMS score of 12, indicating that he had moderately impaired cognition. Section O, question O0100, 2c indicated that resident had received Insulin in the previous 14 days.</p> <p>Record review of the medication administration record for Resident #40 for the months of July 2024 and August 2024 indicated that he had not received insulin for the look-back period (previous 14 days) of the MDS. Resident received a weekly injection of Bydureon BCise 2 MG/0.85ML which was not insulin.</p> <p>Record review of Resident #40's care plan revised 6/22/24 indicated problem: Diagnosis of Diabetes with an intervention to monitor effectiveness of medications.</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 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Record review of Resident #40's physician orders dated July and August 2024 indicated that he had no orders for insulin.</p> <p>During an Interview on 09/18/24 at 11:20 AM the MDS Co-Ordinator said that she thought the Bydureon BCise 2 MG/0.85ML Auto-injector was a type of insulin and coded the MDS to reflect that in error. The MDS Co-Ordinator said the MDS must be completed accurately to ensure proper care is planned for the resident.</p> <p>2. Record review of a face sheet for Resident #53 dated 9/17/2024 for Resident #53 indicated she admitted to the facility 2/21/2024 and was [AGE] years old with diagnosis of acute and chronic respiratory failure (a condition that makes it difficult to breathe on your own), type 2 diabetes, COPD (a lung disease causing restricted airflow and breathing problems) and osteoarthritis (inflammation of one or more joints).</p> <p>Record review of active physician orders for Resident #53 dated 9/17/2024 indicated an order with a start date of 12/7/2023 for use of enabler bars to turn and reposition in bed.</p> <p>Record review of a Quarterly MDS assessment dated [DATE] for Resident #53 indicated she did not have any impairment in thinking with a BIMS score of 15. She used a walker or wheelchair in the 7 day look back period. She was independent with the ability to roll left and right, sit to lying and lying to sitting on side of bed. Physical restraints of bed rails were not used.</p> <p>Record review of a care plan for Resident #53 dated 12/19/2023 indicated she had an ADL self-care performance deficit related to activity tolerance with interventions for bed mobility: requires 1 staff participation to reposition and turn in bed. May use enabler bars to turn/position in bed added on 9/17/2024.</p> <p>During an observation and interview on 9/16/2024 at 11:56 AM, Resident #53 was in her room sitting on the side of her bed. She said she had been at the facility since December 2023. She had 1/4 rails on both sides of the bed.</p> <p>During an observation and interview on 9/18/2024 at 8:14 AM, Resident #53 said on admission to the facility bed rails were on the bed when she arrived, and no one asked her if she wanted to keep them or not. She said she always kept the rails in the upright position, so they were positioned by her head to grab. 1/4 rails were observed in the upright position on both sides of the bed.</p> <p>Record review of an Admission Record dated 9/17/2024 for Resident #70 indicated she admitted to the facility on [DATE] and was [AGE] years old with diagnoses of unspecified tracheostomy (tube that in in the neck that allows them to breathe through the tube instead of their mouth or nose) and hypertension.</p> <p>Record review of active physician orders dated 9/17/2024 for Resident #70 indicated an order that may use enable bars to turn and reposition in bed that started on 5/31/2023.</p> <p>Record review of a Quarterly MDS Assessment for Resident #70 dated 7/20/2024 indicated she did not have any impairment in thinking with a BIMS score of 15. She used a walker and wheelchair during the 7 day look back period. Restraints and alarms indicated no use of bed rails.</p> <p>(continued on next page)</p>		

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Record review of a care plan for Resident #70 dated 4/13/2023 indicated she had an ADL self-care performance deficit related to mobility status with an intervention for bed mobility: requires 1 staff participation to reposition and turn in bed. May use an enabler bar to turn/reposition in bed dated 9/17/2024.</p> <p>During an observation and interview on 9/16/2024 at 9:31 AM, Resident #70 was in bed awake, using oxygen via (through) her trach. She had 1/4 rails on both sides of the bed.</p> <p>Record review of a face sheet for Resident #7 dated 9/17/2024 indicated he admitted to the facility on [DATE] and was [AGE] years old with diagnosis of type 2 diabetes, anemia, contracture of left hand (a shortening and hardening of the muscles) and hypertension.</p> <p>Record review of active physician orders for Resident #7 dated 9/17/2024 indicated an order that they may use enabler bars to turn and reposition in bed dated 5/21/2023.</p> <p>Record review of a Quarterly MDS Assessment for Resident #7 dated 8/7/2024 indicated he had moderate impairment in thinking with a BIMS score of 6. He was dependent on staff with assistance with rolling left and right, sitting to lying, and lying to sitting on side of bed. The use of bed rails was not used.</p> <p>Record review of a care plan for Resident #7 dated 6/15/2016 indicated he had an ADL self-care performance deficit related to limited mobility with interventions of bed mobility: may use enabler bars for help with repositioning and turning in bed dated 6/27/2016.</p> <p>During an observation on 9/16/2024 at 9:21 AM, Resident #7 was in bed resting with eyes closed. He had 1/4 rails on both side of the bed in the middle with sheep skin covering them.</p> <p>During an observation on 9/17/2024 at 12:20 PM. Resident #7 was in bed watching tv and the 1/4 rails that were on the bed were up in the middle of the bed. The rails had sheep skin covering both of them.</p> <p>Record review of a facility face sheet dated 9/17/24 for Resident #74 indicated that she was an [AGE] year-old female admitted to the facility on [DATE] and subsequently readmitted on [DATE] with diagnoses including: Urinary tract infection, type 2 diabetes mellitus, and reduced mobility.</p> <p>Record review of a comprehensive MDS assessment dated [DATE] for Resident #74 indicated that she had a BIMS score of 7, which indicated that she had severely impaired cognition. She was dependent on staff for transfers, rolling left to right, sitting to lying, and lying to sitting on side of bed. Assessment indicated that bed rails were not used.</p> <p>Record review of a comprehensive care plan dated 8/27/24 for Resident #74 indicated that she had an ADL self-care performance deficit, required 2 staff participation to reposition and turn in bed, and may use enabler bar to turn/reposition in bed was added on 9/17/24.</p> <p>Record review of a physician's order summary report dated 9/17/24 indicated that Resident #74 had the following order dated 8/26/24: .may use enabler bars to turn and reposition in bed .</p> <p>(continued on next page)</p>		

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Record review of a Side Rail/Mobility/Positioning Bar Assessment - V 1 dated 9/10/24 for Resident #74 read . Please specify the type of rails being used . and form then read .1/4 rails, enabler bars, both sides .</p> <p>Record review of a facility form titled Physical Device Consent and Acknowledgement dated 5/30/24 for Resident #74 read .Type of Device Recommended by Inter-Disciplinary Team (IDT): .Side rails; 1/4 side rails and 1/2 side rails .</p> <p>During an observation on 9/16/24 at 10:11 am Resident #74 was observed lying in bed with 1/4 rails observed on both sides of bed. Resident did not speak.</p> <p>During an interview on 9/17/2024 at 2:27 PM, MDS Coordinator said she had been employed at the facility for [AGE] years. She was responsible for the care plans, MDS assessments and PASSR. She said she revised care plans every day and quarterly with MDS assessments. She said what the Surveyors are calling side rails in the facility were enabler bars and that what was told to them by their corporate staff. She said she did not code side rails on the MDS assessments as side rails because they consider them enabler bars until the Surveyors brought it to their attention on 9/16/2024.</p> <p>During an interview on 9/17/2024 at 2:48 PM, the Regional Nurse said she had been in her position for [AGE] years. Said that bed rails in the facility were classified as enabler bars to assist in bed with mobility. They looked at the side rails as 1/2 rails that covered 3/4 of the side of the bed and they were used as enabler bars but said she would go and look facility wide at the side rails.</p> <p>During an interview on 9/17/2024 at 2:59 PM, the DON said she had been employed at the facility for 4 years. She said they always classified the bars on beds as enablers as it allowed the residents to help turn themselves and they were able to hold on if they wanted to while being turned. She said rails were on the beds on admission to the facility. She said side rails were not a restraint.</p> <p>During a follow up interview on 9/17/2024 at 3:16 PM, the Regional Nurse said the problem with the side rails on the bed were the placements of some of them being in the middle of the bed. She said residents could be at risk for entrapment.</p> <p>During an interview on 09/18/24 12:04 PM, the Administrator said the MDS assessments should reflect accurate information to ensure the highest level of well-being for the resident.</p> <p>Record review of a facility polity titled Resident Assessment Instrument (MDS 3.0) revised 3/1/2022 indicated, .A comprehensive assessment of a resident's needs shall be made within fourteen (14) days of the resident's admission. 1. Within fourteen (14) days of the resident's admission, a comprehensive assessment of the resident's needs will be made by the Interdisciplinary Assessment Team. 6. Within seven (7) days of the completion of the resident assessment, a comprehensive care plan will be developed. 4. Information derived from the comprehensive assessment enables the staff to plan care that allows the resident to reach his/her highest practicable level of functioning and to meet their unique care needs. 7. All persons who have completed any portion of the MDS 3.0 Resident Assessment Form must electronically sign each document attesting to the accuracy of such information .</p> <p>Record review of manufacturer www.astrazeneca-us.com accessed 09/18/2024 indicated Bydureon BCise Auto injector, generic name: exenatide extended release, drug class Incretin Mimetics (GLP-1 Agonists)</p> <p>(continued on next page)</p>		

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Record review of facility policy titled Certifying Accuracy of the Resident assessment dated 2001 with revision date of November 2019 indicated .The information captured on the assessment reflects the status of the resident during the observation (look-back) period for that assessment .</p>

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<p>F 0644</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43994</p> <p>Based on interviews and record review, the facility failed to refer all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change of condition for 1 of 6 Residents (Resident #53) reviewed for PASSAR (Preadmission Screening and Resident Review Services).</p> <p>The facility failed to ensure Resident #53 had a new level 1 PASSAR completed with a diagnosis of bipolar disorder on admission 12/7/2023.</p> <p>These failures could place residents at risk of not receiving the needed PASSAR services to meet their individual needs and could result in a decreased quality of life.</p> <p>The findings included:</p> <p>Record review of a face sheet for Resident #53 dated 9/17/2024 for Resident #53 indicated she admitted to the facility 2/21/2024 and was [AGE] years old with diagnosis of acute and chronic respiratory failure (a condition that makes it difficult to breathe on your own), type 2 diabetes, COPD (a lung disease causing restricted airflow and breathing problems), osteoarthritis (inflammation of one or more joints) and bipolar disorder (a mental illness characterized by extreme mood swings) that was effective on 12/7/2023.</p> <p>Record review of a care plan for Resident #53 dated 12/19/2023 indicated she would have a PASSR screening according to regulatory guidelines. This was completed on 12/7/2023 and revealed a need for no specialized services.</p> <p>Record review of a Quarterly MDS assessment dated [DATE] for Resident #53 indicated she did not have any impairment in thinking with a BIMS score of 15. A referral was not made to the local contact agency because the referral was not wanted.</p> <p>During an interview on 9/17/2024 at 3:50 PM, the MDS Coordinator said she had been employed at the facility for [AGE] years and was responsible for the coordination of PASSR. She said she missed on the diagnosis list for Resident #53 that she had bipolar on admission to the facility on [DATE]. She said she was not aware of it until 9/16/2024 when the Surveyor questioned her about an evaluation for PASSR for the resident. She said Resident #53 should have had a PASSR evaluation on admission with her mental illness diagnosis of bipolar. She said she was responsible for looking at the orders and would run an order report daily and just missed recognizing that Resident #53 had a mental illness diagnosis of bipolar. She said she generated a new PASSR Level 1 (PL1) today 9/17/2024 and contacted the local authority to notify them to conduct an evaluation with the resident. She said residents could be at risk for a relapse or exacerbation of their mental illnesses if they did not get the services they qualified for. She said she submitted the new PL1 into the portal in SIMPLE and would be waiting on a response. She said she had training on PASSR in the past and was not sure how it was missed with Resident #53, and it was an error on her part.</p> <p>(continued on next page)</p>

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<p>F 0644</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 9/18/2024 at 2:27 PM, the Administrator said she was made aware on yesterday 9/17/2024 about Resident #53 not having a PASSR evaluation on admission to the facility. She said she was told it was an oversight on the MDS Coordinator's part. She said the MDS Coordinator has a regional support contact that provides offsite checks and going forward would have her supervisor check to ensure residents had coordination of services if necessary. She said they would put a plan in place to check in the facility and with corporate.</p> <p>A copy of a PASSR policy was requested from the facility and was told they did not have a policy and they followed the RAI manual for guidance.</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40124</p> <p>43994</p> <p>46273</p> <p>Based on observations, interviews and record reviews the facility failed to develop and implement comprehensive person-centered care plan that includes measurable objectives and time frames to meet a resident medical and nursing needs to be furnished to attain or maintain the residents highest practicable physical, mental, and psychosocial well-being for 5 of 18 residents (Residents #53, #70, #13, #74, and #130) reviewed for care plans in that:</p> <p>The facility failed to develop a comprehensive care plan for the use of enabler bars for Resident #13 that were put into use on 4/3/21.</p> <p>The facility failed to develop a comprehensive care plan for the use of side rails for Resident #74 that were put into use on 5/29/24.</p> <p>The facility failed to develop a comprehensive care plan for the use of a side rails for Resident #130 that was put into use on 7/30/24.</p> <p>The facility failed to develop a comprehensive care plan for the use of side rails for Resident #53 that was put into use on 12/7/2023.</p> <p>The facility failed to develop a comprehensive care plan for the use of side rails for Resident #70 that was put into use on 5/31/2023.</p> <p>This failure could place residents at risk of inappropriate care and decreased quality of life.</p> <p>This deficient practice could place residents in the facility at risk of not receiving the necessary care or services and having personalized plans developed to address their needs.</p> <p>Findings included:</p> <p>Record review of a facility face sheet dated 09/17/24 for Resident #130 indicated that he was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses of acute respiratory failure with hypoxia (Inability to adequately maintain adequate oxygen in the blood), reduced mobility and gastro-esophageal reflux disease (heart burn).</p> <p>Record review of a comprehensive MDS dated [DATE] for Resident #130 Section C (Cognitive Patterns) indicated that he was moderately cognitively impaired. Section P indicated no use of bed rails.</p> <p>Record review of a comprehensive care plan dated 08/05/24 for Resident #130 indicated interventions for use of an enabler bar for bed mobility, requires 1-2 staff participation to reposition and turn in bed. May use enabler bars to turn/reposition in bed. Use of side rails were not addressed.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Record review of a face sheet for Resident #53 dated 9/17/2024 for Resident #53 indicated she admitted to the facility 2/21/2024 and was [AGE] years old with diagnosis of acute and chronic respiratory failure (a condition that makes it difficult to breathe on your own), type 2 diabetes, COPD (a lung disease causing restricted airflow and breathing problems) and osteoarthritis (inflammation of one or more joints).</p> <p>Record review of active physician orders for Resident #53 dated 9/17/2024 indicated an order with a start date of 12/7/2023 for use of enabler bars to turn and reposition in bed.</p> <p>Record review of a Quarterly MDS assessment dated [DATE] for Resident #53 indicated she did not have any impairment in thinking with a BIMS score of 15. She used a walker or wheelchair in the 7 day look back period. She was independent with the ability to roll left and right, sit to lying and lying to sitting on side of bed. Physical restraints of bed rails were not used.</p> <p>Record review of a care plan for Resident #53 dated 12/19/2023 indicated she had an ADL self-care performance deficit related to activity tolerance with interventions for bed mobility: requires 1 staff participation to reposition and turn in bed. May use enabler bars to turn/position in bed added on 9/17/2024.</p> <p>Record review of an Admission Record dated 9/17/2024 for Resident #70 indicated she admitted to the facility on [DATE] and was [AGE] years old with diagnoses of unspecified tracheostomy (tube that in the neck that allows them to breathe through the tube instead of their mouth or nose) and hypertension.</p> <p>Record review of active physician orders dated 9/17/2024 for Resident #70 indicated an order that may use enable bars to turn and reposition in bed that started on 5/31/2023.</p> <p>Record review of a Quarterly MDS Assessment for Resident #70 dated 7/20/2024 indicated she did not have any impairment in thinking with a BIMS score of 15. She used a walker and wheelchair during the 7 day look back period. Restraints and alarms indicated no use of bed rails.</p> <p>Record review of a care plan for Resident #70 dated 4/13/2023 indicated she had an ADL self-care performance deficit related to mobility status with an intervention for bed mobility: requires 1 staff participation to reposition and turn in bed. May use an enabler bar to turn/reposition in bed dated 9/17/2024.</p> <p>Record review of a facility face sheet dated 9/17/24 for Resident #74 indicated that she was an [AGE] year-old female admitted to the facility on [DATE] and subsequently readmitted on [DATE] with diagnoses including: Urinary tract infection, type 2 diabetes mellitus, and reduced mobility.</p> <p>Record review of a comprehensive MDS assessment dated [DATE] for Resident #74 indicated that she had a BIMS score of 7, which indicated that she had severely impaired cognition. She was dependent on staff for transfers, rolling left to right, sitting to lying, and lying to sitting on side of bed. Assessment indicated that bed rails were not used.</p> <p>Record review of a comprehensive care plan dated 8/27/24 for Resident #74 indicated that she had an ADL self-care performance deficit, required 2 staff participation to reposition and turn in bed, and may use enabler bar to turn/reposition in bed was added on 9/17/24.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Record review of a physician's order summary report dated 9/17/24 indicated that Resident #74 had the following order dated 8/26/24: .may use enabler bars to turn and reposition in bed .</p> <p>Record review of a Side Rail/Mobility/Positioning Bar Assessment - V 1 dated 9/10/24 for Resident #74 read . Please specify the type of rails being used . and form then read . 1/4 rails, enabler bars, both sides .</p> <p>Record review of a facility form titled Physical Device Consent and Acknowledgement dated 5/30/24 for Resident #74 read .Type of Device Recommended by Inter-Disciplinary Team (IDT): .Side rails; 1/4 side rails and 1/2 side rails .</p> <p>During an observation on 9/16/24 at 10:11 am Resident #74 was observed lying in bed with 1/4 rails observed on both sides of bed. Resident did not speak.</p> <p>Record review of a facility face sheet dated 9/17/24 for Resident #13 indicated that he was a [AGE] year-old male admitted to the facility on [DATE] and subsequently readmitted on [DATE] with diagnoses including: congestive heart failure, reduced mobility, and repeated falls.</p> <p>Record review of a Quarterly MDS assessment dated [DATE] for Resident #13 indicated that he had a BIMS score of 7, which indicated that he had severely impaired cognition. He was dependent with transfers, required substantial/maximal assistance with sitting to lying and with lying to sitting, and required partial/moderate assistance with rolling left to right. Assessment indicated that bed rails were not used.</p> <p>Record review of an Order Summary Report dated 9/17/24 for Resident #13 indicated that he had the following order dated 5/31/23: .May use enabler bars to turn and reposition in bed .</p> <p>Record review of a comprehensive care plan dated 7/2/24 for Resident #13 indicated that he was at risk for falls and had an ADL self-care performance deficit. Care plan did not address the use of enabler bars or side rails.</p> <p>Record review of a facility form titled Physical Device Consent and Acknowledgement for Resident #13 read . Type of restraint recommended by inter-disciplinary team (IDT) .Side Rails - 1/4 side rail .</p> <p>During an interview on 9/17/2024 at 2:27 PM, MDS Coordinator said she had been employed at the facility for [AGE] years. She was responsible for the care plans, MDS assessments and PASSR. She said she revised care plans daily and quarterly with MDS assessments. She said what the Surveyors were calling side rails in the facility were called enabler bars and that was what corporate staff told them they were . She said the care plans already had enablers on them and they do not consider them as side rails.</p> <p>During an interview with the MDS Co-Ordinator on 09/18/24 09:49 AM the MDS Co-Ordinator said she had worked at the facility for [AGE] years and she used the orders and observations to code the MDS and complete the care plan for resident #130. She said she uses the term enabler when addressing the rails on resident's beds.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676257	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/18/2024
NAME OF PROVIDER OR SUPPLIER Trucare Living Centers		STREET ADDRESS, CITY, STATE, ZIP CODE 2265 S Sycamore St Palestine, TX 75801	

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 09/18/24 at 9:55 am Administrator said that going forward she was expecting the MDS nurse to complete assessments and care plans accurately. She said residents could be at risk of not getting the care they needed since care plan focus areas were pulled over from assessment data on the MDS.</p> <p>Record review of a facility policy titled Care Plan Revised date 03-01-2022, read .An individualized Comprehensive Care Plan that includes measurable objectives and timetables to meet the resident's medical, nursing, mental, and psychological needs is developed for each resident .3. Each resident's Comprehensive Care Plan has been designed to: a. Incorporate identified problem, area: Incorporate risk factors associated with identified problems.</p> <p>Record review of a facility policy titled Care Plans-Comprehensive revised on 3/1/2022 indicated, .An individualized comprehensive care plan that includes measurable objectives and timetables to meet the residents' medical, nursing, mental and psychological needs is developed for each resident. 4. The resident's comprehensive care plan is developed within seven (7) days of the completion of the resident's comprehensive assessment (MDS). 5. Care plans are revised as changes in the resident's condition dictate. Care plan are reviewed at least quarterly and any significant change in status .</p>

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40124</p> <p>Based on observation, interview, and record review, the facility failed to ensure the residents' environment remains as free of accident hazards as possible for 2 of 11 residents reviewed for quality of care, (Resident #6 and #281) in that:</p> <p>The facility failed to remove worn, damaged and bleached mechanical lift slings from service for Residents #6 and #281.</p> <p>The facility failed to obtain physician orders for mechanical lift transfers for Resident #6.</p> <p>This deficient practice could result in a loss of quality of life due to injuries.</p> <p>Findings included:</p> <p>Record review of a facility's face sheet dated 5/21/24 for Resident #6 indicated that she was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses including: Lack of co-ordination, osteoarthritis (degeneration of the bones) and muscle weakness.</p> <p>Record review of a Quarterly MDS assessment dated [DATE] for Resident #6 indicated that she was rarely/never understood, and that Resident #6 was severely cognitively impaired. Assessment also indicated that she was totally dependent with transfers.</p> <p>Record review of a comprehensive care plan dated 8/27/24 indicated that Resident #6 was totally dependent on a mechanical lift with the assistance of 2 persons for transfers.</p> <p>Record review of a physician order report dated 09/17/24 for Resident #6 indicated that she did not have a physician order for mechanical lift transfers.</p> <p>Record review of a facility face sheet dated 09/16/2024 indicated Resident #281 was an [AGE] year-old male that admitted to the facility on [DATE] with diagnosis of displaced intertrochanteric fracture of right femur (common hip fracture), reduced mobility and chronic obstructive pulmonary disease (a condition that limits airflow into and out of the lungs).</p> <p>Record review of a comprehensive care plan initiated 06/24/2024 indicated Resident #281 required transfer assist of 2 staff with or without mechanical device.</p> <p>Record review of an admission MDS assessment dated [DATE] indicated Resident #281 had a BIMS of 07 indicating severely impaired cognition. Resident required moderate to maximal assistance with transfers and moderate assist with rolling left to right.</p> <p>During an observation on 09/16/2024 at 10:11 AM, of a Hoyer lift sling under Resident #281 while he was sitting in his wheelchair, the colored connection tabs were faded, light in color and the care label was illegible and shrunken.</p> <p>(continued on next page)</p>		

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<p>F 0689</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 09/16/24 at 10:15 AM Resident #6 in room sitting in chair watching TV dressed neatly, denies any problems with staff. She was sitting in a chair with a Hoyer lift sling underneath her. The straps are faded in color they all appear to be a light purple pink not bright Blue, Bright Purple, or Bright green.</p> <p>During an interview with the DON on 9/17/2024 at 07:49 AM who said that she was aware that the resident was in a sling that needed to be replaced and that a new sling was being delivered and would be replaced as soon as it arrived.</p> <p>During an Interview on 09/16/24 10:31 AM with CNA A, unable to answer why or what she would look for to ensure the Hoyer sling was safe.</p> <p>During an interview on 09/16/24 10:32 AM with CNA B said she would look for rips or tears on the Hoyer sling before use. Asked her what is wrong with Resident #6's Hoyer sling, and she could not give an answer.</p> <p>During an observation and interview on 09/16/24 10:40 AM with the DON who said she was not aware faded slings needed to be taken out of service. She said the faded slings would be removed from service immediately.</p> <p>During an interview with the DON on 9/17/2024 at 07:49 AM she said that she was aware that the resident was in a sling that needed to be replaced and that a new sling was being delivered and would be replaced as soon as it arrived.</p> <p>During an interview on 9/17/24 at 10:06 AM, Laundry Aide said she had been employed at the facility for [AGE] years. She said the Hoyer lift slings were washed with personals, if there were a lot of them, they were washed by themselves. She said if a resident was in isolation and the laundry arrived in a yellow bag, the slings would be washed, and the wash included bleach. She said the slings were hung up to dry. She said they used a log in the past when the lift slings came into the laundry to keep track but no longer use it and no one has informed her that she needed to. She said once the slings were removed from the washer, she would inspect them for any tears or frays, if they had them would discard them in the trash.</p> <p>During an interview and observation on 09/17/24 at 10:10 am, the DON said sling pads should be inspected by the staff before using them to transfer a resident and that worn sling pads could put residents at risk for falls.</p> <p>During an interview on 09/17/24 at 11:00 am, Med Aide D said she had been employed [AGE] years. She said she looked for signs of wear on the lift pads such as loose strings and faded coloring on the straps. She said if she observed any signs of wear, she would not use the lift pad to transfer a resident. She said worn pads could break causing a resident to fall.</p> <p>During an interview on 09/17/24 at 11:10 pm, Med Aide E said she had been employed for about two years. She said she would look for loose seams, faded colors, rips and tears on the lift pads before use. She said that lift pads that had faded coloring, loose seams, and rips or tears could break while using them, and a resident could fall.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an observation on 09/17/24 at 12:30 pm, Medical Record Staff brought in approximately 12 new Hoyer lifts slings for the staff to put in rotation and remove any faded and worn slings out of rotation.</p> <p>During an interview on 09/18/24 at 10:30 pm, the Administrator said there could be a chance of the sling breaking if it was worn. She said they ordered new slings, and the DON would be inspecting them routinely from then on. She said they educated the CNAs, and they would be expecting the CNAs to inspect all slings prior to using them for a resident.</p> <p>Record review of the facility's policy titled Lifting Machine, using a Portable revised March 2014 read .The purpose of this procedure is to help lift residents using a manual device .</p> <p>There were no interventions to ensure the sling were examined before use for rips, frays, tearing or other indications of potential failure as specified by the manufacturer.</p> <p>Record review of the facility's policy titled Safety and Supervision of Residents revised March 2014 read .Our facility strives to make the environment as free from accident hazards as possible.</p> <p>Resident safety and supervision and assistance to prevent accidents are facility-wide priorities 4. Employees shall be trained on potential accident hazards and demonstrate competency on how to identify and report accident hazards and try to prevent avoidable accidents.</p> <p>Record review of manufacture guidelines Full Body Slings - Instructions for use accessed at www.medline.com on 09/18/24 read .Always inspect slings prior to each use. Signs of rips, tears, or frays indicate sling wear which is unsafe and could result in injury. Signs of color fading, bleached areas, or permanent wrinkles on the straps indicate improper laundering which is unsafe and could result in injury. Any slings with signs of wear or improper laundering should be immediately removed from use . and .Do not remove sling labels. If sling labels are removed or no longer legible, sling must be immediately removed from use .</p> <p>49017</p>		

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<p>F 0700</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>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.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43994</p> <p>Based on observation, interview, and record review the facility failed to attempt to use appropriate alternatives prior to installing a side or bed rail, assess the resident for risk of entrapment from bed rails prior to installation, and review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation for 4 of 24 residents (Resident #53, #70, #74, and #16) reviewed for bed rails.</p> <p>1.The facility failed to attempt to use an alternative for the use of bedrails and complete quarterly side rail assessments for Resident #53 who readmitted to the facility on [DATE] and a order with a start date of 12/7/2023 for use of enabler bars to turn and reposition in bed.</p> <p>2.The facility failed to attempt to use an alternative for the use of bedrails and complete quarterly side rail assessments for Resident #70 who admitted to the facility on [DATE] and an order for Resident #70 that reflected the use of enable bars to turn and reposition in bed that started on 5/31/2023.</p> <p>3.The facility failed to attempt to use an alternative for the use of bedrails for Resident #74 who admitted on [DATE] and an order dated 8/26/24: .may use enabler bars to turn and reposition in bed .</p> <p>4. The failed to attempt to use an alternative for the use of bedrails and complete quarterly side rail assessments for Resident #16 who admitted to the facility on [DATE] and a siderail assessment was done one time in past 12 months on 05/16/2024</p> <p>This failure could place residents at risk of entrapment or injury.</p> <p>Findings included:</p> <p>1.Record review of a face sheet for Resident #53 dated 9/17/2024 indicated she readmitted to the facility 2/21/2024 and was [AGE] years old with diagnosis of acute and chronic respiratory failure (a condition that makes it difficult to breathe on your own), type 2 diabetes, COPD (a lung disease causing restricted airflow and breathing problems) and osteoarthritis (inflammation of one or more joints).</p> <p>Record review of active physician orders for Resident #53 dated 9/17/2024 indicated an order with a start date of 12/7/2023 for use of enabler bars to turn and reposition in bed.</p> <p>Record review of a Quarterly MDS assessment dated [DATE] for Resident #53 indicated she did not have any impairment in thinking with a BIMS score of 15. She used a walker or wheelchair in the 7 day look back period. She was independent with the ability to roll left and right, sit to lying and lying to sitting on side of bed. Physical restraints of bed rails were not used.</p> <p>(continued on next page)</p>		

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<p>F 0700</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Record review of a Side Rail/Mobility/Positioning Bar assessment dated [DATE] for Resident #53 indicated the resident made the request for side rails, no diagnoses was indicated, type of rails used 1/4 rails for both sides for bed mobility, and indicated it was care planned.</p> <p>Record review of a care plan for Resident #53 dated 12/19/2023 indicated she had an ADL self-care performance deficit related to activity tolerance with interventions for bed mobility: required 1 staff participation to reposition and turn in bed. May use enabler bars to turn/position in bed was added on 9/17/2024.</p> <p>Record review of a Side Rail/Mobility/Positioning Bar assessment dated [DATE] for Resident #53 indicated the resident made the request for side rails, no diagnoses was indicated, type of rails used 1/4 rails for both sides for bed mobility, and indicated it was care planned.</p> <p>Record review of a physical device consent and acknowledge form for Resident #53 dated 12/7/2023 indicated use of 1/4 side rails to assist with self-care-bed mobility was signed by the residents RP.</p> <p>During an observation and interview on 9/16/2024 at 11:56 AM, Resident #53 was in her room sitting on the side of her bed and said she had been at the facility since December 2023. She had 1/4 rails on both sides of the bed.</p> <p>During an observation and interview on 9/18/2024 at 8:14 AM, Resident #53 was in her room. She said on admission to the facility, the bed rails were on the bed when she arrived, and no one asked her if she wanted to keep them or not. She said she was able to move them up and down and did not remember if she signed a consent or not. She said she always kept the rails in the upright position, so they were positioned by her head to grab. Observation of 1/4 rails were in the upright position on both sides of the bed.</p> <p>2. Record review of an Admission Record dated 9/17/2024 for Resident #70 indicated she admitted to the facility on [DATE] and was [AGE] years old with diagnoses of unspecified tracheostomy (tube that in in the neck that allows them to breathe through the tube instead of their mouth or nose) and hypertension.</p> <p>Record review of active physician orders dated 9/17/2024 for Resident #70 indicated an order that reflected Resident #70 may use enable bars to turn and reposition in bed that started on 5/31/2023.</p> <p>Record review of a Quarterly MDS Assessment for Resident #70 dated 7/20/2024 indicated she did not have any impairment in thinking with a BIMS score of 15. She used a walker and wheelchair during the 7 day look back period. Restraints and alarms indicated no use of bed rails.</p> <p>Record review of a Side Rail/Mobility/Positioning Bar Assessment for Resident #70 dated 4/19/2024 indicated the request for use of side rails was done by the resident for right sided weakness. Type of rails used were 1/4 rails. Alternatives tried prior to the use of side rails were staff and was care planned.</p> <p>Record review of a care plan for Resident #70 dated 4/13/2023 indicated she had an ADL self-care performance deficit related to mobility status with an intervention for bed mobility: requires 1 staff participation to reposition and turn in bed. May use an enabler bar to turn/reposition in bed dated 9/17/2024.</p> <p>(continued on next page)</p>		

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<p>F 0700</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Record review of a physical device consent and acknowledgement for Resident #70 dated 3/27/2023 for use of 1/4 side rails as enablers indicated the resident signed consent electronically on 3/27/2023.</p> <p>Record review of a Side Rail/Mobility/Positioning Bar Assessment for Resident #70 dated 4/19/2024 indicated the request for use of side rails was done by the resident for right sided weakness. Type of rails used were 1/4 rails. Alternatives tried prior to the use of side rails were staff and was care planned.</p> <p>During an observation and interview on 9/16/2024 at 9:31 AM, Resident #70 was in bed awake, using oxygen via (through) her trach. She had 1/4 rails on both sides of the bed.</p> <p>During an observation on 9/16/2024 at 9:45 AM, 1/4 rails were on the bed in an upright position that looked like assist bars on the bed.</p> <p>During an observation and interview on 9/18/2024 at 8:20 AM, Resident #70 was in her room eating breakfast and 1/4 rails were in the upright position on both sides of the bed. She said when she admitted to the facility no one asked her if she wanted the bed rails or not. She said they did not explain to her any risks associated with having the bed rails on the bed. She said she was able to let the bed rails up and down on her own. She said she did remember signing a consent form for the rails when she admitted .</p> <p>3. Record review of a facility face sheet dated 9/17/24 for Resident #74 indicated that she was an [AGE] year-old female admitted to the facility on [DATE] and subsequently readmitted on [DATE] with diagnoses including: Urinary tract infection, type 2 diabetes mellitus, and reduced mobility.</p> <p>Record review of a comprehensive MDS assessment dated [DATE] for Resident #74 indicated that she had a BIMS score of 7, which indicated that she had severely impaired cognition. She was dependent on staff for transfers, rolling left to right, sitting to lying, and lying to sitting on side of bed. Assessment indicated that bed rails were not used.</p> <p>Record review of a comprehensive care plan dated 8/27/24 for Resident #74 indicated that she had an ADL self-care performance deficit, required 2 staff participation to reposition and turn in bed, and may use enabler bar to turn/reposition in bed was added on 9/17/24.</p> <p>Record review of a physician's order summary report dated 9/17/24 indicated that Resident #74 had the following order dated 8/26/24: .may use enabler bars to turn and reposition in bed .</p> <p>Record review of a Side Rail/Mobility/Positioning Bar Assessment - V 1 dated 9/10/24 for Resident #74 read . Please specify the type of rails being used . and form then read .1/4 rails, enabler bars, both sides .</p> <p>Record review of a facility form titled Physical Device Consent and Acknowledgement dated 5/30/24 for Resident #74 read .Ineffective alternatives for use of this device to manage the medical symptom have included: lowest level intervention/first intervention .</p> <p>During an observation on 9/16/24 at 10:11 am Resident #74 was observed lying in bed with 1/4 rails observed on both sides of bed. Resident did not speak.</p> <p>(continued on next page)</p>		

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<p>F 0700</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>4. Record review of a facility face sheet dated 09/17/2024 indicated Resident #16 was a [AGE] year-old female that admitted to the facility on [DATE] with diagnosis of muscle weakness (generalized), moderate dementia (a group of symptoms that affects memory, thinking and interferes with daily life), and muscle wasting.</p> <p>Record review of a comprehensive care plan initiated 04/30/2018 and updated 9/17/2024 indicated Resident #16 had an ADL self-performance deficit and bed mobility requires 2 staff participation to reposition and turn in bed and that she may use enabler bar to turn and reposition in bed and an intervention of side rails to aid in mobility and promote independence.</p> <p>Record review of a quarterly MDS assessment dated [DATE] indicated Resident #16 had a BIMS of 09 indicating moderately impaired cognition. She was totally dependent on staff for transfers and rolling left to right.</p> <p>Record review of active physician orders for Resident #16 dated 9/18/2024 indicated an order with a start date of 05/31/2023 for use of enabler bars to turn and reposition in bed.</p> <p>Record review of quarterly assessments and a siderail assessment for Resident #16 show that they were done one time in past 12 months on 05/16/2024.</p> <p>During an observation on 09/16/2024 at 10:11 AM, Resident #16 was lying in bed. She was on an air mattress and quarter siderails were raised on left and right side of bed.</p> <p>During an observation on 09/17/2024 at 07:35 AM, Resident #16 was lying in bed. She was on an air mattress and quarter siderails were raised on left and right side of bed.</p> <p>During an observation on 09/18/2024 at 8:45 AM, Resident #16 was lying in bed. She was on an air mattress and quarter siderails were raised on left and right side of bed.</p> <p>During an interview on 9/17/2024 at 2:27 PM, MDS Coordinator said she had been employed at the facility for [AGE] years. She was responsible for the care plans, MDS assessments and PASSR. She said she revised care plans every day and quarterly with MDS assessments. She said what the Surveyors are calling side rails in the facility were enabler bars and that what was told to them by their corporate staff. came from corporate staff. She said she did not code side rails on the MDS assessments as side rails because they consider them enabler bars until the Surveyors brought it to their attention on 9/16/2024.</p> <p>During an interview on 9/17/2024 at 2:34 PM, the Maintenance Supervisor said he had been employed at the facility since July 31, 2024. He said he had never worked in maintenance before. He said she inspected the rails on the beds monthly, 2nd week of the month and checked all of the beds in the facility. He said his first inspection was in August 2024 and did not find anything on his first assessment. He said he had a form that he used to check for the zones in the beds for measuring the space between the mattress and the frame of the bed. He said if he had a question that the Administrator would not answer, then he would call the corporate maintenance for answers. He said he also checked the assist bars to ensure they were able to go up and down but had not changed a bed side rail out and did not know if they were the correct ones that went with the beds. He said as far as he knew, all the bed rails in facility came on the beds that they were on and he just checked the functionality of them. He said if he noticed they were loose, he would tighten them.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676257	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/18/2024
NAME OF PROVIDER OR SUPPLIER Trucare Living Centers		STREET ADDRESS, CITY, STATE, ZIP CODE 2265 S Sycamore St Palestine, TX 75801	
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 0700</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 9/17/2024 at 2:48 PM, the Regional Nurse said she had been in her position for [AGE] years. Said that bed rails in the facility were classified as enabler bars to assist in bed with mobility. They looked at the side rails as 1/2 rails that covered 3/4 of the side of the bed and they were used as enabler bars but said she would go and look facility wide at the side rails.</p> <p>During an interview on 9/17/2024 at 2:59 PM, the DON said she had been employed at the facility for 4 years. She said they always classified the bars on beds as enablers as it allowed the residents to help turn themselves and they were able to hold on if they wanted to while being turned. She said rails were on the beds on admission to the facility. She said side rails were not a restraint. When residents come in to admit, they ask the resident or family if they want the enabler bars on bed. She said they did offer alternatives but was not sure and told the Surveyors that they would have to ask staff if they ask that. She said consents were included in the admission packet and signed before admission in the facility. She said if a resident/family requested not to have rails, then they would offer a lower bed, or other alternatives, and etc. She said the side rail assessments should be completed every 3 months and the charge nurses were responsible for completing them. She said they did check the mattresses in the facility for risk of entrapment.</p> <p>During a follow up interview on 9/17/2024 at 3:16 PM, the Regional Nurse said the problem with the side rails on the bed were the placements of some of them being in the middle of the bed. She said residents could be at risk for entrapment.</p> <p>Record review of facility log forms titled Bed Rail Inspection dated 6/19/24, 7/17/24, 7/18/24, and 8/15/24 indicated that facility was inspecting beds in the facility with bed rails for entrapment risk.</p> <p>Record review of a facility policy titled Proper Use of Side Rails revised 11/27/2017 indicated, .The purpose of these guidelines are 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. 2. Side rails are only permissible if they are used to treat a resident's medical symptoms or to assist with mobility and transfers of residents. 3. An assessment will be made to determine the resident's symptoms, risk of entrapment and reason for using side rails. When used for mobility or transfer, an assessment will include a review of the resident's: a. bed mobility; b. ability to change positions, transfer to and from bed or chair, and to stand and toilet; c. risk of entrapment from the use of side rails; and d. that the bed's dimensions are appropriate for the resident's size and weight. 4. The use of side rails as an assistive device will be addressed in the resident care plan. 7. Documentation will indicate if less restrictive approaches are not successful, prior to considering the use of side rails .</p> <p>46273</p> <p>49017</p>		

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<p>F 0813</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Have a policy regarding use and storage of foods brought to residents by family and other visitors.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43994</p> <p>Based on observation, interview, and record review, the facility failed to maintain and ensure safe and sanitary storage of residents' food items, per facility policy, for 1 of 11 resident's (Resident #54) personal refrigerators reviewed for food and nutrition services.</p> <p>The facility failed to ensure a personal refrigerator on [DATE] for Resident #54 did not contain a jar of mayonnaise with an expiration date of [DATE].</p> <p>These failures could place residents at risk for food borne illnesses.</p> <p>Findings include:</p> <p>Record review of a face sheet for Resident #54 dated [DATE] indicated he admitted to the facility on [DATE] and was [AGE] years old with diagnoses of venous insufficiency (occurs when the veins in the legs have difficulty returning blood to the heart), malignant neoplasm of prostate (prostate cancer) and dementia.</p> <p>Record review of a resident/patient refrigerator log dated [DATE] indicated on [DATE] the refrigerator was checked as indicated by the initials of RNA.</p> <p>Record review of an Admission MDS Assessment for Resident #54 dated [DATE] indicated he had moderate impairment in thinking with a BIMS score of 8. He required set up or clean up assistance with eating.</p> <p>Record review of a care plan for Resident #54 dated [DATE] indicated he had an ADL self-care performance deficit related to activity intolerance with interventions for eating: required set up help from staff participation to eat.</p> <p>During an observation and interview on [DATE] at 9:12 AM, Resident #54 was in his room sitting up in a wheelchair. He had a personal refrigerator in his room that had a jar of mayonnaise that expired [DATE]. He said he ate foods from his refrigerator and that staff checked it.</p> <p>During an observation and interview on [DATE] at 8:17 AM, Resident #54 was in his room and the jar of mayonnaise was not in his refrigerator. He said a staff member removed it on yesterday [DATE].</p> <p>During an interview on [DATE] at 8:25 AM, RNA said she had been employed at the facility for 11 ,d+[DATE] years and was responsible for checking the personal refrigerators on halls 200 and 400. She said she checked the refrigerators daily for expired food items or foods that had been left for more than 3 days and then would throw them away. She said she checked Resident #54's refrigerator daily but did not remember seeing a bottle of expired mayonnaise. She said she did not keep a log of the refrigerators that she checked and only put the temperatures on the temperature log that was on the refrigerators. She said residents could be sick from eating foods that were expired especially mayonnaise. She said she had not removed anything from his refrigerator. She said some residents would get upset if they removed foods from their personal refrigerators but Resident #54 did not.</p> <p>(continued on next page)</p>		

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<p>F 0813</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on [DATE] at 2:13 PM, the DON who said the personal refrigerators were the responsibility of the restorative aides. She said they were responsible for checking refrigerators daily for temperatures, foods that are not left more than 3 days, and milk to make sure it was not spoiled. She said residents could be at risk for food poisoning or getting sick if items were left in their refrigerators.</p> <p>During an interview on [DATE] at 2:27 PM, the Administrator said the RNAs were responsible for checking the personal refrigerators daily for temperatures and foods. She said the department heads checked daily to be sure the temperatures were done and what was in the refrigerators. She said she removed the expired mayonnaise from Resident #54's refrigerator on Monday night [DATE]. She said going forward she would continue to have the RNA's check the refrigerators daily and would require the department heads to check daily as well. She said residents could get ill if they ate expired foods.</p> <p>Record review of a facility policy titled Foods Brought by Family/Visitors revised on [DATE] reflected, .Staff must be aware of, and approve, food(s) [NAME] to a resident by family/visitors. 1. Family members should inform nursing staff of their desire to bring foods into the facility. 7. The nurse staff is responsible for discarding perishable foods on or before the use by date .</p>