

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676269	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/23/2024
NAME OF PROVIDER OR SUPPLIER Rayburn Health Care & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 144 Bulldog Avenue Jasper, TX 75951	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33460</p> <p>Based on observation, interview, and record review, the facility failed to provide a clean and comfortable environment for 1 of 1 secured unit reviewed for environmental concerns.</p> <p>The facility failed to ensure that floors were clean and devoid of dirt and debris in the secured unit.</p> <p>These failures could place residents at risk of living in an unsafe, unsanitary, and uncomfortable environment.</p> <p>The findings included:</p> <p>During observations on 10/21/24 from 8:45 a.m. to 9:25 a.m. in the secured unit indicated the following:</p> <p>*The hall floor was dusty and had bits of debris. There was a thick buildup of grime 3 inches wide along the edges of the hallway and sitting area.</p> <p>*The dining room floor / activity room was dirty with debris and spilled beverages. There was a medication patch stuck in the middle of the floor covered with dirt. The patch was deteriorated, unable to read the label on the patch. The edges of the activity/dining room had a buildup of grime.</p> <p>*Resident room [ROOM NUMBER] had wheelchair tracks with dirt all over the floor beside the bed and the perimeter of the room had buildup of grime.</p> <p>*Resident room [ROOM NUMBER] had trash behind the night side table and was covered with heavy dust layer. The door into the room had dirt, grime and a dead spider behind the door.</p> <p>During an interview on 10/22/24 at 1:00 p.m., Housekeeper C said she had been trained and was aware to sweep and mop all halls and resident rooms. She said the secure unit was cleaned by 2 housekeepers each day.</p> <p>During an interview on 10/22/24 at 1:30 p.m., Housekeeper D said she had been trained in cleaning resident rooms, halls and common areas on hire. She said there were 4 housekeepers for the building each day.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 10/22/24 at 2:30 p.m., the Administrator said her expectations were for the halls and resident's rooms to be cleaned each day.</p> <p>During an interview on 10/23/24 at 12:30 p.m., the Housekeeping Supervisor said his expectation was for the secure unit to be clean and free of buildup of grime. He said the housekeepers were to sweep and mop all rooms and halls each day. He said he was responsible for ensuring the facility was clean. He said the floors were not clean in the secure unit. He said each room and hall should be kept clean. He said the floors on the secure unit needed to be cleaned better.</p> <p>Record review of the facility's Operations Policies and Procedures manual that was dated 2001, section Homelike Environment, indicated Residents are provide a safe, clean, comfortable and homelike environment .</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>Ensure each resident receives an accurate assessment.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32217</p> <p>Based on observation, interview, and record review, the facility failed to ensure residents received an accurate assessment, reflective of the resident's status for 3 of 19 residents reviewed for accuracy of assessments. (Resident #s 21, 23 and 27)</p> <p>The facility did not accurately complete the MDS assessment to indicate Resident #21 did not have a restraint.</p> <p>The facility did not accurately complete the MDS assessment to indicate Resident #23 did not have a restraint.</p> <p>The facility did not accurately complete the MDS assessment to indicate Resident #27 did not have a restraint.</p> <p>This failure could place the residents at risk of not receiving the appropriate care and services to maintain their highest level of well-being.</p> <p>Findings included:</p> <p>1. Record review of a face sheet dated 10/21/24 indicated Resident #21 was a [AGE] year-old male admitted on [DATE]. His diagnoses included dementia (group of thinking and social symptoms that interfere with daily function) and glaucoma (a group of eye conditions that can cause blindness).</p> <p>Record review of the physician's orders dated 10/21/24 indicated Resident #21 was prescribed Geri-chair (large, padded chair that provides support and comfort for people with limited mobility) for poor trunk control every shift with a start date of 06/03/24.</p> <p>Record review of Resident #21's October 2024 MAR indicated Geri-chair for out of bed every shift with documentation he was in the Geri-chair every shift with a start date of 06/03/24.</p> <p>Record review of the most recent quarterly MDS assessment dated [DATE] indicated Resident #21 had a BIMS score of 3 indicating moderately impaired cognition and was totally dependent on staff to transfer resident from chair to bed or chair to chair. The assessment indicated Resident #21 had a physical restraint used in chair or out of bed as other used daily during the last 7 days.</p> <p>Record review of Resident #21's care plans initiated 06/11/24 indicated Resident #21 required the use of enablers related to the inability to safely transfer self, poor positioning, high risk for falls, poor cognition, and poor redirection with interventions including Geri-chair for out of bed stimulation.</p> <p>During an observation on 10/21/24 at 11:00 a.m., Resident #21 was lying in a Geri-chair in the television room. He was non-interviewable and appeared comfortable with no signs of distress.</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>During an interview on 10/21/24 at 1:30 p.m., the MDS Nurse said Geri-chairs were restraints because residents could not put the foot of it down themselves. She said she was taught by a previous MDS nurse who had told her Geri-chairs were always restraints.</p> <p>During a phone interview on 10/23/24 at 8:00 a.m., the NP said Geri-chairs were not considered restraints regarding Resident #21. She said she did not know why the facility would think they were because Resident #21 had never attempted to get out of the Geri-chair.</p> <p>During a joint interview on 10/23/24 at 8:49 a.m., LVN A and LVN F said Resident #21 had never made any attempt to get out of the Geri-chair. They said they did not consider it a restraint.</p> <p>2. Record review of a face sheet dated 10/21/24 indicated Resident #23 was a [AGE] year-old male admitted on [DATE]. His diagnoses included dementia (group of thinking and social symptoms that interfere with daily function) and cerebral vascular accident (stroke).</p> <p>Record review of the physician's orders dated 10/21/24 indicated Resident #23 was prescribed Geri-chair (large, padded chair that provides support and comfort for people with limited mobility) for poor trunk control every shift with a start date of 08/30/23.</p> <p>Record review of Resident #23's October 2024 MAR indicated Geri-chair for out of bed every shift with documentation he was in the Geri-chair every shift with a start date of 08/30/23.</p> <p>Record review of the most recent quarterly MDS assessment dated [DATE] indicated Resident #23 had a BIMS score of 99 indicating severely impaired cognition and was total dependent on staff to transfer resident from chair to bed or chair to chair. The assessment indicated Resident #23 had a physical restraint used in chair or out of bed as other used daily during the last 7 days.</p> <p>Record review of Resident #23's care plans initiated 06/06/24 indicated Resident #23 required the use of enablers related to the inability to safely transfer self, poor positioning, high risk for falls, poor cognition, and poor redirection with interventions including Geri-chair for out of bed stimulation.</p> <p>During an observation on 10/22/24 at 10:00 a.m., Resident #23 was lying in a Geri-chair in the television room. He was non-interviewable and appeared comfortable.</p> <p>During an interview on 10/21/24 at 1:30 p.m., the MDS Nurse said Geri-chairs were restraints because residents could not put the foot of it down themselves. She said she was taught by a previous MDS nurse who had told her Geri-chairs were always restraints.</p> <p>During a phone interview on 10/23/24 at 8:00 a.m., the NP said Geri-chairs were not considered restraints regarding Resident #23. She said she did not know why the facility would think they were because Resident #23 had never attempted to get out of the Geri-chair.</p> <p>During a joint interview on 10/23/24 at 8:49 a.m., LVN A and LVN F said Resident #23 had never made any attempt to get out of the Geri-chair. They said they did not consider it a restraint.</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>3. Record review of a face sheet dated 10/21/24 indicated Resident #27 was a [AGE] year-old female admitted on [DATE]. Her diagnoses included dementia (group of thinking and social symptoms that interfere with daily function), bipolar disorder (disorder associated with episodes of mood swings ranging from depressive lows to manic highs), and heart disease (heart conditions that include diseased vessels, structural problems, and blood clots).</p> <p>Record review of the physician's orders dated 10/21/24 indicated Resident #27 was prescribed Geri-chair for out of bed stimulation every shift with a start date of 06/19/23.</p> <p>Record review of Resident #27's October 2024 MAR indicated Geri-chair for out of bed stimulation every shift with documentation she was in the Geri chair every shift with a start date of 06/19/24.</p> <p>Record review of the most recent quarterly MDS assessment dated [DATE] indicated Resident #27 had a BIMS score of 8 indicating moderately impaired cognition and was total dependent on staff to transfer resident from chair to bed or chair to chair. The assessment indicated Resident #27 a physical restraint used in chair or out of bed as other used daily during the last 7 days.</p> <p>Record review of Resident #27's care plans initiated 06/06/24 indicated Resident #27 required the use of enablers related to the inability to safely transfer self, poor positioning, high risk for falls and poor cognition with interventions including Geri-chair for out of bed stimulation.</p> <p>During an observation and interview on 10/21/24 at 02:04 p.m., Resident #27 was lying in Geri-chair near the nurse's station. She said she was treated well, the staff provided needed care and her chair was comfortable.</p> <p>During an interview on 10/22/24 at 3:33 p.m., the MDS Nurse said she was responsible for all MDSs in the facility and her back up was the Regional RN. She said she was educated on completion of MDS, frequently watched Webinar trainings, and could call her Regional RN for any questions. She said Resident #'s 21, 23, and 27 were captured on their MDSs as restrained but after surveyor intervention and consultation with her Regional RN they were incorrect. She said she was confused about documentation of Geri-chairs related to the RAI but received confirmation from the Regional RN. The MDS nurse said the risk to residents captured as restrained that were not restrained was an inaccurate reporting of the resident.</p> <p>During an interview on 10/23/24 at 8:35 a.m., LVN A said she was providing care for Resident #27 today. She said Resident #27 did not try to get out of the Geri chair. She said it was an enabler not a restraint.</p> <p>During an interview on 10/23/24 at 8:40 a.m., the Regional RN said the MDS nurse was responsible for all MDSs in the facility and was educated on completion and accuracy of MDSs. The Regional RN said she was the back up and signed all the MDSs for completion and checked for accuracy. She said Resident #'s 21, 23 and 27's MDSs captured for restraints related to Geri chairs were overlooked and should not have been captured as restraints. The Regional RN said the risk of an MDS marked as restraints and resident did not have restraints was an inaccuracy of an MDS.</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>During an interview on 10/23/24 at 09:02 a.m., the DON said the MDS Nurse was responsible for all MDSs in the facility and the Regional RN was her back up to double check MDSs and signed the completed MDSs. She said the MDS nurse was educated on completion and accuracy of MDSs. The DON said Geri chairs were not used as restraints they were enablers in this facility. She said the MDS nurse misunderstood and thought since the residents could move their arms all Geri chairs were restraints but after a consult with the Regional RN, she modified Resident #21, 23 and 27's MDSs to indicate no restraints. The DON said her expectation was all MDS to be completed accurately.</p> <p>During an interview on 10/23/2024 at 10:00 a.m., the Administrator said the MDS nurse was responsible for all MDS in the facility and the Regional RN was her back up. She said the MDS nurse was educated on completion and accuracy of MDSs. The Administrator said her expectation was all MDS completed accurately. She said the risk of a resident captured on the MDS having a restraint that did not have a restraint was an inaccurate picture of the resident.</p> <p>Record review of a facility policy dated November 2019, titled, Certifying Accuracy of the Resident Assessment indicated, . Any person completing a portion of the Minimum Data Set/ MDS (Resident Assessment Instrument) must sign and certify the accuracy of that portion of the assessment. 3. The information captured on the assessment reflects the status of the resident during the observation (look-back) period for that assessment. Different items on the MDS may have different observation periods.</p> <p>Record review of Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual dated October 2023 indicated, . P0100: Physical Restraints Physical restraints are 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 restrict freedom of movement or normal access to one's body Coding: 1. Not used 2. Used less than daily 2. Used daily . Used in chair or Out of Bed . D. Other . For resident who have no ability to transfer independently, the geriatric chair does not meet the definition of a restraint and should not be coded at P0100 G - Chair Prevents Rising.</p> <p>41057</p> <p>44596</p>		

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<p>F 0655</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44596</p> <p>Based on interview and record review, the facility failed to develop and implement a baseline care plan for each resident that included the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care within 48 hours of a resident's admission including the minimum healthcare information necessary to properly care for 1 of 3 residents reviewed for new admissions (Resident #267).</p> <p>The facility failed to develop and implement a baseline care plan within 48 hours of admission for Resident #267.</p> <p>This failure could place residents at risk of not receiving care and services to meet their needs.</p> <p>Findings included:</p> <p>Record review of an undated face sheet revealed Resident #267 was a [AGE] year-old male admitted [DATE] with the diagnoses of prostate cancer, hypertension (high blood pressure), and PVD (refers to any disease or disorder of the circulatory system outside of the brain and heart).</p> <p>Record review of an admission MDS for Resident #267 was incomplete.</p> <p>Record review of the baseline care plan 10/21/2024 for Resident #267 indicated no baseline care plan was initiated prior to survey intervention.</p> <p>Record review of the MD orders dated October 2024 for Resident #267 indicated he was on oxygen at 2 liters per minute via nasal cannula continuously. MD orders indicated Resident #267 was taking Celexa (antidepressant) for depression/</p> <p>Record review of the comprehensive care plans 10/21/2024 for Resident #267 indicated no comprehensive care plan was initiated.</p> <p>During an interview on 10/21/2024 at 9:50 a.m., Resident #267 stated he had plans to return home and was unsure why he could not go now. Resident #267 stated he had cancer and wore hearing aids. Resident #267 was unable to answer any further questions.</p> <p>During an interview on 10/21/2024 at 10:20 a.m., the DON stated the floor nurses were to complete the baseline care plan on admission as part of the admission process within 24 hours of admission. The DON reviewed Resident #267's record and stated, Resident #267 had no baseline care plan completed prior to 10/21/2024 at 10:20 a.m.</p> <p>(continued on next page)</p>		

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<p>F 0655</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 10/22/2024 at 12:45 p.m., the Administrator said she expected the staff members to do their part to complete the baseline care plans. She felt baseline care plans were important information to help the staff care for each resident. The Administrator said it was hard to care for new residents without having an outline of their needs and the baseline care plan gave the staff an outline until the MDS was completed and the comprehensive care plan was created to guide resident care.</p> <p>Record review of the policy dated 11/08/2023 titled Baseline Care Plan, indicated the baseline care plan are developed and implemented within 48 hours of a resident's new admission Baseline care plans are developed by the Registered Nurses and other healthcare team members.</p>

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</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** 33460</p> <p>Based on observation, interview, and record review, the facility failed to develop and implement a comprehensive person-centered care plan to include measurable objectives and timeframe to meet a resident's medical, nursing, and mental and psychosocial needs that were identified in the comprehensive assessment for 1 of 19 residents reviewed for care plans. (Resident #'s 16).</p> <p>The facility did not follow the physician orders for Resident #16's LCS (low concentrated sweet) diet.</p> <p>This failure could place the residents at risk of not receiving the care and services to maintain their highest practicable physical, mental, and psychosocial well-being.</p> <p>Findings included:</p> <p>Record review of admission report dated 10/22/24 indicated Resident #16 was admitted on [DATE] was [AGE] years old with diagnoses of diabetes (high blood glucose), stroke and altered mental status.</p> <p>Record review of the physician orders dated October 2024 indicated Resident #16 had a diet order for LCS/NSOT (No salt on tray) Mechanical Soft Texture with Nectar Thick Liquids/Chopped Meats diet with start date of 11/09/2023. The orders did not include a health shake.</p> <p>Record review of a care plan dated 07/21/2024 indicated Resident #16 had diabetes mellitus (Type 2): with interventions including to monitor nutritional intake. Therapeutic or altered consistency diet with interventions including LCS/NSOT (No salt on tray) mechanical soft texture with nectar thick liquids/chopped meats, offer snacks within diet limits and serve diet as ordered and offer subs if less than 75% is eaten, monitor intake. Care plan did not address the health shake.</p> <p>Record review of a progress notes for Resident #16 dated 09/01/24 to 10/21/24 indicated no documentation of physician being notified of the need for a change in the plan of care for regular health shakes or about the resident's refusing meals or diabetic health shakes.</p> <p>Record review of the quarterly MDS assessment dated [DATE] indicated Resident #16 received oral diabetic medications and a therapeutic diet. No behaviors of rejection of care were noted.</p> <p>During an observation on 10/21/24 at 12:38 p.m., Resident #16 refused her lunch meal. LVN E went and got the resident a regular chocolate health shake (nutritional shake high in protein and calories) from the kitchen. Resident #16's tray card indicated her diet was an LCS diet.</p> <p>During an interview on 10/21/24 at 12:40 p.m., LVN E said Resident #16 was on an LCS diet . She said, I gave her the chocolate health shakes today. She said the resident did not like diabetic health shakes, she gives her the regular health shake. She said she should have called the physician to obtain approval for the regular health shakes because of the high sugar. She said when a resident refuses a meal, they would offer a substitute and if substitute was not taken would give a health shake.</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 - Few</p>	<p>During an interview on 10/21/24 at 12:42 p.m., the DM said residents on LCS diet would receive diabetic shakes because the regular health shake was high in sugar.</p> <p>During an interview on 10/21/24 at 12:44 p.m., Resident #16 said she would try the diabetic shake.</p> <p>During an interview on 10/23/24 at 9:30 a.m., the Administrator said her expectation was for the nurse to follow physician's orders or to notify the physician of the need to change his plan of care/orders.</p> <p>Record review of the health shakes labels obtained from the website per the internet the regular health shakes contained 19 grams of sugar and the diabetic health shake contained 3 grams of sugar.</p> <p>Record review of the Care Plans, Comprehensive Person - Centered policy dated 2001 indicated 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. 4. d. request revisions to the plan of care.g. receives the services and or items included in the plan of care.</p>

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>33460</p> <p>Based on observation, interview and record review, the facility failed to ensure the resident environment remained free of accident hazards for 1 of 4 Halls (Hall 200).</p> <p>There was lighter fluid stored closer than 20 feet to the outside of Hall 200.</p> <p>This failure could place the residents at risk of accidents.</p> <p>Finding included:</p> <p>During an observation of the outside of the building on 10/22/24 at 1:50 p.m., a barbeque pit was approximately 10 feet down the sidewalk which had a shelf with 2 bottles of lighter fluid with approximately 4 ounces in each bottle. The bottles were labeled Flammable and Keep out of reach of children. The bottles were approximately 2 feet from the wall of the building (Hall 200). This area was accessible to residents and visitors from Hall 200.</p> <p>During an interview on 10/22/24 at 1:58 p.m., the Maintenance Supervisor said flammable chemicals needed to be at least 20 feet away from the building, to prevent accidents and fires. He said any flammable chemical was to be stored offsite at his office. He said he was responsible for making sure flammable chemicals were 20 feet away from the building. He said he knew to keep flammable chemicals at least 20 feet away from the building. He said he was not sure who left the lighter fluid there.</p> <p>During an interview on 10/22/24 at 2:15 p.m., the Administrator said she wanted chemicals stored correctly or stored off site to prevent accidents.</p> <p>Record review of the policy titled Fire Safety and Prevention indicated All personnel must learn methods of fire prevention and must report condition(s) that could result in a potential fire hazard. Flammable items: . e Store paints, thinners and other flammable liquids away from resident living areas. F. Store flammable liquids in a locked metal cabinet.</p>		

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NAME OF PROVIDER OR SUPPLIER Rayburn Health Care & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 144 Bulldog Avenue Jasper, TX 75951	
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe, appropriate pain management for a resident who requires such services.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44596</p> <p>Based on interview, and record review, the facility failed to ensure pain management was provided to residents who required such services consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices for 1 of 4 resident reviewed for pain management. (Resident #32)</p> <p>The facility failed to ensure Resident #32 had effective pain management by failing to have routine pain medication available.</p> <p>This failure could place residents at risk for increased pain and decreased quality of life.</p> <p>Findings included:</p> <p>Record review of an undated face sheet indicated Resident #32 was a [AGE] year-old female admitted to the facility on [DATE] with the diagnoses dementia (general term for loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life), pain(physical suffering or discomfort caused by illness or injury), and rheumatoid arthritis (a chronic inflammatory disorder that can affect more than just your joints. In some people, the condition can damage a wide variety of body systems, including the skin, eyes, lungs, heart, and blood vessels).</p> <p>Record review of Resident #32's admission MDS assessment dated [DATE] indicated she had a BIMS score of 13 and required substantial to maximum assistance for toileting, transfer, and hygiene. The MDS indicated Resident #32 had pain almost constantly and it was rated a 9 on a pain scale of 1-10.</p> <p>Record review of Resident #32's care plan dated 08/21/2024 indicated she had chronic pain related to rheumatoid arthritis. The intervention was to administer hydrocodone-APAP as ordered and to maintain a pain level of 3 or below on a scale of 1-10.</p> <p>Record review of Resident #32's MAR dated October 2024 indicated she received hydrocodone/ APAP 10/325 mg (1) tablet 4 times daily from 10/01/2024 through 10/19/2024. The MAR revealed Resident #32 received the 8 a.m. dose of hydrocodone/APAP 10/325mg (1) tab on 10/20/2024. Resident #32's MAR indicated she missed the 12:00 p.m., 4:00 p.m., and 8:00 p.m. doses of hydrocodone/APAP 10/325mg. Resident #32's MAR indicated she received Morphine Sulfate 20mg/ml 0.75ml twice on 10/20/2024 at 12:00 p.m. and 8:00 p.m. and once the morning of 10/21/2024 at 7:00 a.m.</p> <p>Record review of Resident #32's narcotic count sheet for October 2024 indicated the final last hydrocodone/APAP 10/325mg (1) was administered at 8:00 a.m. on 10/20/2024. The count was zero after the 8:00 a.m. dose was administered on 10/20/2024.</p> <p>(continued on next page)</p>		

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<p>F 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 10/21/2024 at 8:15 a.m., Resident #32 stated she was in pain and had not slept well because the facility was out of her pain medication. Resident #32 stated she currently had a pain level of 3-4. She stated it was not excruciating but it made it harder to rest. She stated she woke up twice and it took her about 15 minutes each time to get comfortable and go back to sleep. She stated she had not gotten her routine pain medication but one time yesterday (10/21/2024) and the medication nurse this morning (10/21/2024) told her it had not come in yet. She stated she always had pain because of her rheumatoid arthritis, but she could function normally if her pain was between 2-3. She stated her pain had not kept her from eating breakfast, had not kept her from walking with her walker in her room and taking herself to the bathroom. Resident #32 stated she was given morphine sulfate that she had ordered prn while she was out of hydrocodone, and it helped take the edge off.</p> <p>During an interview on 10/21/2024 at 2:00 p.m., LVN B stated Resident #32 was out of hydrocodone/APAP 10/325mg (1) this morning (10/21/2024) when she counted the cart. She stated Resident #32 was not happy this morning when she had to tell her she was still out of her routine hydrocodone. She stated the resident told her the prn morphine was not working to keep her pain under control. Resident #32 stated her pain was a 4. She stated Resident #32 said it was not excruciating pain, just dull and annoying and keeping her from resting. LVN B stated she called the pharmacy at 9:00 a.m. and they stated the courier was in route to the facility with the medication. She stated the courier arrived 15 minutes later and the resident received her morning dose of hydrocodone/APAP 10/325 (1) tablet. LVN B stated had she not been able to get the medication so quickly, the facility had an emergency narcotic box that she could have gotten the medication from.</p> <p>During an interview on 10/22/2024 at 10:00 a.m., LVN A stated she called the MD for Resident #32 on 10/20/2024 around 10:00 a.m. and requested a refill of hydrocodone. She stated the MD sent a refill prescription to the pharmacy at that time. She stated she gave prn morphine per the resident's request at 12:00 p.m. and 8:00 p.m. on 10/20/2024 when she assessed her pain, and she said her pain was a 5. She stated when she reassessed her pain an hour after the morphine at 1:00 p.m. and 9:00 p.m., both times it was a 3. She stated to get into the emergency narcotic box a hard copy of the prescription for the narcotic had been faxed to the pharmacy and the pharmacist gives you a code to retrieve the needed narcotic. She stated there was no way to get a hard copy of the narcotic prescription from the MD on a Sunday evening.</p> <p>During an interview on 10/22/2024 at 2:15 p.m., the DON stated Resident #32's hydrocodone/APAP 10/325mg was missed for 3 doses on 10/20/2024. She stated Resident #32 was given prn morphine while she was without the hydrocodone. She stated the facility had an emergency narcotic kit for times when the resident's need the medication and the facility was without. She stated she asked LVN A why she had not attempted to get a narcotic prescription for Resident #32's hydrocodone to use the emergency narcotic box because she had no way to get the prescription to fax to the pharmacy to be able to get the hydrocodone out of the emergency kit.</p> <p>During an interview on 10/23/2024 at 12:20 p.m., the ADM stated she was made aware of the 3 missed doses of the hydrocodone/APAP 10/325mg on 10/21/2024 by the DON. She stated she expected the resident's medication to be ordered in a timely manner to ensure they were not without any medication. She stated Resident #32 was given morphine in the time she was without hydrocodone and had not complained of pain to the nursing staff.</p> <p>(continued on next page)</p>		

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<p>F 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of a facility policy dated 2001 indicated the general guidelines for pain management were defined as the process of alleviating the resident's pain based on his or her clinical condition and established treatment goals Acute pain should be assessed every 30 to 60 minutes after the onset and reassessed as indicated until relief is obtained.</p>		

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<p>F 0727</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33460</p> <p>Based on interview and record review, the facility failed to use the services of a registered nurse for 8 at least consecutive hours 7 days a week (140 days) and have a DON licensed in her state of residency (since [DATE]) reviewed for sufficient staffing.</p> <p>The facility failed to ensure they had a full time DON licensed in Texas and failed to ensure there was an RN for 8 consecutive hours 7 days a week.</p> <p>These failures could place residents at risk of lack of nursing oversight and a higher level of care.</p> <p>Findings included:</p> <p>Record review of the personnel file from 09/01/23 through 10/23/24 indicated the DON had a valid Florida license for RN and assume the DON position on 09/01/23. She had an active LVN license in Texas. Her driver's license indicated a Texas address.</p> <p>Record review of a list of no RN coverage based off time sheets provided by the facility from 09/01/23 through 10/23/24 indicated there was no RN coverage for the following months:</p> <p>September 2023 for 9 days;</p> <p>October 2023 for 14 days;</p> <p>November 2023 for 10 days;</p> <p>December 2023 for 11 days;</p> <p>January 2024 for 13 days;</p> <p>February 2024 for 12 days;</p> <p>March 2024 for 13 days;</p> <p>April 2024 for 13 days;</p> <p>May 2024 for 11 days;</p> <p>June 2024 for 12 days;</p> <p>July 2024 for 14 days;</p> <p>August 2024 for 13 days;</p> <p>(continued on next page)</p>		

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<p>F 0727</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>September 2024 for 12 days;</p> <p>October 2024 for 8 days.</p> <p>During an interview on 10/23/24 at 10:30 a.m., the staff member of the BON said the nurse should have applied for a Texas licensed. She said there had been some schools in Florida involved in fraud. She said if this nurse had gone to the school involved in fraud this would need to be reported. She said the BON would investigate this matter after it was reported to determine if license was a case of fraud.</p> <p>Record review of the BON website on 10/23/24 at 10:45 a.m., indicated the RN license was required to be in the state of the nurse's residency.</p> <p>During an interview on 10/23/24 at 11:44 a.m., DON said she had gone to school and tested in Texas and had a Florida RN license. She said she resided in both states and during her time in college and there was on a waiver because of COVID. She said during the training, the college had her to travel more frequently to Florida during her training. She denied notifying the BON for assistance or for application for Texas license and said some of her classmates had trouble getting a Texas license. She said she was going to check into it but never did. She denied having any knowledge of any wrongdoing on her part. She said she went to Florida once a month for her classes for almost 2 years. She said the name of her school was College AA. She said she had transcripts and her license at home.</p> <p>Record Review obtained on 10/23/24 from the internet site of the Texas BON indicated College AA was on the top of the list of the schools that were involved in fraud during the operation nightingale.</p> <p>During an interview on 10/23/24 at 12:00 p.m., the Administrator said she was not aware the college that the DON went to was involved in fraud and was unaware that nurses had to be licensed in the state they live in. She said they had checked the nursysnurses website to verify licensure status prior to her being the DON. She said the system indicated a Florida license was active and multi state so she could work in Texas because Texas was compact state and so was Florida. She said she and HR were responsible for checking backgrounds prior to hire. She said if RN license was not good, they did not have RN coverage 8 hour a day.</p> <p>During an interview on 10/23/24 at 12:45 p.m., DON said she did not try to obtain her license illegally/fraudulently and she earned her license and would investigate this matter with the Texas board of Nursing.</p> <p>The list of days without RN coverage provided by Administrator was attached to this survey.</p> <p>Record review of the undated Job Description - Director of Nursing indicated . He/She must be a graduate of an accredited school of nursing currently registered with the state agency for nursing licensure and hold a valid licensed in the state he/she is employed. Must have and maintain a License according to the Board of Nursing Examiners.</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are free from significant medication errors.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44596</p> <p>Based on interview and record review the facility failed to ensure residents were free of any significant medication errors for 1 of 10 residents reviewed for medications. (Resident #32)</p> <p>The facility failed to ensure:</p> <p>Resident #32 missed 3 doses of hydrocodone 10/325mg (12:00 p.m., 4:00 p.m., and 8:00 p.m. doses) on 10/20/2024.</p> <p>These failures could cause increased pain and decreased quality of life Resident #32</p> <p>Findings included:</p> <p>Record review of an undated face sheet indicated Resident #32 was a [AGE] year-old female admitted to the facility on [DATE] with the diagnoses dementia (general term for loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life), pain(physical suffering or discomfort caused by illness or injury), and rheumatoid arthritis (a chronic inflammatory disorder that can affect more than just your joints. In some people, the condition can damage a wide variety of body systems, including the skin, eyes, lungs, heart, and blood vessels).</p> <p>Record review of Resident #32's admission MDS assessment dated [DATE] indicated she had a BIMS of 13 and required substantial to maximum assistance for toileting, transfer, and hygiene. The MDS indicated Resident #32 had pain almost constantly and it was rated a 9 on a pain scale of 1-10.</p> <p>Record review of Resident #32's care plan dated 08/21/2024 indicated she had chronic pain related to rheumatoid arthritis. The intervention was to administer hydrocodone-APAP as ordered.</p> <p>Record review of Resident #32's MAR dated October 2024 indicated she received hydrocodone/ APAP 10/325 mg (1) tablet 4 times daily from 10/01/2024 through 10/19/2024. The MAR revealed Resident #32 received the 8 a.m. dose of hydrocodone/APAP 10/325mg (1) tab on 10/20/2024. Resident #32's MAR indicated she missed the 12:00 p.m., 4:00 p.m., and 8:00 p.m. doses of hydrocodone/APAP 10/325mg.</p> <p>Record review of Resident #32's narcotic count sheet for October 2024 indicated the final last hydrocodone/APAP 10/325mg (1) was administered at 8:00 a.m. on 10/20/2024. The count was zero after the 8:00 a.m. dose was administered on 10/20/2024.</p> <p>During an interview on 10/21/2024 at 8:15 a.m., Resident #32 stated she was in pain and had not slept well because the facility was out of her pain medication. Resident #32 stated she currently had a pain level of 4-5. She stated it was excruciating but it made it hard to rest. She stated she had not gotten her routine pain medication but one time yesterday and the medication nurse this morning (10/21/2024) told her it had not come in yet. She stated she always had pain because of her rheumatoid arthritis, but she could function normally if her pain was between 2-3. She stated her pain had not kept her from eating breakfast, had not kept her for walking with her walker in her room and taking herself to the bathroom.</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 10/21/2024 at 2:00 p.m., LVN B stated Resident #32 was out of hydrocodone/APAP 10/325mg (1) this morning (10/21/2024) when she counted the cart. She stated Resident #32 was not happy this morning when she had to tell her she was still out of her routine hydrocodone. She stated the resident told her the prn morphine was not working to keep her pain under control. Resident #32 stated her pain was a 4. She stated Resident #32 said it was not excruciating pain, just dull and annoying and keeping her from resting. LVN B stated she called the pharmacy at 9:00 a.m. and they stated the courier was in route to the facility with the medication. She stated the courier arrived 15 minutes later and the resident received her morning dose of hydrocodone/APAP 10/325 (1) tablet. LVN B stated had she not been able to get the medication so quickly, the facility had an emergency narcotic box that she could have gotten the medication from.</p> <p>During an interview on 10/22/2024 at 10:00 a.m., LVN A stated she called the MD for Resident #32 on 10/20/2024 around 10:00 a.m. and requested a refill of hydrocodone. She stated the MD sent a refill prescription to the pharmacy at that time. She stated she gave prn morphine per the resident's request at 12:00 p.m. and 8:00 p.m. on 10/20/2024 when she assessed her pain, and she said her pain was a 5. She stated when she reassessed her pain an hour after the morphine at 1:00 p.m. and 9:00 p.m., both times it was a 3. She stated in order to get into the emergency narcotic box a hard copy of the prescription for the narcotic had been faxed to the pharmacy and the pharmacist gives you a code to retrieve the needed narcotic. She stated there was no way to get a hard copy of the narcotic prescription from the MD on a Sunday evening.</p> <p>During an interview on 10/22/2024 at 2:15 p.m., the DON stated Resident #32's hydrocodone/APAP 10/325mg was missed for 3 doses on 10/20/2024. She stated Resident #32 was given prn morphine while she was without the hydrocodone. She stated the facility had an emergency narcotic kit for times when the resident's need the medication and the facility is without. She stated she asked LVN A why she had not attempted to get a narcotic prescription for Resident #32's hydrocodone to use the emergency narcotic box because she had no way to get the prescription to fax to the pharmacy to be able to get the hydrocodone out of the emergency kit.</p> <p>During an interview on 10/23/2024 at 12:20 p.m., the ADM stated she was made aware of the 3 missed doses of the hydrocodone/APAP 10/325mg on 10/21/2024 by the DON. She stated she expected the resident's medication to be ordered in a timely manner to ensure they were not without any medication. She stated Resident #32 was given morphine in the time she was without hydrocodone and had not complained of pain to the nursing staff.</p> <p>Record review of policy dated April 2019 was documented Administering Medications, Medications are administered in a safe and timely manner, and as prescribed. Only persons licensed or permitted by this state to prepare, administer, and document the administration of medications may do so. The director of nursing services supervises and directs all personnel who administer medications and/or have related functions. Medications are administered in accordance with prescriber orders, including any required time frame.</p>		