STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676295	A. Building B. Wing	02/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Epic Nursing & Rehabilitation	3210 W Hwy 22 Corsicana, TX 75110

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)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45957 Based on interviews and record review, the facility failed to ensure that residents received treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices for 1 (Resident #1) of 6 residents reviewed for quality of care. The facility failed to document fluid intake for Residents #1 according to physician orders. This failure could place residents at risk of not receiving necessary medical care, and hospitalization . Findings included: Review of Resident #1's undated face sheet reflected a [AGE] year-old female who was admitted to the facility on [DATE] with diagnoses including heart failure (occurs when the heart cannot pump enough blood and oxygen to the body), cognitive communication deficit (difficulty paying attention to a conversation, staying on topic, remembering information) essential primary hypertension (high blood pressure with no clear, identifiable cause), and Type 2 diabetes mellitus with diabetic neuropathy (complication of diabetes that causes nerve damage). Review of Resident #1's admission MDS, dated [DATE], reflected a BIMS score of 10, indicating moderate cognitive impairment. Resident #1 admission MDS also reflected she was dependent in the following areas: eating, toileting hygiene, lower body dressing, and putting on/taking off footwear. Resident #1 was substantial/maximal assistance in the following areas: oral hygiene, shower/bathe self, upper body dressing, and personal hygiene. Review of Resident #1's care plan, dated 02/12/25, reflected Resident #1 was care planed for resident is on a fluid restriction and is at risk for a fluid imbalance, amount of restriction: 1.5L per day r/t diagnosis CHF. Review of Resident #1's physician order, dated 02/12/25, reflected fluid restriction 1.5 liters daily every shift (day, night). Resident #1 had a previous discontinued physician order dated 02/06/25 - 2/09/25 of monitor fluid intake closely every shift - fluid restriction 48oz every 24 hours (day, night). Resident #1 had a previous discontinued physician order dated 12/17/24 - 02/06/25 of monitor fluid intake closely every shift fluid restriction 1 liter every 24 hours every shift (day, night). (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #1's Fluids in her EMR, dated 02/12/25, reflected Resident #1's fluids had not been documented from 12/17/24 - 02/12/25. During an interview with Resident #1 on 02/12/25 at 2:05 pm, Resident #1 was not aware that her fluids documented. During an interview with LVN A on 02/12/25 at 3:15 pm, LVN A she stated she was aware that Resident #1 fluids needed to be documented due to an alert in the resident's EMR. LVN A stated that she had made the fluid intake entry for the day shift around 2:45 pm. LVN A stated she did not know why Resident #1's fluid had not been documented on prior to 02/12/25. LVN A stated a negative outcome of not documenting Resident #1's fluid intake would be that the resident could gain or lose weight and you would not know how much the resident had received that day. During an interview with MD on 02/12/25 at 3:30 pm, the MD stated that Resident #1 was seen by her cardiologist on 02/06/25 and her fluid restriction was increased from 1L to 1.5L. The MD stated that he expects the facility to follow physician order. The MD stated there would not be any major negative outcome from the facility not documenting Resident #1's fluid intake due to Resident #1 receiving her diuretic medication twice a day and attending cardiology appointments. The MD stated that the resident could be dehydrated or have weight gain or loss due to her fluid not being documented per orders. During an interview with the DON on 02/12/25 at 3:40 pm, the DON stated physician orders should always be followed. The DON stated it was her expectation for the nurse to document how much fluid intake Resident #1 had twice a day. The DON stated it was important for a resident with a diagnosis of CHF fluid to be monitored to ensure the resident did not have excess fluid. The DON stated a negative outcome of not documenting Resident #1's fluid intake would be you would not know of much fluid she has had and that could cause weight gain as well. During an interview with the interim ADM on 02/12/25 at 3:50 pm, the interim ADM stated physician orders should always be followed. The interim ADM stated it was her expectation for the nurse to document how much fluid intake Resident #1 had twice a day. The interim ADM stated that it's important that Resident #1's fluid intake was documented due to her diagnosis of CHF. The interim ADM stated a negative outcome of not documenting Resident #1's fluid intake would be the unknown amount of fluid she had received, and she could possibly gain or loss weight. The interim ADM stated it was the nurses for the hall Resident #1 resided on responsibility for ensuring her weight was documented per the physician orders. The interim ADM stated that she or her regional compliance nurse could find a policy regarding following physician orders.