| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 676304 | A. Building<br>B. Wing | 04/24/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Creekside Village | 914 N Brazosport Blvd<br>Richwood, TX 77531 |

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0552<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure that residents are fully informed and understand their health status, care and treatments.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48315<br><br>Based on interview, and record review, the facility failed to inform residents in advance of the risks and benefits of proposed care and treatment for 1 of 5 resident (Resident #257) reviewed for resident rights, in that:<br><br>The facility failed to obtain a signed consent for antipsychotic medication, Buspirone HCl 10MG, Klonopin 0.5 MG, Olanzapine 5 MG and Veriafaxine HCl ER 75 MG that was administered to Resident #257.<br><br>The failure could affect residents who received psychoactive medications without informed consents and placed them at risk of receiving treatments without informed consent.<br><br>Findings include:<br><br>Record review of Resident #257's face sheet dated 03/26/24 revealed she was an [AGE] year-old female who admitted to the facility on [DATE], with diagnoses of Cerebral infraction , Major Depressive Disorder, Unspecified fracture of upper end of left Humerus, Bacteria Pneumonia, UTI, Esophageal Reflux Disease, Anemia, Hypo-Osmolality and Hyponatremia, Epilepsy, Altered Mental Status.<br><br>Record review of the comprehensive MDS assessment, dated 03/26/2024, revealed Resident #257 was able to complete MDS.<br><br>Interview on 4/22/24 at 9:00am with MDS Nurse Resident was able to complete MDS and she was not able to put BIMS score in. Based off interaction with Resident # 257 her BIMS would be 13.<br><br>The MDS nurse stated that Resident # 257 may have had some short term and long-term memory problems but was not sure due to Resident being in and out of facility.<br><br>Record review of Resident #257 revealed that Resident# 257 uses antipsychotic medication Venfaxine HCL ER 75 MG related to Depressive Disorder, medication was given on the following dates 3/30,31/24, Buspirone HCl 7.5 MG was given on3/27, 3/28,3/29,3/30,3/31, 4/1, 4/21/4/22Olanzapine 5MG was given on the following dates3/21,3/22 and Klonopin 0.5 MG on 4/22/24<br><br>Record review of Resident #257 physician's order summary report revealed the following order:<br><br>Medication is to be given as follow: Buspirone HCl 10MG 1 tablet orally twice a day, Klonopin 0.5 MG 1 tablet once a day, Olanzapine 5 MG and Veriafaxine HCl ER 75MG 1 tablet once a day.<br><br>(continued on next page) |



| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| F 0552<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Record review of Resident #257 history and physical dated 3/27/24 revealed the following anti psych medications:<br><br>Venlafaxine HCi 75 MG tablet with food orally once a day, Buspirone HCl 7.5 MG tablet orally twice a day, Fluoxetine HCl 20 MG tablet 1 tablet orally once a day.<br><br>Record review of Resident #257 history and physical dated 3/27/24 revealed the following diagnosis of Resident #257:<br><br>Seizure, HLD, GERD, HTN, Anxiety, MDD and CVA<br><br>Interview on 4/23/24 at 10:00 am with DON stated orders to give Resident#257 antipsychotic medication came from the doctor of Oceans Behavior Hospital and our doctor here at the facility followed the orders from the hospital and medication was for her behaviors of yelling, smearing feces and throwing herself to the floor.<br><br>Interview on 04/23/24 at 10:43 AM, the DON stated [NAME] a nurse received an order for a psychotropic, they should make sure they have consents. If a resident does not have consent the nurse should contact the management nurse and the management nurse would let the doctor know. The DON stated all charge nurse should check for signed consents on a daily basis due to medications changes on daily basis. The DON was asked why it is important to inform a resident of the risk and benefits of the medication. The DON stated that it is every resident's right to be informed about the treatment and medication they received.<br><br>Interview on 04/23/24 at 11:05 AM, the charge nurse stated that she was aware that Resident #257 was diagnosed with depression and had been order the medication, related to yelling out, mood disturbance, and agitation. The Charge Nurse stated Resident #257 was initially admitted on [DATE] with the diagnosis of depression. The Charge Nurse stated that Resident #257 was initially ordered Venfaxine HCL ER 75 MG 1 capsule by mouth daily with a started date of 3/26/24 related to Resident #257 behavior of yelling out. The Charge Nurse stated that Resident #257 had frequency changes to the medication on 3/29/24 and an additional change to the medication frequency on 3/29/24 to 75 MG 2 capsule by mouth daily. The surveyor requested the documented consent for antipsychotic medication treatment for Resident #257.<br><br>The Charge Nurse stated that the facility did not have a current consent for treatment. The Charge Nurse stated that she was working on obtaining consent from Resident #257's POA. The Charge Nurse stated Resident #257 was always in out of psych hospital since her admission. The Charge Nurse was asked why it is important to inform a resident of the risk and benefits of the medication. The Charge Nurse stated that it is every resident's right to be informed about the treatment and medication they received.<br><br>Record review of the facility's policy last revised January 2023, titled Psychotropic medication use, revealed the following:<br><br>o Prior to administration of or with a change in the dosage of an antipsychotic medication, the facility shall obtain informed consent from the resident/resident representative. This will be documented on form 3713 in conjunction with the resident/resident representative, attending physician and/or psychiatrist and the facility staff. |

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| F 0640<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Encode each resident's assessment data and transmit these data to the State within 7 days of assessment.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26867<br><br>Based on interview and record review, the facility failed to ensure resident assessments were completed,, electronically transmitted, encoded accurately and , MDS data entered to the CMS System within 7 to14 days after the death for 1 of 16 residents (CR #56) reviewed for encoding and transmitting resident assessments:<br><br>- The facility failed to encode and transmit MDS data after the a Death in Facility for CR #56 within the required timeframe<br><br>This failure could place discharged residents at risk of not having their assessments transmitted/exported timely.<br><br>Findings include:<br><br>Record review of Resident #56's electronic face sheet dated 4/24/24 revealed a -[AGE] year-old female admitted to facility 03/12/24. Her diagnoses included Malignant neoplasm (Cancer) of left lung.<br><br>Record review of CR #56's MDS assessment dated [DATE] indicated section A identifying information was initiated and signed by the MDS coordinator as completed on 04/01/24. Record review of the MDS revealed no RN signature as completed.<br><br>Record review of nurse's notes dated 03/15/24 read in part 3/15/2024 04:55 Nursing Progress Note: Hospice nurse notified local PD and res son. Meds released to [NAME] PD. Nursing<br><br>3/15/2024 04:01 Nursing Progress Note: Hospice nurse here and pronounced time of death. Nursing<br><br>3/15/2024 03:40 Nursing Progress Note: Resident noted to have no respiration, no heartbeat. Pupils non-reactive to light. Notified Hospice.<br><br>During an interview with MDS Coordinator and the DON on 04/24/24 at 4:50PM, she looked at the MDS and said CR #56 came to the facility to die. She said the MDS was not completed because she had to work on the floor. She said that was when she was needed to work the floor.<br><br>Policy on MDS completion was requested on 04/24/24 at 5:00 PM The MDS Coordinator said she followed the RAI manual in submitting the MDS. |

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| F 0655<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26867<br><br>Based on Record review and interview, the facility failed to develop and implement a Baseline Care Plan for resident 1 of 1 (CR #56) reviewed for baseline care plans.<br><br>The facility failed to initiate a Baseline Care plan within 48 hours of admission for CR # 56 admitted for respite care on 03/12/24.<br><br>This failure could place the resident at risk of not receiving person-centered care that is needed for communicating with staff to ensure the resident's needs are met.<br><br>Findings include:<br><br>Record review of Resident #56's electronic face sheet dated 4/24/24 revealed a -[AGE] year-old female admitted to facility 03/12/24. Her diagnoses included Malignant neoplasm (Cancer) of left lung.<br><br>Record review of CR #56's MDS assessment dated [DATE] indicated section A identifying information was initiated and signed by the MDS coordinator as completed on 04/01/24. Record review of the MDS revealed no RN signature as completed.<br><br>Record review of nurse's notes dated 03/15/24 read in part 3/15/2024 04:55 Nursing Progress Note: Hospice nurse notified the local PD and responsible party. Meds released to local PD.<br><br>3/15/2024 04:01 Nursing Progress Note: Hospice nurse here and pronounced time of death.<br><br>3/15/2024 03:40 Nursing Progress Note: Res noted to have no respiration, no apical heartbeat. Pupils non-reactive to light. Notified Hospice.<br><br>Record review of Resident #56's physician orders 03/12/24 revealed Resident #56 was admitted to the facility on hospice. Record review of Resident # 56 clinical records revealed no further documentation.<br><br>During an interview with DON and the MDS coordinator on 04/24/24 at 4:00pm, the MDS coordinator said Resident # 56 came to the facility to die. The DON said there was no interim plan of care. She said it was the facility's policy to complete and interim plan of care within 48 hours of admission by the admitting nurse or the next nurse on duty. She said this was overlooked due to the fact that the resident was at the facility for a short stay.<br><br>Record review of facility's policy titled Baseline care plan dated 2001 updated 2016 read in part-<br><br>Policy Statement<br><br>A baseline plan of care to meet the resident's immediate needs shall be developed for each resident within forty-eight (48) hours of admission.<br><br>(continued on next page) |

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| F 0655<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Policy Interpretation and Implementation<br><br>1. To assure that the resident's immediate care needs are met and maintained, a baseline care plan will be developed within forty-eight (48) hours of the resident's admission.<br><br>2. The Interdisciplinary Team will review the healthcare practitioner's orders (e.g., dietary needs, medications, routine treatments, etc.) and implement a baseline care plan to meet the resident's immediate care needs including but not limited to:<br><br>a. Initial goals based on admission orders.<br><br>b. Physician orders.<br><br>c. Dietary orders.<br><br>d. Therapy services.<br><br>e. social services; and<br><br>f. PASARR recommendation, if applicable.<br><br>3. The baseline care plan will be used until the staff can conduct the comprehensive assessment and develop an interdisciplinary person-centered care plan.<br><br>4. The resident and their representative will be provided a summary of the baseline care plan that includes but is not limited to:<br><br>a. The initial goals of the resident.<br><br>b. A summary of the resident's medications and dietary instructions.<br><br>c. Any services and treatments to be administered by the facility and personnel acting on behalf of the facility; and<br><br>d. Any updated information based on the details of the comprehensive care plan, as necessary. |