STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676406	A. Building B. Wing	03/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Trucare Living Centers - Selma	16550 Retama Parkway Selma, TX 78154

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48753 Based on observations, interview and record review, the facility failed to treat each resident with respect and dignity and care for each resident in a manner and environment that promoted personal privacy for each resident's individuality for 1 (Resident #6) of 12 residents reviewed for dignity in that: Resident #6's Foley catheter bag was observed without a privacy cover on it to provide dignity and privacy. This failure could affect the privacy and dignity of residents with Foley catheters. Findings included: Record review of Resident #6's face sheet revealed Resident #6 was a [AGE] year-old male who admitted to the facility on [DATE] with diagnoses that included pneumonia (an infection that inflames one or both lungs), acute respiratory failure with hypoxia (caused when a person does not have enough oxygen in the blood) and reflux uropathy (a urinary tract obstruction). Record review of Resident #6's care plan, date initiated 02/24/2025 revealed Resident #6 had an indwelling Foley catheter and the potential to display physical and verbally abusive behaviors related to Dementia (a general term for impaired ability to remember, think or make decisions). Record review of Resident #6's February MAR revealed an order that stated, verify privacy bag in place every shift, order date was 02/23/2025. The MAR is initialed as completed on every shift for 02/24/2025, 02/25/2025, 02/26/2025 and 02/27/2025. Observation of Resident #6 on 02/27/2025 at 10:35 a.m., revealed the resident was in bed, asleep, with his door open. Resident #6 had a Foley catheter bag hanging on the side of the bed facing the door making it visible to anyone who walked by the room. The bag contained a yellow fluid and did not have a cover to provide privacy. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676406	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/04/2025
NAME OF PROVIDER OR SUPPLIER Trucare Living Centers - Selma		STREET ADDRESS, CITY, STATE, ZIP CODE 16550 Retama Parkway Selma, TX 78154	

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with CNA A, 02/27/2025 at 11:05 a.m., CNA A stated she was the CNA assigned to provide care to Resident #6 that day. CNA A stated Resident #6 did not have a privacy cover over his Foley bag. CNA A stated the nurses were responsible for placing the privacy covers over the bags and CNA A stated she did not have access to the privacy covers. CNA A stated the privacy bags were important because no one needs to see their business and what output they had and stated the privacy covers should be on at all times. During an interview with LVN B, 02/27/2025 at 11:51 a.m., LVN B stated she was the charge nurse assigned to provide care to Resident #6 that day and stated that Resident #6 did not have a privacy cover over his Foley catheter bag. LVN B stated the nurses and CNAs were responsible for ensuring the privacy covers were on the bags. LVN B stated the covers were important to provide privacy to the resident. LVN B stated she had been trained on the importance of privacy covers in orientation. During an interview with the DON, 03/04/2025 at 8:58 a.m., the DON stated that all staff were responsible for making sure catheter bags had privacy covers when rounding in the facility and stated the CNAs and nurses were responsible for providing the providing the Foley catheter bags with privacy covers. The DON stated all residents should have privacy covers on the Foley catheter bags at all times. The DON stated he was not sure when facility staff received training on providing privacy to residents by using privacy covers on the catheter bags but stated it was important for the resident's dignity and their right to privacy. Record review of a facility document titled, Resident's Rights in Nursing Homes (dated April 2019), stated in part that a resident has the right to privacy and confidentiality, including the right to privacy in treatment, and the care of their personal needs and confidentiality regarding their medical, personal or financial affairs. It also stated residents had the right to dignity, respect and freedom including the right to be treated with the fullest measure of consideration, respect and dignity.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48753 Based on observation, interview and record review, the facility failed to notify the residents representative when the resident experienced a change in physical condition for 1 (Resident #1) of 12 residents reviewed for change in condition. The facility failed to notify Resident #1's resident representative when Resident #1 had episodes of diarrhea, a temperature and exhibited increased lethargy. This failure could result in the family or guardian not being aware of conditions that may require them to make medical decisions. The findings included: Record review of Resident #1's undated face sheet revealed Resident #1 was a [AGE] year old female who admitted to the facility in 06/15/2023 and had diagnoses that included Kidney Failure (a condition in which the kidneys can no longer filter waste products from the blood sufficiently), Dementia (a general term for impaired ability to remember, think, or make decisions), Edema (swelling caused by excess fluid trapped in the body's tissues), Type II Diabetes (a disease that occurs when a person's blood sugar is too high), Peripheral Vascular Disease (narrowing of the blood vessels), Hypertension (high blood pressure) surgical amputation (surgical removal of a limb) and morbid obesity (defined as having a body mass index of 40 or higher). Record review of Resident #1's undated face sheet revealed Resident #1 family member was listed as responsible party, POA -Financial, POA -Care, Substitute Decision Maker, Care Conference Person and Emergency Contact #1. Record review of Resident #1's quarterly MDS assessment, dated 02/08/2025, revealed a BIMS score of 9, indicating moderate cognitive impairment. Record review of Resident #1's care plan, date initiated 06/16/2023, revealed Resident #1 had care plan that reflected the resident had a history of osteomyelitis (an infection in the bone) and was at risk for future infections. The care plan was updated 02/07/2025 to reflect Resident #1 readmitted from the hospital with antibiotics for colitis (inflammation of the lining of the colon) x 7 days and 2/13/2025 Resident #1 was on antibiotics for the flu x 7 days. Resident #1 also had a care plan for Dementia, Diabetes, Hypertension, Peripheral Vascular Disease and full code status. Record review of Resident #1's progress note written by LVN H, dated 2/24/2025 at 1:00 p.m., revealed, LVN H notified NP N that Resident #1 has a slight temperature of 101.2 [degrees Fahrenheit], B/P 125/69, pulse 89, Res. 18, 02 is 95RA. Informed resident has no appetite, had three episodes of diarrhea and that resident was previously hospitalized with Dx of ileus (temporary and often painful lack of movement in the bowels that can lead to a bowel obstruction) and proctocolitis (a general term for inflammation of the rectum and colon). New order received for a STAT KUB, CBC, CMP. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #1's progress note written by the DON, dated 02/24/2025 at 8:50 p.m., revealed, during morning clinical, it was reported that the resident was not feeling well and had experienced a loose bowel movement the previous afternoon. The resident's vital signs obtained that morning were blood pressure 116/70 mmHg, temperature 99.1F (temporal), heart rate 85bpm, and respiratory rate 19 breaths per minute. The Nurse Practitioner was notified promptly, and stat orders were obtained for a KUB, CBC and CMP at approximately 11:30 a.m. At 4:30 p.m., the [resident's family member] stated that the resident was not feeling well; upon immediate reassessment, the resident exhibited an altered mental status, being non-verbal and responding only to gentle stimuli. At that time, the resident's vital signs had declined to blood pressure 88/52 mmHg, temperature 97.9F, heart rate 86 bpm, and respiratory rate 17 breaths per minute. Due to this rapid deterioration in her condition, a 911 emergency call was placed, and the resident was transferred to the hospital, with the resident's [family member] escorting her to the hospital. During an interview with Resident #1's family member, 02/26/2025 at 3:30 p.m., Resident #1's family member stated she arrived at the facility on 2/24/2025 around 4:30 p.m. to visit Resident #1. The family member stated no one had called her during the day to tell her that Resident #1 was having a change in condition. The family member said when she entered Resident #1's room she immediately knew something was wrong and said she looked like a corpse and her face looked swollen. I went to the charge nurse and told her that I wanted [Resident #1] sent out to the hospital and she said she had to call the Nurse Practitioner and get an order to send her out. The DON came in the room to check on her and her blood pressure was 85/52 when EMS got there. She was sent to the hospital, and she was being treated for a change in her dementia, low potassium and an infection of sort. I don't think they know yet. During an interview with the Hospital RN, 02/27/2025 at 3:45 p.m., the hospital RN stated Resident #1's admitting diagnosis was altered mental status, hypotension (low blood pressure), acute kidney injury (reduce in kidney function), and C-Diff (a highly contagious bacterium that causes diarrhea and colitis often infects people who've recently taken antibiotics).The Hospital RN stated the acute kidney injury was likely contributed to the diarrhea with the CDIFF and the CDIFF was a side effect of the recent usage of antibiotics to treat previous infections. During an interview with LVN H, 02/28/2025 at 3:11 p.m., LVN H stated she was notified on Monday, 02/24/2025, by the CNA that Resident #1 was having diarrhea and the CNA had asked for a medication to be administered. LVN H stated she obtained Resident #1's vitals and then notified NP N around 12:00 p.m. of the temperature and diarrhea. LVN H stated she provided NP N a background of Resident #1's recent hospitalization for an ileus so NP N ordered a STAT KUB, CBC and CMP. LVN H said she entered the orders for the stat labs and stated Resident #1's family member came in later in the day and I told her I had not had a chance to call her yet, but we were doing STAT labs for [Resident #1] because of the diarrhea and temperature. LVN H stated Resident #1's family member became upset and was yelling and stating Resident #1 looked bad and she wanted her sent out 911. LVN H stated she told the family member that she had to call and get an order from NP N to send her out and Resident #1's family member stated she did not want to wait for the labs to come back and wanted Resident #1 assessed in the hospital. LVN H stated she spoke to NP N and she gave orders to send Resident #1 to the hospital for an evaluation. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with LVN H, 03/02/2025 at 11:35 a.m. LVN H stated she did not notify Resident #1's responsible party at the time of the change in condition and she should have notified the responsible party around the same time she notified NP N of the changes in condition Resident #1 was experiencing. LVN H stated she last observed Resident #1 around 4 p.m. when she completed an accu check for Resident #1 and stated Resident #1's blood sugar was 98. LVN H stated she provided Resident #1 some orange juice. LVN H stated Resident #1 was talking and alert at that time. LVN H stated Resident #1's responsible party arrived at the facility around 4:30 p.m. and that was when she notified her of the change in condition. LVN H stated it was important to notify the responsible at the time of the change of condition so they are aware. During an interview with the DON, 03/04/2025 at 8:58 a.m., the DON stated that staff had received training on notifying the physician and responsible party when a resident has a change in condition. The DON stated some examples of changes in condition included fever, abnormal labs, not eating, and skin tears or breakdown. The DON stated that LVN H failed to notify Resident #1's responsible party at the time of the change in condition and stated it was extremely important to notify the responsible party. The DON stated LVN H got busy with an admission or it was lunch time but yes, she should have called. The DON stated staff had received training on changes in condition and notifications as recently as 01/30/2025. During an interview with NP N, 03/04/2025 at 11:50 a.m., NP N stated she started providing clinical services to the facility on [DATE]. NP N stated she was notified by LVN H on 02/24/2025 around noon that Resident #1 was having diarrhea, was not feeling well and had a slight temperature and all other vitals were ok. NP N stated LVN H informed NP N of Resident #1 history of a recent ileus and NP N ordered a STAT KUB, CMP and CBC. NP N stated she was notified later in the day by a nurse that the [family member] was at the facility and the resident was continuing to decline and wanted her to go to the hospital and NP N stated she gave the orders to send Resident #1 to the hospital for evaluation. Record review of a facility document titled, [Facility Name] Inservice Education, revealed an in-service topic, Importance of Reporting Changes of Condition, dated 01/22/2025 and listed the Instructor as the DON. The in-service revealed, Monitoring and reporting changes in a resident's condition is a critical part of ensuring their safety and well-being. Early detection of subtle changes, such as unusual behavior, altered mental status, changes in appetite, or new physical symptoms, can be a sign of an underlying health issue. By promptly recognizing and reporting these changes, nurses can initiate early interventions that may prevent condition from worsening. Failure to report these changes can delay treatment, leading to complications or even life-threatening situations. Nurses are responsible for completing the Change of Condition (COC) assessment in (PCC) to ensure proper documentation of any changes. They must also promptly notify the resident's physician, family and the Director of Nursing to ensure a coordinated response. Timely reporting saves lives by notifying providers to identify potential problems before they escalate, enabling early treatment and improved outcomes. The document was signed by 25 direct care employees. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of a facility document titled, [Facility Name] Inservice Education, revealed an in-service topic, Change of Condition and Notification, dated 02/25/2025 and listed the Instructor as the DON. The in-service revealed, All nursing staff are required to complete a change in condition report immediately for any resident showing signs of illness or when it is reported that a resident is not feeling well, with immediate notification to the attending physician and family members; failure to follow these protocols will be considered a serious breach of policy and may result in disciplinary action, up to and including termination. The document was signed by 20 direct care staff including LVN H.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48753 Based on observation, interview, and record review, the facility failed to provide care and services to prevent complications for 1 (Resident# 6) of 3 residents reviewed for enteral nutrition, in that; Resident #6's enteral feeding order did not include a frequency for changing the formula bottle or tubing. This failure could affect residents receiving enteral feedings by placing them at risk of complications related to expired formula, clogged tubing, delay in care and decline in health. The findings included: Record review of Resident #6's face sheet revealed Resident #6 was a [AGE] year-old male who admitted to the facility on [DATE] with diagnoses that included pneumonia (an infection that inflames one or both lungs), acute respiratory failure with hypoxia (caused when a person does not have enough oxygen in the blood) and reflux uropathy (a urinary tract obstruction). Record review of Resident #6's care plan, date initiated [DATE], revealed Resident #6 required a tube feeding related to Dysphagia (difficulty swallowing) and stated Resident #6 was dependent for tube feedings and water flushes. Record review, [DATE] at 12:14 p.m., of Resident #6 February 2025 MAR revealed, Enteral Feed Order. Every shift formula: Jevity 1.2 at 20ml/hr for 24 hours. The order date was [DATE] at 10:57 p.m. The MAR was initialed as completed on [DATE], [DATE] and [DATE] on shifts 6 a.m. -2 p.m., 2 p.m. -10 p.m., 10 pm. - 6 a.m., and on [DATE] on 6 a.m. -2 p.m. Record review, [DATE] at 12:41 p.m., of Resident #6's February 2025 MAR revealed,, change all tubing and hang new formula of Jevity 1.2 to run at 20ml/hr one time a day for enteral feed, order date [DATE] at 12:34 p.m. The MAR reflected a scheduled time of 1:00 a.m. daily. During an observation, [DATE] at 10:35 a.m., Resident #6 was observed lying in bed in his room. Resident #6's tube feeding formula was on a feeding pump and the pump was running at a rate of 20ml/hr. The tube feeding formula was a 1500ml bottle of Jevity 1.2 and it was dated [DATE] at 1030hrs. During an observation, [DATE] at 3:05p.m., Resident #6 was observed lying in bed in his room. Resident #6's feeding pump was running at a rate of 20ml/hr. The Jevity 1.2 bottle was dated [DATE] at 12:45 p.m. During an observation, [DATE] at 1:44 p.m., Resident #6 was observed lying in bed in his room. Resident #6's feeding pump was running at a rate of 20ml/hr. The Jevity 1.2 bottle was dated [DATE] at 12:45 p.m. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with LVN B, [DATE] at 11:51a.m., LVN B stated Resident #6's Jevity formula was dated [DATE] and stated 1030hrs meant the bottle was hung at 10:30 a.m. LVN B stated she knew when to change a resident's formula and tubing because it was reflected in a resident's administration record. LVN B stated Resident #6's orders did not specify when to change the tubing and formula and stated the order should have had included how often the tubing and formula should be changed. LVN B stated her initials on the MAR on [DATE] for the 6 a.m.- 2p.m. shift meant that Resident #6's formula was running but she had not changed the formula or the tubing. During an interview with the LVN B, [DATE] at 3:04 p.m., LVN B stated she hung a new formula bag and changed out the tubing for Resident #6. LVN B said she clarified the administration order for Resident #6 to include changing the tubing and formula once a day. During an interview with the facility Dietician, [DATE] at 12:50 p.m., the Dietician stated she was notified of Resident #6's admission on [DATE] and was planning to assess Resident #6 and increase his tube feeding rate on [DATE]. The Dietician stated the tube feeding orders should include a frequency on changing the tubing and the formula and stated that should be completed every 24 hours. The Dietician stated she did not give the original order and stated the facility must have received it from the hospital and had not clarified it. The Dietician stated the order was corrected to include a frequency for changing the formula and tubing on [DATE]. The Dietician stated Resident #6's feedings were running at a rate of 20ml/hr because Resident #6 had been an aspiration risk. The Dietician stated the tube feeding formula would expire after being hung for 48 hours. The Dietician stated the original order, without clarification of when to change the tubing and formula, could cause the formula to expire leading to the resident receiving expired nutritional formula. During an interview with the DON, [DATE] at 8:58 a.m., the DON stated that tube feeding orders from the hospital for a new admission are entered in the administration record by the admitting nurse and then the nurse managers, including himself, review the orders in the clinical meeting to validate accuracy. The DON stated that the facility policy was that tube feeding tubing had to be changed every 24 hours and a new bottle of formula would be hung with the new tubing because the bottle cannot be re-spiked (reinserted). The DON said staff had been educated that tubing should be changed every 24 hours and the staff have to sign off on it in the MAR as being completed. The DON stated if a resident's formula expired, or the tubing was not changed it could cause the resident to become sick or contract an infection. Record review of [Product Manufacturer] Product Information Sheet for Jevity 1.2 Cal, updated [DATE], revealed in part for ready to hang containers hang product up to 48 hours when clean technique and only one screw cap set is used. Record review of facility policy titled, Administration Set Changes with revision date of [DATE], revealed the purpose of the policy was to provide guidelines for aseptic administration set changes in order to prevent infections associated with contaminated IV therapy equipment and stated, if parenteral nutrition is administered continuously or intermittently, change administration set every 24 hours.

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48753 Based on interview and record review, the facility failed to have complete and accurate documented medical records for 1 (Resident #1) of 12 residents whose clinical record was reviewed for accuracy. The facility failed to identify and discontinue an order for a fluid restriction for Resident #1 that was listed on Resident #1's MAR twice and listed as an intervention in Resident #1's care plan. This deficient practice could place residents at risk for not receiving necessary care and services due to the staff not having an accurate record upon which to make care decisions. The findings included: Record review of Resident #1's undated face sheet revealed Resident #1 was an [AGE] year old female who admitted to the facility in 06/15/2023 and had diagnoses that included Kidney Failure (a condition in which the kidneys can no longer filter waste products from the blood sufficiently), Dementia (a general term for impaired ability to remember, think, or make decisions), Edema (swelling caused by excess fluid trapped in the body's tissues), Type II Diabetes (a disease that occurs when a person's blood sugar is too high), Peripheral Vascular Disease (narrowing of the blood vessels), Hypertension (high blood pressure) surgical Amputation (surgical removal of a limb) and Morbid Obesity (defined as having a body mass index of 40 or higher). Record review of Resident #1's quarterly MDS assessment, dated 02/08/2025, revealed a BIMS score of 9, indicating moderate cognitive impairment. Section J - Health Conditions revealed Resident #1 had not been dehydrated at the time of the MDS assessment. Section K -Swallowing/Nutritional Status revealed Resident #1 had not had weight loss or weight gain at the time of the assessment and was on a therapeutic diet (e.g., low salt, diabetic, low cholesterol). Section M -Skin Conditions revealed Resident #1 did not have any ulcers or wounds at the time of the assessment. Record review of Resident #1's care plan revealed Resident #1 had a care plan, date initiated 06/16/2023, that reflected, Nutrition: at risk for changes and was updated 12/28/2023 to reflect Resident #1 was on a CCD/NAS (no added salt) diet, regular texture, thin consistency. An intervention listed on the nutrition care plan was, 07/28/23 Fluid restriction 300cc 6-2pm-125mls, 2-10pm -125mls and 10-6am 50mls 3 x a day for fluid monitoring, dated initiated 07/31/2023. Resident #1 had a care plan that reflected she was on diuretic therapy related to edema, date initiated 07/27/2023. Record review of Resident #1's February 2025 MAR, dated 08/19/2023 revealed, Fluid restriction Nursing-300cc - 6-2p, - 125mls, 2-10pm 125mls and 10-6am 50mls every shift for fluid monitoring. The order was initialed as completed on the MAR on all 3 shifts. Resident #1's MAR revealed a duplicate order for the same fluid restriction and was also initialed as completed. Record review of Resident #1's Nutritional Comprehensive Assessment, effective date 02/11/2025, by the Dietician revealed Resident #1's current food and fluid intake at the time of the assessment was 75% and listed a nutrition goal of 2470cc of fluid per day. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #1's assessment titled, Dietary Profile Admission/Change of Status/Quarterly, and completed by the Dietary Manager or the Dietician on 06/16/2023, 03/18/2024, 06/17/2024, 09/23/2024, 12/24/2024 and 02/10/2025 revealed Resident #1 was not on a fluid restriction. A Dietary Profile assessment completed by the Dietitian on 09/19/2023 and 12/18/2023 revealed Resident #1 was on a 1500cc fluid restriction. Record review of a facility document titled, Diet Order & Communication, listed Resident #1 name, indicated with a check mark the communication form was for a diet change. Under a section titled, Restrictions/Modifications, the Fluid Restriction option was circled and 900 was written in the space for the amount of mls/24hrs. Beside the number 900 reflected (Dietary) and beneath it reflected, Nursing = 300mls. The document was signed by an LVN and dated 07/27/2023. Record review of Resident #1's meal tray ticket, dated 02/23/2025, revealed Resident #1 was on a 300cc fluid restriction per day. Fluids listed on Resident #1's breakfast tray card was Milk 8 oz, Coffee or hot tea 6 oz, and orange juice 4 oz., Lunch and Dinner fluid listed was Tea of choice 6 oz. During an interview with CNA A, 02/27/2025 at 11:05 a.m., CNA A stated she was not aware of Resident #1 being on a fluid restriction. CNA A stated she did not usually provide direct care to Resident #1 but would see Resident #1 at meals in the dining room and stated she always had juice, tea, and water on her tray and she knew other staff would get her cokes and other drinks. During an interview with LVN D, 02/28/2025 at 8:45 a.m., LVN D stated she no longer worked at the facility but stated she had worked with Resident #1 and that Resident #1 had always been on a fluid restriction. LVN D stated she could not remember the exact amount of the fluid restriction but thought it was 1200cc or 1500cc a day. LVN D stated she did not know why Resident #1 was on a fluid restriction. During an interview with LVN E, 02/28/2025 at 9:53 a.m., LVN E stated Resident #1 was on a fluid restriction, but LVN E did not know how much. LVN E stated the fluid restriction was listed on the MAR and care plan and she believed Resident #1 was on the fluid restriction due to edema. LVN E stated nursing was responsible for communicating fluid restrictions to dietary so the fluid restriction dietary was provided would have been the same as the order in Resident #1's MAR. During an interview with CNA G, 02/28/2025 at 10:44 a.m., CNA G stated she was not sure if Resident #1 was on a fluid restriction and stated Resident #1 always had at least 2 drinks on her meal trays and CNA G stated she would fill up Resident #1 water pitcher in her room each day. CNA G stated she had not seen a fluid restriction listed with Resident #1's diet on the resident's profile in the computer where a fluid restriction would be listed. During an interview with the Dietician, 02/28/2025 at 12:50 p.m., the Dietician stated the physician was responsible for prescribing a fluid restriction and it should have been reevaluated by the physician probably monthly I would say. The Dietician stated Resident #1's order in the administration record said Resident #1 had a fluid restriction with nursing for 300cc but stated the order did not look right and stated that was not how the fluid restriction orders were written. The Dietician stated there was a duplicate order in the MAR and it did not make any sense to her that the order was for nursing only. The Dietician stated she completed dietary profiles on Resident #1 monthly and did not recall her being on a fluid restriction. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Trucare Living Centers - Selma		STREET ADDRESS, CITY, STATE, ZIP CODE 16550 Retama Parkway Selma, TX 78154	

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with CNA C, 02/28/2025 at 3:03 p.m., CNA C stated she did not think Resident #1 had a fluid restriction and she would give Resident #1 the Dr. Pepper's Resident #1 kept in her refrigerator. CNA C stated she passed fresh ice water to Resident #1 at the start of each shift and Resident #1 always drank the water. CNA C also stated she observed fluids on Resident #1's meal trays and Resident #1 would ask for additional coffee and would be served. CNA C stated she would know if a resident was on a fluid restriction because it would be reflected at the top of a resident's profile in the computer and it was not listed there. During an interview with LVN H, 02/28/2025 at 3:11 p.m., LVN H stated Resident #1 was on a 1500cc fluid restriction and stated the fluid restriction was on Resident #1's MAR that the nurses had to sign off on and stated dietary gave Resident #1 300cc at each meal. LVN H looked at Resident #1's MAR and stated it did not say 1500cc and she thought it used to say 1500cc. LVN H stated Resident #1 carried around a large cup that was always full of fluid and Resident #1 was noncompliant with the fluid restriction. LVN H stated Resident #1's family member would bring her drinks for her refrigerator and flavor packets to mix in her water and Resident #1 would always get water and fluids from the drink stations provided in the facility. LVN H stated Resident #1 was put on a fluid restriction a long time ago after going to a doctor appointment for edema and fluid retention. During an interview with Resident #1's Responsible Party, 02/28/2025 at 4:45 p.m., the Responsible Party stated Resident #1 was on a fluid restriction a long time ago when Resident #1 went to a kidney doctor and that doctor told her she was retaining fluids and had edema. The Responsible Party stated Resident #1 had been seeing a nephrologist for years prior to admitting to the facility and had kidney issues for a long time but stated she did not think Resident #1 was currently on a fluid restriction. The responsible party stated if Resident #1 was on a fluid restriction she would not have been compliant and stated Resident #1 did what she wanted and she loved her drinks and she drank what she wanted and when she wanted. The Responsible Party stated Resident #1 was always carrying around a large cup and the she (Responsible Party) never had concerns about Resident #1 not getting enough fluids. During an interview with the Dietary Manager, 03/03/2025 at 9:41 a.m., the Dietary Manager stated she received a diet communication form from nursing on new admissions and readmission residents that included the type of diet the resident was on and if the resident was on a fluid restriction. The Dietary Manager stated she entered the diet information into her tray card system and the diet would appear on each resident's tray card along with their food preferences. The Dietary Manager stated she was provided a dietary communication form by a nurse a long time ago and said Resident #1 was on a 300cc a day diet. The Dietary Manager stated she felt that number was very odd but did not question the fluid restriction. The Dietary Manager stated she provided Resident #1 10 oz of fluid at each meal. The Dietary Manager stated she tried to audit her diet tickets about once a month and stated if Resident #1 returned from a hospital stay and The Dietary Manager did not receive a new diet communication form, the Dietary Manager would just continue what was already on the tray ticket. During an interview with LVN H, 03/03/2025 at 11:35 a.m., LVN H stated she believed Resident #1's fluid restriction originated from a vascular surgeon appointment Resident #1 went to a few months after her admission because her amputation stump was swollen. LVN H stated she remembered there being an order that the DON put in the system and nursing was providing 300cc of fluid a day and dietary would provide 300cc each meal. LVN H stated she did not know why the order was entered like it was and believed the order had been entered wrong. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with NP M, 03/03/2025 at 1:16 p.m., NP M stated she reviewed a resident's prescribed orders every time she would assess a resident and stated fluid restrictions were usually determined by the resident physician or outside specialist and was monitored by the facility. NP M stated she did not know when Resident #1 was placed on a 300cc fluid restriction and stated That is not a normal order,. I do not know if she came back from the hospital with that order or where that came from. I cannot imagine the facility was following that order. The group I work for was not even seeing patients in the building at that time when it was ordered. NP M stated she never saw that fluid restriction in her orders and stated, It had to have been buried way back in her orders because I would have questioned that. NP M stated, That is not a common fluid restriction, and she is not even a dialysis patient. A nephrologist would not even order that. During an interview with Resident #1's facility Physician,03/03/2025 at 3:02 p.m., the Physician stated he was not aware that Resident #1 was on a fluid restriction and stated, I know she had the flu and diarrhea and I know she was in and out of the hospital. I am not sure what fluid restriction you are talking about. The Physician stated, If we do a fluid restriction it would not be 300cc.; 3000cc maybe or 1500cc, but that is not correct. We would not have been following that. I think someone missed a zero The Physician stated, This is the first time I am hearing about this whatsoever. She would be dehydrated in a week if she had that for 2 years. There is no way. The Physician stated he reviewed residents' orders monthly and did not recall seeing Resident #1's fluid restriction. During an interview with the MDS Nurse, 03/04/2025 a 11:34 a.m., the MDS Nurse stated she was responsible for completing and updating resident care plans. The MDS Nurse stated she was not aware that Resident #1 was on a fluid restriction and MDS Nurse stated she reviewed the care plans quarterly and updated the care plan as needed when a change occurred. The MDS Nurse stated reviewing a residents' orders and care plan was part of the MDS assessment process when an MDS and care plan was updated quarterly or annually. During an interview with the DON, 03/04/2025 at 8:58 a.m., the DON stated a physician would have given a fluid restriction order and some of the reasons a resident was placed on a fluid restriction included dialysis, heart problems, edema or kidney problems. The DON stated when a fluid restriction order was received by a nurse for a resident, that nurse would have entered the order in the resident's MAR provided a dietary communication form to dietary to inform dietary of the fluid restriction. The DON stated staff were able to identify residents on a fluid restriction because the fluid restriction was listed in the resident Kardex (summary of resident plan of care) that contained profile information. The DON stated the facility had a subcommittee meeting that meets monthly to discuss resident weights, fluid restriction, skin changes, etc. and stated he did not think they had discussed Resident #1. The DON stated he thought Resident #1 was on a 1200cc diet and then looked in Resident #1's chart and stated he could not find the 1200cc anywhere mentioned in the orders or notes. The DON said Resident #1 was discussed in the clinical meeting around 02/06/2025 or 02/13/2025 and the DON thought Resident #1 was on a 1200cc fluid restriction. The DON stated no one had looked at the orders and stated the Dietary Manager was not at the meeting that day and stated, We should have looked at it. There is no excuse but the order for the 300 cc probably should have been discontinued a long time ago and it was not. The DON said Resident #1 was very noncompliant with her fluid restriction and would drink whatever she wanted to drink, including coffee in the morning and multiple hot cocoas at lunch or dinner meals in addition to other fluids and her family brought her snacks and drinks. The DON said, since becoming DON of the facility in December 2024, when a resident admitted to the facility or returned from the hospital, the nursing managers reviewed the hospital orders and orders added to the resident's MAR to validate accuracy of the transcribed orders. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the DON, 03/04/2025 at 1:38 p.m., the DON stated that when a resident returned from the hospital, the nursing staff reviewed the hospital orders and got clarification orders as needed. The DON stated when Resident #1 would return from hospital stays, the DON thought the fluid restriction orders were entered as part of the standard house orders for Resident #1 and that was why the order was reinstated each time she returned from the hospital. The DON stated the fluid restriction should have been discontinued and that NP M and the physician were not aware of Resident #1 being on a fluid restriction. The DON stated the facility did not have a policy for fluid restriction.