Printed: 09/27/2024
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676458	A. Building B. Wing	07/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mabank Nursing Center	18957 US Hwy 175 W. Mabank, TX 75147

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 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	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** 44637 Based on interview and record review the facility failed to immediately inform the resident, consult with the resident's physician and notify, consistent with his or her authority, the resident representative when there was a significant change in the resident's physical, mental, or psychosocial status that was, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications for 1 of 6 residents (Resident #1) reviewed for notification of changes. 1. The facility failed to notify the physician of Resident #1's change in condition including head leaning heavily to the left, heavy incontinence, confusion, weakness, and need for 2-person assist on 7/15/24. 2. The facility failed to notify the physician of Resident #1's respiratory distress on 7/20/24 at 10:47 a.m. The noncompliance was identified as PNC. The IJ began on 7/15/24 and ended on 7/26/24. The facility had corrected the noncompliance before the survey began. These failures could result in residents with changes in condition not being treated leading to hospitalization or death. Findings include: 1. Record review of a face sheet dated 7/30/24 indicated Resident #1 was an [AGE] year-old female admitted to the facility on [DATE] with diagnoses including Alzheimer's, muscle weakness, cognitive communication deficit, major depressive disorder, and anxiety. Record review of the MDS dated [DATE] indicated Resident #1 was understood by others and usually understood others. The MDS indicated Resident #1 had a BIMS of 01 and was severely cognitively impaired. The MDS indicated Resident #1 ambulate with walker assist. Record review of the care plan revised on 5/5/24 indicated Resident #1 had an ADL self-care deficit. (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

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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 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of the nursing progress note, written by RN A, dated 7/15/24 at 9:10 a.m. indicated, [Resident #1] required two persons transfer and with ambulation to the bathroom for shower, up to chair after shower, and being dressed. [Resident #1's] head [was] leaning severely to the left. Assisted to straighten up her head and neck . [Resident #1 has been confused, heavily incontinent, weak - requiring assistance x 2 personnel . Record review of the nursing progress note, written by RN A on 7/17/24 at 9:50 a.m., indicated [Resident #1's] urine output [had a] very strong odor. [Resident #1] has had a different/altered generalized status/mental status over the past two days. [Physician] notified [and urine sample was collected] via sterile straight catheterization Record review of the Lab Results Report, dated 7/18/24, indicated Resident #1's urinary analysis findings were reported on 7/18/24 at 11:28 a.m. reflected Resident #1 had amber colored urine (the lab report indicated the reference range for urine color was yellow), had blood of 2+ (the lab report indicated this was an abnormal finding), was positive for nitrite (caused by bacteria in the urine) (the lab report indicated this was an abnormal finding), and had leukocyte esterase 3+ (an enzyme found in white blood cells) (the lab report indicated this was an abnormal finding). Record review of the PCR Lab Report, dated 7/18/24, indicated the results were reported on 7/18/24 at 7:52 p.m. The PCR Lab Report indicated the pathogen detected in Resident #1's urine was Escherichia Coli (a bacteria that normally lives in the human intestinal tract but can cause urinary tract infections if it enters the urinary tract). The PCR Lab Report indicated in the antibiotic notes that ESBL was detected. Record review of the nursing progress note, written by the ADON on 7/19/24 at 1:27 p.m., indicated Spoke with [Resident #1's family and] informed [them] no new orders [had been] received at this time [regarding Resident #1's urine analysis results] and [the Physician] call back [was] pending Record review of the vital signs dated 7/20/24 at 7:50 a.m. indicated Resident #1's oxygen saturation was 88%. Record review of the nursing progress note, written by RN A, on 7/20/24 at 9:41 a.m., indicated [Resident #1's] urine analysis, culture, and sensitivity results [had] been sent/faxed to [the Physician's] office this week. No new orders for antibiotic therapy [had] been received. [The NP was] again available as of today. [Resident #1's urine analysis, culture, and sensitivity results were] sent to [the NP]. Received new order for Macrobid (an antibiotic) 100mg twice daily x 7 days for this acute UTI Record review of the nursing progress note, written by RN A, dated 7/20/24 at 10:47 a.m. indicated Resident #1's vital signs were blood pressure-130/54, heart rate-92 beats per minute (normal range 60-100 beats per minute), respirations-30 breaths per minute (abdominal breathing) (normal range 12-20 breaths per minute), and oxygen saturation 88% on room air. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of the nursing progress note, written by RN A dated, 7/20/24 at 11:20 a.m. indicated, Moist-wet gurgling sounds heard at bedside .lung sounds auscultated, an echo of the gurgling sound heard but no rales, wheezing or rhonchi in [bilateral upper, lower, and middle lobes of lungs]. [Resident #1 was] alert and answering questions appropriately. Encouraged resident to 'cough', resident was able to weakly cough which did essentially clear this gurgling sound coming from the back of her throat. Continuing to monitor closely. Record review of the nursing progress note, written by RN A, dated 7/20/24 at 2:16 p.m., indicated [Resident #1] remains with some respiratory distress. Oxygen has been on via nasal cannula at 2-3Liters/minute. Generalized skin color is pale and slightly diaphoretic. [blood pressure] 86/61 -[temperature] 97.8- [heart rate]86-[respirations] 40 shallow- [oxygen saturation] 54% . [Resident #1] lethargic, awakens only to loud. verbal and some tactile stimuli. [NP] notified that resident will be sent to ER for further - physician evaluation. Record review of the hospital records, dated 7/20/24, indicated Resident #1's admitting diagnoses were sepsis (a life-threatening complication of an infection, pneumonia, leukocytosis (elevated white blood cells), altered mental status, COVID-19, influenza, and dehydration. The hospital records indicated Resident #1's assessment revealed sepsis, pneumonia, COVID-19, influenza B, and oliguric renal failure (also known as acute kidney failure, when a person's urine output is very low). Record review of the record of death, dated 7/22/24, indicated Resident #1's cause of death was COVID-19 with pulmonary comorbidity. During an interview on 7/30/24 at 9:30 a.m., the NP said he was out of the country from 7/14/24 through 7/19/24 and was not on call. The NP said the physician was on call during the time he was out of the country. The NP said when he returned, he was informed Resident #1 was in the hospital. During an interview on 7/30/24 at 9:33 a.m. the Physician said he was somewhat familiar with Resident #1. The Physician said he was not notified on 7/1/5/24 regarding Resident #1's change of condition including head leaning heavily to the left, heavy incontinence, confusion, weakness, and need for 2-person assist. The Physician said he would not have expected to have been notified for one of the changes of condition, but with the cumulative changes in condition he would have expected to have been notified. The Physician said he was not notified of Resident #1's respiratory distress on 7/20/24 at 10:47 am. The Physician said he would have expected a notification from the facility of a resident having respiratory distress. The Physician said the importance of him being notified regarding a resident's change in condition was so the resident could be assessed and a plan of care decided on. The Physician said Resident #1's cause of death was respiratory failure due to COVID pneumonia. During an interview on 7/30/24 at 10:01 a.m., CNA B said she had worked at the facility for approximately 2 years and had worked the 6:00 a.m.to 2:00 p.m. shift in the secured unit for approximately 4 months. CNA B said she was familiar with Resident #1. CNA B said Resident #1 was normally ambulatory and able to feed herself. CNA B said Resident #1 needed encouragement with eating and would require assistance as needed when she was tired. CNA B said the week of 7/15/24-7/20/24 she was off a few days. CNA B said Resident #1 was out of it during the days she worked the week on 7/15/24. CNA B said Resident #1 was more confused and less active during the week of 7/15/24. CNA B said Resident #1's change was reported to RN A. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 7/30/24 at 11:26 a.m., RN A said she was no longer employed at the facility. RN A said her last day to work was 7/23/24. RN A said she was familiar with Resident #1. RN A said when Resident #1 had a change in condition on 7/15/24 they observed her and provided assistance as needed. RN A said she was not sure if the physician was contacted regarding Resident #1's change of condition on 7/15/24. RN A said normally the NP was sent a text regarding changes in condition and lab results, but he was out of town during the week of 7/15/24. RN A said when Resident #1's respirations were 30 and her oxygen saturation was 88% she monitored her closely and faxed the physician. During an interview on 7/30/24 at 2:37 p.m., the DON said if a resident had a decrease in oxygen saturation, shortness of breath, or respiratory distress she expected the nurses to use nursing judgement as to whether the resident needed to be sent to the emergency room immediately or to if notification to the physician would be sufficient. Record review of the facility's Change in a Resident's Condition or Status policy, revised May 2017, indicated Our facility shall promptly notify the resident, his or her Attending Physician or Nurse Practitioner and the resident representative of changes in the resident's medical/mental condition and/or status. The nurse will notify the resident's Attending Physician, Nurse Practitioner, or physician on call when there has been a (an): .d. significant change in the resident's physician/emotional/mental conditions .A 'significant change' of condition is a major decline or improvement in the resident's status that: a. Will not normally resolve itself without intervention by staff or by implementing standard disease related clinical interventions (is no self-limiting); b. Impacts more than one area of the resident's health status .The nurse will record in the resident's medical record information relative to changes in the resident's medical/mental condition or status This was determined to be a PNC IJ on 7/30/24 at 1:20 p.m. The Administrator was notified. The Administrator was provided with the Immediate Jeopardy template on 7/30/24 at 1:22 p.m. The facility had corrected the noncompliance by the following: Suspending and then terminating RN A In-servicing staff to regarding notification of changes Record review of the Confidential Employee Corrective Action Form, dated 7/23/24, indicated on 7/23/24 RN A was suspended pending investigation. The Confidential Employee Corrective Action Form indicated RN A failed to follow facility policy regarding change in a resident's condition or status. Record review of the Employee Separation Report, dated 7/29/24, indicated RN A's last day to work was 7/24/24 and her termination date was 7/26/24. The Employee Separation Report indicated the reason for RN A's termination was policy violation. Record review of the Change in Condition in-service dated 7/23/24 indicated, Charge Nurse assesses resident with full set of vitals. Vital signs should be documented in the progress note along with the vital tab. Notification to the attending physician of the change. If [the attending physician] hasn't responded in [a] timely manner, attempt to call again .obtain orders for treatment .Notify nurse management of the change. Document change in condition using the Change of Condition Form. Place resident on the 24-hour report for follow-up. Follow up documentation in progress notes for at least 72 hours or longer if necessary . (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of sampled residents including 2 residents who had been hospitalized in the past 2-months indicated there had been no change of condition from 7/20/24-7/26/24. The 2 residents with previous hospitalization were appropriately documented on with appropriate notifications documented for all shifts. Staff interviewed (LVN D, CNA E, RN F, CNA G, LVN H, LVN J, and CNA B) on 7/30/24 between 11:56 a.m. and 2:30 p.m. were able to answer all question regarding in-services including adding residents with change of condition to the 24-hour nursing report, charting on residents with change in condition for 72 hours, notifying the physician of change of condition including abnormal lab values, reaching back out to the physician or medical director if no response was received within 1-24 hours depending on the severity of the change or abnormal lab value, and notifying nursing management regarding a resident's change of condition. The noncompliance was identified as PNC. The IJ began on 7/15/24 and ended on 7/26/24. The facility had corrected the noncompliance before the survey began.

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44637 Based on interview and record review the facility failed to ensure residents received treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan and the residents' choices for 1 of 6 residents (Resident #1) reviewed for quality of care. 1.The facility failed to recognize Resident #1's head leaning heavily to the left, heavy incontinence, confusion, weakness, and need for 2-person assist on 07/15/24 as a change of condition. 2. The facility failed to ensure fluid intake was encouraged or increased for Resident #1 after receiving lab results on 7/18/24 which indicated Resident #1 was positive for a UTI. 3. The facility failed to follow-up for 2 days regarding Resident #1's lab results which were positive for UTI. 4. The facility failed to ensure RN A provided oxygen therapy to Resident #1 when she was in respiratory distress. The noncompliance was identified as PNC. The IJ began on 7/15/24 and ended on 7/26/24. The facility had corrected the noncompliance before the survey began. These failures could place residents at risk of not receiving care in a timely manner, a decline in health status and quality of life or death. Findings Included: 1. Record review of a face sheet dated 7/30/24 indicated Resident #1 was an [AGE] year-old female admitted to the facility on [DATE] with diagnoses including Alzheimer's, muscle weakness, cognitive communication deficit, major depressive disorder, and anxiety. Record review of the MDS dated [DATE] indicated Resident #1 was understood by others and usually understood others. The MDS indicated Resident #1 had a BIMS of 01 and was severely cognitively impaired. The MDS indicated Resident #1 ambulate with walker assist. Record review of the care plan revised on 5/5/24 indicated Resident #1 had an ADL self-care deficit. Record review of the nursing progress note, written by RN A, dated 7/15/24 at 9:10 a.m. indicated, [Resident #1] required two persons transfer and with ambulation to the bathroom for shower, up to chair after shower, and being dressed. [Resident #1's] head [was] leaning severely to the left. Assisted to straighten up her head and neck . [Resident #1 has been confused, heavily incontinent, weak - requiring assistance x 2 personnel . (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of the nursing progress note, written by RN A on 7/17/24 at 9:50 a.m., indicated [Resident #1's] urine output [had a] very strong odor. [Resident #1] has had a different/altered generalized status/mental status over the past two days. [Physician] notified [and urine sample was collected] via sterile straight catheterization Record review of the Lab Results Report, dated 7/18/24, indicated Resident #1's urinary analysis findings were reported on 7/18/24 at 11:28 a.m. reflected Resident #1 had amber colored urine (the lab report indicated the reference range for urine color was yellow), had blood of 2+ (the lab report indicated this was an abnormal finding), was positive for nitrite (caused by bacteria in the urine) (the lab report indicated this was an abnormal finding), and had leukocyte esterase 3+ (an enzyme found in white blood cells) (the lab report indicated this was an abnormal finding). Record review of the PCR Lab Report, dated 7/18/24, indicated the results were reported on 7/18/24 at 7:52 p.m. The PCR Lab Report indicated the pathogen detected in Resident #1's urine was Escherichia Coli (a bacteria that normally lives in the human intestinal tract but can cause urinary tract infections if it enters the urinary tract). The PCR Lab Report indicated in the antibiotic notes that ESBL was detected. Record review of the nursing progress note, written by the ADON on 7/19/24 at 1:27 p.m., indicated Spoke with [Resident #1's family and] informed [them] no new orders [had been] received at this time [regarding Resident #1's urine analysis results] and [the Physician] call back [was] pending Record review of the vital signs dated 7/20/24 at 7:50 a.m. indicated Resident #1's oxygen saturation was 88%. Record review of the nursing progress note, written by RN A, on 7/20/24 at 9:41 a.m., indicated [Resident #1's] urine analysis, culture, and sensitivity results [had] been sent/faxed to [the Physician's] office this week. No new orders for antibiotic therapy [had] been received. [The NP was] again available as of today. [Resident #1's urine analysis, culture, and sensitivity results were] sent to [the NP]. Received new order for Macrobid (an antibiotic) 100mg twice daily x 7 days for this acute UTI Record review of the nursing progress note, written by RN A, on 7/20/24 at 10:47 a.m., indicated, Initial dose of Macrobid 100mg oral twice daily x7 for acute UTI obtained from E-Kit and administered [to Resident #1]. [Resident #1] tolerated well, continues to be able to take oral medications with water as per normal .[Vital Signs]: [blood pressure] 130/54- [Temperature] 98.3- [Heart Rate] 92- Respirations 30 [breath per minute] (abdominal breathing) (normal respiration rate 12-20 breaths per minute)- [Oxygen Saturation] 88% (normal oxygen saturation greater than 90%) [on room air]. Will be assessing/monitoring for possible .side effects such as: severe stomach pain, watery or bloody diarrhea, pain/burning w/urination, numbness, tingling or burning pain in hands or feet, pale skin, confusion and/or weakness. Continuing to monitor. Record review of the nursing progress note, written by RN A, dated 7/20/24 at 11:20 a.m. indicated, Moist-wet gurgling sounds heard at bedside .lung sounds auscultated, an echo of the gurgling sound heard but no rales, wheezing or rhonchi in [bilateral upper, lower, and middle lobes of lungs]. [Resident #1 was] alert and answering questions appropriately. Encouraged resident to 'cough', resident was able to weakly cough which did essentially clear this gurgling sound coming from the back of her throat. Continuing to monitor closely. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of the nursing progress note, written by RN A, dated 7/20/24 at 2:16 p.m., indicated [Resident #1] remains with some respiratory distress. Oxygen has been on via nasal cannula at 2-3Liters/minute. Generalized skin color is pale and slightly diaphoretic. [blood pressure] 86/61 Rt reclined position-[temperature]97.8- [heart rate]86-[respirations]40 shallow- [oxygen saturation] 54% . [Resident #1] lethargic, awakens only to loud. Verbal and some tactile stimuli. [NP] notified that resident will be sent to ER for further - physician evaluation. Record review of the hospital records, dated 7/20/24, indicated Resident #1's admitting diagnoses were sepsis (a life-threatening complication of an infection, pneumonia, leukocytosis [elevated white blood cells]), altered mental status, COVID-19, influenza and dehydration. The hospital records indicated Resident #1's assessment reflected sepsis, pneumonia, COVID-19, influenza B, and oliguric renal failure (also known as acute kidney failure, when a person's urine output is very low). Record review of the record of death, dated 7/22/24, indicated Resident #1's cause of death was COVID-19 with pulmonary comorbidity. During an interview on 7/30/24 at 9:30 a.m., the NP said he was out of the country from 7/14/24 through 7/19/24 and was not on call. The NP said the physician was on call during the time he was out of the country. The NP said when he returned, he was informed Resident #1 was in the hospital. During an interview on 7/30/24 at 9:33 a.m., the Physician said he was somewhat familiar with Resident #1. The Physician said he did not recall getting notified of Resident #1's UA results by phone or fax. The Physician said if the facility had faxed UA results to him and not received a prompt response, he would have expected a phone call and the facility not to wait 2 days for an order. The Physician said he was not notified of Resident #1's respiratory distress on 7/20/24 at 10:47 am. The Physician said he would have expected a notification from the facility of a resident having respiratory distress. The Physician said the importance of him being notified regarding a resident's change in condition was so the resident could be assessed and a plan of care decided on. The Physician said Resident #1's cause of death was respiratory failure due to COVID pneumonia. During an interview on 7/30/24 at 10:01 a.m., CNA B said she had worked at the facility for approximately 2 years and had worked the 6:00 a.m.to 2:00 p.m. shift in the secured unit for approximately 4 months. CNA B said she was familiar with Resident #1. CNA B said Resident #1 was normally ambulatory and able to feed herself. CNA B said Resident #1 needed encouragement with eating and would require assistance as needed when she was tired. CNA B said the week of 7/15/24-/720/24 she was off a few days. CNA B said Resident #1 was out of it during the days she worked the week on 7/15/24. CNA B said Resident #1 was more confused and less active during the week of 7/15/24. CNA B said Resident #1's change was reported to the RN A. During an interview on 7/30/24 at 11:26 a.m., RN A said she was no longer employed at the facility. RN A said her last day to work was 7/23/24. RN A said she was familiar with Resident #1. RN A said when Resident #1 had a change in condition on 7/15/24 they observed her and provided assistance as needed. RN A said she was not sure if the physician was contacted regarding Resident #1's change of condition on 7/15/24. RN A said normally the NP was sent a text regarding changes in condition and lab results, but he was out of town during the week of 7/15/24. RN A said when Resident #1's respirations were 30 and her oxygen saturation was 88% she monitored her closely and faxed the physician. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 7/30/24 at 2:30 p.m., LVN C said she had worked at the facility since 2019. LVN C said she worked Monday through Friday the 2:00 p.m.-10:00 p.m. shift in the secured unit for approximately the past 3 months. LVN C said she was familiar with Resident #1. LVN C said after Resident #1's falls the week of 7/15/24 when she assessed Resident #1, she had some redness to her face and a knot on the crown of her head. LVN C said she was not aware of Resident #1 having a urinary analysis the week of 7/15/24. LVN C said Resident #1 did report being more tired the days following her fall. LVN C said she did not receive any information during shift change report the week of 7/15/24 regarding Resident #1's head leaning to the side, increased weakness, increased confusion, increased urinary frequency, or need for additional assistance. LVN C said nursing interventions she would put in place if a resident had a urinary analysis that was positive for a urinary tract infection included encourage and increase in fluids and hydration and monitor and document any altered mental status. During an interview on 7/30/24 at 2:37 p.m., the DON said she considered timely to be within an hour. The DON said if the physician was notified of abnormal labs and did not respond within an hour, she would expect the staff to call the physician back. The DON said nursing interventions she expected nurses to implement for residents who were positive for a urinary tract infection included, monitor vital signs, increase hydration, and observe for further decline. The DON said if a resident had a decrease in oxygen saturation, shortness of breath, or respiratory distress she expected the nurses to use nursing judgement as to whether the resident needed to be sent to the emergency room immediately or to if notification to the physician would be sufficient. Record review of the facility's Change in a Resident's Condition or Status policy, revised May 2017, indicated Our facility shall promptly notify the resident, his or her Attending Physician or Nurse Practitioner and the resident representative of changes in the resident's medical/mental condition and/or status. The nurse will notify the resident's Attending Physician, Nurse Practitioner, or physician on call when there has been a (an): .d. significant change in the resident's physician/emotional/mental conditions .A 'significant change' of condition is a major decline or improvement in the resident's status that: a. Will not normally resolve itself without intervention by staff or by implementing standard disease related clinical interventions (is no self-limiting); b. Impacts more than one area of the resident's health status .The nurse will record in the resident's medical record information relative to changes in the resident's medical/mental condition or status (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676458	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/30/2024
NAME OF PROVIDER OR SUPPLIER: Mabank Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 18957 US Hwy 175 W. Mabank, TX 75147	

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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 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of the facility's Lab and Diagnostic Test Results-Clinical Protocol policy, revised November 2018, indicated 1. The physician will identify, and order diagnostic and lab testing based on the resident's diagnostic and monitoring needs. 2. The staff will process test requisitions and arrange for test. 3. The laboratory, diagnostic radiology provider, or other testing source will report test results to the facility. Review by Nursing Staff 2. When test results are reported to the facility, and nurse will first review the results .2. Before contacting the physician, the person who is to communicate results to a physician will gather, review, and organize the information and be prepared to discuss the following .a. The individual's current condition and details of any recent changes in status, including vital signs and mental status .3. A nurse will identify the urgency of communicating with the Attending Physician based on the physician request, the seriousness of any abnormality, and the individual's current condition .Options for Physician Notification 1. A physician can be notified by phone, fax, voicemail, e-mail, pager, or a telephone message to another person acting as the physician's agent (for example, office staff. A. Facility staff should document information about when, how, and to whom the information was provided and the response. This should be done in the Progress Notes section of the medical record and not on the lab results report, because test results should be correlated with other relevant information such as the individual's overall situation, current symptoms, advanced directives, prognosis, etc. b. Direct voice communication with the physician is the preferred means for presenting any results requiring immediate notification, especially when the resident's clinical status is unstable or current treatment need review or clarification .Physician Responses 1. Time frames. A physician will respond within an appropriate time frame, based on the request from nursing staff and the clinical significance of the information. A. A physician should respond within one hour regarding a lab result requiring immediate notification, and by the end of the next office day to a non-emergency message regarding non-immediate lab test notification with a request for response. b. If the Attending or Covering Physician does not respond immediate notification within an hour, the nursing should contact the Medical Director Record review of the facility's, undated, Indications for Oxygen Policy indicated, The most readily accepted indication for supplemental oxygenation is hypoxemia or decreased levels of oxygen in the blood. For otherwise healthy patient, oxygen saturation targets are generally 92-98%. For patients with chronic hypercapnic conditions (a condition where there is too much carbon dioxide in the blood over a long period of time), target oxygen saturations are generally between 88 to 92%, with oxygen administration indicated at saturations below these levels . This was determined to be a PNC IJ on 7/30/24 at 1:20 p.m. The Administrator was notified. The Administrator was provided with the Immediate Jeopardy template on 7/30/24 at 1:22 p.m. The facility had corrected the noncompliance by the following: Suspending and then terminating RN A In-servicing staff to regarding notification of changes, hydration/keep encouraging hydration/fluids, and indications for oxygen. The surveyor confirmed the facility had corrected the non-compliance prior to survey starting by: Record review of the Confidential Employee Corrective Action Form, dated 7/23/24, indicated on 7/23/24 RN A was suspended pending investigation. The Confidential Employee Corrective Action Form indicated RN A failed to follow facility policy regarding change in a resident's condition or status. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676458	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/30/2024
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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of the Employee Separation Report, dated 7/29/24, indicated RN A's last day to work was 7/24/24 and her termination date was 7/26/24. The Employee Separation Report indicated the reason for RN A's termination was policy violation. Record review of the Hydration/Keep Encouraging Hydration/Fluid in-service, dated 7/22/24, indicated staff were in-serviced regarding hydration. The hydration training indicated, Ten Things You Can Do to Make a Difference in the Care of Your Residents .2. Monitor residents who are at risk for unintended weight loss or dehydration. 3. Regularly assess all residents to determine who is at risk for unintended weight loss or dehydration .6. Identify actions the entire care team can take to improve nutrition and hydration in your facility .Dehydration: What Staff Members Can Do Watch for Warning Signs. The following are some signs that a resident may be at risk for or suffer from dehydration: Drink less than 6 cups of liquids per day. Has one or [NAME] of the following: dry mouth, cracked lips, sunken eyes, dark urine .Is easily confused/tired Record review of the Change in Condition in-service dated 7/23/24 indicated, Charge Nurse assesses resident with full set of vitals. Vital signs should be documented in the progress note along with the vital tab. Notification to the attending physician of the change. If [the attending physician] hasn't responded in [a] timely manner, attempt to call again .obtain orders for treatment .Notify nurse management of the change. Document change in condition using the Change of Condition Form. Place resident on the 24-hour report for follow-up. Follow up documentation in progress notes for at least 72 hours or longer if necessary . Record review of sampled residents including 2 residents who had been hospitalized in the past 2-months indicated there had been no change of condition from 7/20/24-7/26/24. The 2 residents with previous hospitalization were appropriately documented on with appropriate notifications documented for all shifts. Staff interviewed (LVN D, CNA E, RN F, CNA G, LVN H, LVN J, and CNA B) on 7/30/24 between 11:56 a.m. and 2:30 p.m. were able to answer all question regarding in-services including adding residents with change of condition to the 24-hour nursing report, charting on residents with change in condition for 72 hours, notifying the physician of change of condition including abnormal lab values, reaching back out to the physician or medical director if no response was received within 1-24 hours depending on the severity of the change or abnormal lab value, notifying nursing management regarding a resident's change of condition, promoting/encouraging hydration especially for residents with signs and symptoms of dehydration or positive for UTI, and when oxygen therapy should be implemented. The noncompliance was identified as PNC. The IJ began on 7/15/24 and ended on 7/26/24. The facility had corrected the noncompliance before the survey began.