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	03/12/2025

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 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** 47612 Based on observations, interviews, and record review the facility failed to treat each resident with respect and dignity and care for each resident in a manner that promoted maintenance or enhancement of his or her quality of life for 2 of 21 residents (Resident #2 and Resident #76) reviewed for resident rights. The facility did not ensure Laundry Aide M knocked, prior to entering Resident #2's and Resident #76's room on 03/11/2025. This failure could place residents at risk for diminished quality of life, loss of dignity and loss of self-worth. Findings included: 1.Record review of the face sheet, dated 03/12/2025, revealed Resident #2 was a [AGE] year old female with diagnoses which included unspecified intellectual disabilities (a diagnosis used when an individual, typically over 5 years old, was suspected of having an intellectual disability, but standardized testing was not possible or feasible due to factors like physical or sensory impairments, or co-occurring mental health conditions, preventing a determination of the level of disability) altered mental status, unspecified (a change in a person's mental function or consciousness where the specific cause or nature of the change was not yet determined, but there was a noticeable difference in typical mental clarity, perception, awareness, cognition, or responsiveness), unspecified disorder of psychological development (disturbances in psychological functioning without further specification of subtype or features). Record review of the quarterly MDS assessment, dated 02/06/2025, revealed Resident #2 was sometimes able to make herself understood and sometimes understood others. The MDS assessment indicated Resident #2 had a BIMS score of 00, which indicated her cognition was severely impaired. Record review of a care plan, with a revision date of 05/02/2024, indicated Resident #2 was dependent on staff, for meeting emotional, intellectual, physical, and social needs related to intellectual disabilities. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2.Record review of the face sheet, dated 03/12/2025, revealed Resident #76 was an [AGE] year old female with diagnoses which included unspecified dementia, severe, with other behavioral disturbance (a severe dementia diagnosis where the specific type of dementia is unknown, accompanied by behavioral issues like sleep disturbances, social or sexual disinhibition, and other non-cognitive presentations), anxiety disorder (condition in which a person has excessive worry and feelings of fear, dread, and uneasiness), dysthymic disorder (a chronic form of depression characterized by a persistent low mood that lasts for at least two years). Record review of the quarterly MDS assessment, dated 01/14/2025, revealed Resident #76 was usually able to make herself understood and understood others. The MDS assessment indicated Resident #76 had a BIMS score of 04, which indicated her cognition was severely impaired. Record review of care plan, with a revision date of 11/14/2024, indicated Resident #76 was able to communicate basic needs daily. Interventions: ask yes or no questions in order to determine the resident's needs. During an observation and interview on 03/11/2025 at 10:23 a.m., Surveyor observed Laundry Aide M going into Resident #2's and Resident #76's rooms without knocking prior to entering the rooms. Laundry Aide M stated when entering a resident's room, she was supposed to knock, introduce herself and let the resident know why she was in their room. Laundry Aide M stated she did not knock, identify herself, or let the residents know what she was doing because both residents were sleeping. Laundry Aide M stated it was important to knock, introduce herself, and let the residents know what she was doing in their room so they would not feel uncomfortable, for them to know who she was and that she was not a stranger, coming into their private room. During an interview on 03/12/2025 at 1:50 p.m., the Housekeeping Supervisor stated she expected the laundry staff to knock and introduce themselves when entering the residents room. The Housekeeping Supervisor stated it was important to knock before entering a resident's room to show respect and it was the resident's home. The Housekeeping Supervisor stated the harm of not knocking before entering the resident's room was the laundry staff could invade the resident's privacy. During an interview on 03/12/2025 at 2:22 p.m., the DON stated the staff should knock before walking into a room and announce themselves. The DON stated she expected the staff to knock, introduce themselves, and explain what they were doing in the room. The DON stated it was important for the staff to let residents know what they are doing in their rooms to make them feel comfortable and safe, especially with the residents on the memory care unit. The DON stated she would in-service the staff. During an interview on 03/12/2025 at 2:37 p.m., the Regional [NAME] President stated he expects the staff to knock, introduce themselves, and tell the residents what they were doing in their room. The Regional [NAME] President stated it was important because the facility was their home, and he expected the staff to treat the residents with dignity and respect. Record review of the facility's policy titled, Resident Rights revised October 4, 2022, indicated . Employees shall treat all residents with kindness, respect, and dignity

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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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45879 Based on observation, interview, and record review, the facility failed to ensure each resident had the right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences for 1 of 8 residents (Resident #37) reviewed for reasonable accommodations. The facility failed to ensure Resident #37's call button was within reach while Resident #37 was in a standard chair on 03/10/25. This failure could place residents at risk for a delay in assistance and decreased quality of life, self-worth, and dignity. Findings included: Record review of Resident #37's face sheet, dated 03/12/25, indicated a [AGE] year-old male who was admitted to the facility on [DATE] with diagnoses which included Atherosclerotic heart disease also known as AHD (a condition where the coronary arteries, which supply blood to the heart, become narrowed or blocked due to plaque buildup), type 2 diabetes (uncontrolled blood sugar), depression (low mood), and high blood pressure. Record review of Resident #37's quarterly MDS assessment, dated 12/10/24, indicated Resident #37 sometimes understood and was usually understood by others. Resident #37's BIMS score was 02, which meant he was severely cognitively impaired. The MDS indicated Resident #37 required help with toileting, bed mobility, dressing, transfers, personal hygiene, and supervision with eating. The MDS indicated he was occasionally incontinent of his bladder. Record review of Resident #37's care plan dated 08/15/22 indicated he had an ADL Self Care Performance (such as Bed Mobility, Transfers, Eating, Bathing, Dressing, and Personal Hygiene) Deficit related to his Intellectual disabilities. The interventions were for staff to encourage and remind the resident to use the bell to call for assistance when in his room. During an observation on 03/10/25 at 10:25 a.m., Resident #37 was sitting up in a standard chair with his feet in his wheel chair and his call light was noted on the other side of his bed on the floor. Resident #37 was unable to answer questions about his call light. During an interview on 03/10/25 at 10:26 a.m., CNA B said Resident #37 could move around the room, but she helped him toilet. She verified the call light was on the floor on the other side of the bed. She said he does not understand how to use the call light, so he comes out or hollers for help. She said she felt like the call light would be a hazard because he would pull the call light out of the wall or throw it and he could fall on it. She said she had not put the call light next to him since the start of her shift at 6 am. During an interview on 03/11/25 at 4:51 p.m., LVN A said he expected all residents to have a call light. He said even if they have a cognitive deficit, they should have their call light because sometimes their cognition changes throughout the day. He said the call light was a way of communication to let staff know if they needed something. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 03/12/25 at 2:00 p.m., the DON said all staff should check on the residents and ensure they have a call light within reach. She said call lights should be within reach of residents so they could use them when they needed assistance. The DON said failure to have or keep call lights within reach could cause a resident to fall, receive a bump, bruise, or even a fracture. During an interview on 03/12/25 at 3:32 p.m., the Regional [NAME] President said all staff was responsible for ensuring call lights were within reach. He said the failure of not having the call light accessible could lead to several things such as a resident falling or not getting the help they needed timely. Record review of the facility's policy titled, Resident Call Light System, dated 06/2023, indicated, The purpose of this procedure: #1 to respond to the resident's requests and needs. Policy implementation: A call light system (audible and visual) is in place and operative in the facility. This system allows individual residents to access a system that notifies nursing that the resident has a need. Residents can communicate with the Nurse's Station from their room and/or bathing and toileting facilities. General Guidelines: #4 Ensure that the call light is easily reachable by the resident.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45879 Based on observations, interviews, and record reviews the facility failed to provide a safe, clean, comfortable, and homelike environment for 1 of 8 residents (Resident #19) reviewed for a clean and homelike environment. The facility failed to ensure Resident #19, and her room was without urine odor. This failure could place residents at risk for diminished quality of life due to the lack of a well-kept and clean environment. Findings included: Record review of Resident #19's face sheet, dated 03/11/25, indicated an [AGE] year-old female who was admitted to the facility on [DATE] and readmitted [DATE] with diagnoses which included Dementia (loss of memory, language, problem-solving, and other thinking abilities that were severe enough to interfere with daily life), Chronic obstructive pulmonary disease also known as COPD (a common lung disease causing restricted airflow and breathing problems), Parkinson's (a movement disorder of the nervous system that worsens over time), and high blood pressure. Record review of Resident #19's quarterly MDS assessment, dated 02/06/25, indicated Resident #19 usually understood and was usually understood by others. The MDS assessment indicated she had a BIMS score of 5 indicating she was severely cognitively impaired. Resident #19 required assistance with bathing, toileting, dressing, bed mobility, personal hygiene, and eating. The MDS indicated she was incontinent of bowel and bladder. The MDS did not indicate any refusal of care or behaviors. Record review of Resident #19's care plan dated 05/03/24 indicated she had a mixed bladder incontinence related to Dementia and a history of kidney stones. The intervention was for staff to check during rounds. Wash, rinse, and dry perineum after each incontinence episode and change clothing as needed. During an observation on 03/10/25 at 10:32 a.m., Resident #19's room smelled of urine. During an observation on 03/10/25 at 12:29 p.m., Resident #19 was in the dining room eating lunch and smelled of urine. During an interview on 03/10/25 at 02:57 p.m., Resident #18 (roommate of Resident #19) said the room does smell like urine most of the time. She said her roommate was incontinent of urine and she knew she could not help it but wished she did not have to have a room smelling of urine. She said the staff was aware and tried to keep Resident #19 clean, but the urine smell lingered on for hours. During an attempted interview on 03/10/25 at 3:19 p.m., Resident #19 was in the dining room, but when asked about being incontinent and odors she did not respond. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 03/11/25 at 1:42 p.m., CNA B said Resident #19's room smelled like urine. She said Resident #19 went to the bathroom a lot. She said Resident #19 had a diffuser in her room to help with the odor; CNA D looked in the diffuser, but it was empty. CNA B said she tries to keep Resident #19 as clean as she could but often the resident goes to the bathroom by herself. During an interview on 03/11/25 at 4:04 p.m., LVN A said Resident #19 does have a urine odor. He said the roommate had complained to him about the odor and was not happy about the odor. He said Resident #19 was a heavy wetter and refused care at times. He said she had a diffuser in her room to help with the odor. He said staff attempted to bathe Resident #19 daily and keep her clean. During an interview on 03/12/25 at 2:00 p.m., the DON said she was aware Resident #19 had a strong urine odor. She said the staff does try to keep her clean and offers showers daily. She said the problem was Resident #19 was incontinent at times and refused care. She said sometimes she would go to the bathroom by herself and leave the dirty clothes on the floor. She said they had tried a diffuser in the bathroom, and when it was on it helped with the odor. She said Resident #18 had mentioned the strong urine odor last week and they offered a different room, but she declined. She said they were in the process of looking for other ideas for eliminating the urine odor. She said she wanted this home to be free from odors as much as possible. During an interview on 03/12/25 at 3:32 p.m., the Regional [NAME] President said they did their best to ensure the facility was clean and odor-free. He said staff tried to keep each resident clean as long as they were honoring the residents' rights. He said he expected the facility to be odor-free. Record review of the facility policy of Homelike Environment, revised May 2017, revealed, Policy Statement: Residents are provided with a safe, clean, comfortable, and homelike environment and encouraged to use their personal belongings to the extent possible. Policy Interpretation and Implementation: #2. The facility staff and management shall maximize, to the extent possible, the characteristics of the facility that reflect a personalized, home-like setting. These characteristics include A. Clean, sanitary, and orderly environment.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46892 Based on interview and record review, the facility failed to develop and implement a comprehensive person-centered care plan to meet a resident's medical, nursing, mental and psychosocial needs identified in the comprehensive assessment for 2 of 21 residents (Resident #37 and Resident #39) reviewed for care plans. 1. The facility failed to ensure a care plan was developed specific to Resident #39's non-pressure wounds and included the wound care treatments she was receiving to her first and second toe on her right foot, right shin, and left posterior (back) ankle. 2. The facility failed to revise Resident #37's care plan to remove his Full Code (a medical term indicating a patient's preference to receive all possible life-saving measures in the event of a cardiac or respiratory arrest) status once his code status changed to Do Not Resuscitate, also known as DNR (a medical order instructing healthcare providers not to perform CPR or other resuscitative measures if a patient's heart or breathing stops). This failure could place the residents at increased risk of not having their individual needs met and a decreased quality of life. Findings included: 1. Record review of a face sheet dated [DATE] indicated Resident #39 was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses which included laceration without foreign body left foot, laceration without foreign body of right lesser toe(s) without damage to nail, laceration without foreign body of right great toe without damage to nail, laceration without foreign body, left ankle, laceration without foreign body, right lower leg. Record review of Resident #39's Comprehensive MDS assessment dated [DATE] indicated she was able to understand others and was understood. The MDS assessment indicated Resident #39 had a BIMS score of 09, which indicated her cognition was moderately impaired. The MDS assessment indicated Resident #39 required partial/moderate assistance with dressing, showering/bathing self, personal hygiene, and substantial/maximal assistance with toileting. The MDS assessment indicated Resident #39 had other open lesion(s) on the foot, skin tear(s), and received application of nonsurgical dressings and dressings to feet. Record review of Resident #39's Order Summary Report dated [DATE] indicated: non-pressure wound of the right foot, first digit cleanse with normal saline, pat dry, apply hydrogel with silver, cover with clean dry dressing daily and as needed for wound healing as needed with a start date of [DATE]. wound to right foot second toe, cleanse with normal saline, pat dry, apply hydrogel with silver, cover with clean dry dressing every day and as needed with a start date [DATE]. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Clobetasol Propionate External Gel 0.05 % apply to right shin, left posterior ankle topically one time a day for wound healing cleanse with normal saline, pat dry, apply gel, apply xeroform (petrolatum-impregnated gauze dressing), cover with clean dry dressing with a start date of [DATE]. Record review of Resident #39's Wound Evaluation & Management Summary dated [DATE], indicated: non-pressure wound of the left posterior ankle, Etiology trauma/injury, duration more than 96 days: wound size 3.8 x 3.2 x 0.1 cm. non-pressure wound of the right shin, Etiology trauma/injury, duration more than 103 days, wound size 4.1 x 2.2 x 0.1 cm. non-pressure wound of the right first toe, Etiology trauma/injury, duration more than 69 days, wound size 0.2 x 0.2 x not measurable cm. non-pressure wound of the right second toe, Etiology trauma/injury, duration more than 37 days, wound size 0.2 x 0.6 x not measurable cm. Record review of Resident #39's care plan revised [DATE] indicated, she required EBP related to being at increased risk for MDRO acquisition due to wound to lower extremity. The resident had skin tears of the right lower extremity related to scratching herself with interventions which included if a skin tear occurs treat per facility protocol and notify MD and family. The resident had actual impairment to skin integrity of the left lower extremity related to eczema and fragile skin follow facility protocols for treatment of injury, observe/document location, size and treatment of skin injury report abnormalities, failure to heal, signs and symptoms of infection, maceration (skin in contact with moisture too long) to MD, weekly treatment documentation to include measurement of each area of skin breakdown's width, length, depth, type of tissue and exudate (drainage, discharge from tissue) and any other notable changes or observations. Resident #39's care plan did not indicate the wound care treatments and specific locations of her wounds to her first and second toes on her right foot, right shin, and left posterior (back) ankle. During an interview on [DATE] at 3:12 PM, the DON said the wound care nurse was responsible for care planning wounds and any skin issues. During an interview on [DATE] at 3:33 PM, the Wound Care Nurse said Resident #39's wounds were included in her care plan. The Wound Care Nurse said when she care planned the wounds she put in the location of the wound, and then selected from the prompted goals and interventions given in the care planning system. The Wound Care Nurse said the care plan should be person-centered and it should include any treatments and services the residents received. The Wound Care Nurse said it was important for the resident's care plan to be person-centered because it was their treatments and their health and so they could get the care they needed based upon their health needs. During an interview on [DATE] at 3:56 PM, the RVP said care plans were supposed to be resident specific. The RVP said care plans were collaborative and different members had different responsibilities. The RVP said the clinical team was responsible for ensuring wounds were included in the residents' care plans. The RVP said it was important to individualize the care for the resident. 45879 (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2.Record review of Resident #37's face sheet, dated [DATE], indicated a [AGE] year-old male who was admitted to the facility on [DATE] with diagnoses which included Atherosclerotic heart disease also known as AHD (a condition where the coronary arteries, which supply blood to the heart, become narrowed or blocked due to plaque buildup), type 2 diabetes (uncontrolled blood sugar), depression (low mood), and high blood pressure. Record review of Resident #37's quarterly MDS assessment, dated [DATE], indicated Resident #37 sometimes understood and was usually understood by others. Resident #37's BIMS score was 02, which meant he was severely cognitively impaired. The MDS indicated Resident #37 required help with toileting, bed mobility, dressing, transfers, personal hygiene, and supervision with eating. Record review of Resident 37's physician orders dated [DATE] indicated, DNR status. Record review of Resident 37's electronic medical records of his code status indicated he had a DNR signed on [DATE]. Record review of Resident #37's care plan dated [DATE] indicated he was a full code. The intervention was to provide CPR. During an interview on [DATE] at 1:37 p.m., the SW said she was the person who got the DNR signed. She said she then told a nurse or the ADON, and they wrote the order. She said the MDS nurse should have placed the DNR code status on the care plan. During an interview on [DATE] at 2:00 p.m., the DON said she expected the care plans to be accurate. She said the MDS Coordinator was responsible for ensuring the care plans were kept current with the resident's care. She said when she received an order for code status, she or the ADON would update the care plan. She said she did not know how Resident #37's code status change was missed. She said she would update it to reflect the DNR status today ([DATE]). She said it was important to have the most updated care plan so that staff would know what care they needed to provide. During an interview on [DATE] at 2:18 p.m., the MDS Coordinator said she was responsible for the care plans for the long-term residents. She said the ADON/DON did the acute care plans. She said care plans were done so the staff would know how to care for the resident. She said when Resident #37 became a DNR, either the ADON/DON or herself should have updated his care plan. She could not explain how the change in code status was not updated. She said not changing the code status could have affected the residents' wishes. During an interview on [DATE] at 3:25 p.m., the ADON said the SW was responsible for getting the DNR signed and scanned into the electronic medical records. She said once the signed DNR had been uploaded in the electronic medical records, she would write the DNR order. She said she was unaware of who was responsible for updating the care plan. During an interview on [DATE] at 3:32 p.m., the Regional [NAME] President said the MDS Coordinator was responsible for the care plans. He said the DON was the overseer of the care plans. He said the DNR code status should have been part of the care plan process and checked during the care plan meeting. He said if care plans were not done, or revised residents might not have their wishes honored. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the facility's policy titled, Care Plans, Comprehensive Person-Centered, revised [DATE], indicated, A comprehensive, person-centered plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident . The comprehensive, person-centered care plan: a. includes measurable objectives and timeframes; b. describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being . assessments of residents are ongoing and care plans are revised as information about the residents and the residents' conditions change .

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46892 Based on observation, interview, and record review the facility failed to ensure residents with limited range of motion received appropriate treatment and services to prevent further decrease in range of motion for 1 of 7 residents (Resident #63) reviewed for range of motion. The facility failed to ensure Resident #63's carrots (medical device used to treat hand contractures, permanent tightening of the muscles, tendons, skin, and surrounding tissues that causes stiffness, placed in the hands to help improve range of motion) were in place to his hands. This failure could place residents at risk for decrease in mobility and range of motion and contribute to worsening of contractures. Findings included: Record review of a face sheet dated 03/12/2025 indicated Resident #63 was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses which included quadriplegia (paralysis of the arms, trunk, and legs resulting from damage to the brain and/or spinal cord), diffuse traumatic brain injury with loss of consciousness of unspecified duration (injury to the brain which results in loss of consciousness), and muscle wasting and atrophy (the wasting or thinning of muscle mass due to disuse). Record review of Resident #63's Quarterly MDS assessment dated [DATE] indicated he was rarely/never able to make himself understood and was rarely/never able to understand others. The MDS assessment indicated Resident #63 had a short and long-term memory problem. The MDS assessment indicated Resident #63 was dependent on staff for all ADLs. The MDS assessment indicated Resident #63 had functional limitations in range of motion to both upper extremities and both lower extremities. The MDS assessment indicated Resident #63 received occupational therapy. The MDS assessment did not indicate Resident #63 received restorative therapy. Record review of Resident #63's Order Summary Report dated 03/11/2025 indicated resident to have carrots in left and right hand, ensure proper placement and function with a start date of 11/18/2024. Record review of Resident #63's care plan revised 03/10/2025 indicated he had an ADL self-care performance deficit related to quadriplegia resulting in range of motion limitation, contractures to bilateral upper and lower extremities, required total care, resident will work the carrot out of his hand as soon as staff leaves the room, and carrots to bilateral hands. During an observation on 03/10/2025 at 3:18 PM, Resident #63 was in his bed. There were no carrots in his hands or observed around him in the bed. Resident #63 was not interviewable. During an observation on 03/11/2025 at 8:02 AM, Resident #63 did not have anything in his hands for his contractures. (continued on next page)

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

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and interview on 03/11/2025 at 2:13 PM with LVN G Resident #63 did not have the carrots in his hands. LVN G said Resident #63 did not keep the carrots in his hands, but she did not know where they were. LVN G then proceeded to look for the carrots in Resident #63's room and found them in a drawer in his nightstand. LVN G said Resident #63 should have the carrot in one of his hands to help with his contractures and so his fingernails would not dig into his hands. LVN G said the carrots were supposed to relax Resident #63 and help him open his hands up. LVN G said she had signed off Resident #63's carrots on his MAR as completed but she had not gotten around to put them in. LVN G said she could also delegate it to the CNAs, and it was something they usually did. During an interview on 03/12/2025 at 1:54 PM, CNA K said she provided care to Resident #63, and he was supposed to have the carrots in his hands. CNA K said she had a hard time getting them in his hands because they were contracted, but she usually let the nurse or therapy do it. CNA K said she was not the one who put them in Resident #63's hands. CNA K said the carrots were supposed to be placed in Resident #63's hands to make his hands easier to open. CNA K said if the carrots were not placed in Resident #63's hands they were going to clamp tight, and they would not be able to clean his hands. During an interview on 03/12/2025 at 3:18 PM, the DON said Resident #63's carrots should be placed in his hands by the CNAs. The DON said therapy trained the CNAs, so they knew how to do it safely. The DON said if the CNAs did not feel comfortable placing the carrots in Resident #63's hands, they should communicate with the nurse, and the nurse and the treatment nurse could assist them with doing that. The DON said it was important to place the carrots in Resident #63's hand to prevent anymore wounds and prevent tighter contractures. During an interview with the DON on 03/12/2025 at 3:27 PM, the policy for contracture management was requested and not received prior to exit of the facility.

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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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46892 Based on observations, interviews, and record review, the facility failed to ensure a resident who was incontinent of bladder received appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible for 1 of 3 residents (Resident #40) reviewed for treatment and services related to indwelling catheters. The facility failed to ensure Resident #40's foley catheter drainage bag (bag holding urine that is drained from a tube inserted into the bladder) was kept off the floor. This failure could place residents at risk for urinary tract infections and a decreased quality of life. Findings included: Record review of a face sheet dated 03/12/2025 indicated Resident #40 was a [AGE] year-old male initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included neuromuscular dysfunction of the bladder (problems due to disease or injury of the central nervous system or nerves involved in the control of urination), benign prostatic hyperplasia with lower urinary tract symptoms (overgrowth of prostate tissue pushes against the urethra and the bladder, blocking the flow of urine which results in symptoms such as urinary frequency, urgency, weak stream, trouble urinating, and not being able to empty the bladder), and urinary tract infection. Record review of Resident #40's Comprehensive MDS assessment dated [DATE] indicated, he was usually able to make himself understood and usually understood others. The MDS assessment indicated Resident #40 required partial/moderate assistance with toileting, showering/bathing himself, and personal hygiene. The MDS assessment indicated Resident #40 had an indwelling catheter. Record review of Resident #40's Order Summary Report dated 03/11/2025 indicated he had an order for change foley catheter bag and accessories size: 20 French, bulb: 10 milliliters every day shift every 30 days with a start date of 01/11/2025. Record review of Resident #40's care plan revised 02/18/2025 indicated he had an indwelling foley catheter and to position the catheter bag and tubing below the level of the bladder and away from the entrance room door. Resident #40's care plan indicated he required EBP and was at risk for MDRO (bacteria and other organisms that are resistant to multiple antibiotics and can cause infections) acquisition due to an indwelling catheter. During an observation on 03/10/2025 at 9:59 AM, Resident #40 was sitting in his recliner and his foley catheter bag was on the floor. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 03/11/2025 at 2:10 PM, LVN G said Resident #40 required limited assistance of one staff for transfers. LVN G said Resident #40's foley catheter bag should not be placed on the floor. LVN G said the CNAs and herself should be making sure the foley catheter bag was no placed on the floor. LVN G said it was important for the bag not to be placed on the floor because bacteria could get on the bag and cause an infection, or the urine could drip on the floor. During an interview on 03/12/2025 at 1:52 PM, CNA H said she provided care to Resident #40. CNA H said Resident #40 required assistance with transfers to his recliner. CNA H said they usually hung Resident #40's catheter bag on his recliner, and she did not know why it was on the floor. CNA H said Resident #40's catheter bag should not be placed on the floor to make sure it did not cause an infection. During an interview on 03/12/2025 at 3:05 PM, the DON said the resident's catheter bag should be anchored below the waist and it should not be placed on the floor. The DON said the nurse was responsible and the CNAs should check when making rounds. The DON said it was important for the catheter bag not to be on the floor for contamination and infection control. During an interview on 03/12/2025 at 3:42 PM, the ADON said all staff were responsible for ensuring the residents' catheter bags were not on the floor. The ADON said when the staff noticed a catheter bag was on the floor, they should report it to the nurse. The ADON said the resident's foley catheter bag being on the floor could contaminate the bag and be a risk for infection. During an interview on 03/12/2025 at 3:52 PM, the RVP said he expected for the foley catheter bags to not be placed on the floor. The RVP said nursing was responsible for ensuring the foley catheter bags were not on the floor. The RVP said the foley catheter bags should not be placed on the floor for cleanliness. Record review of the facility's policy titled, Emptying a Urinary Drainage Bag, revised October 2010 indicated, .Keep the drainage bag and tubing off the floor to prevent contamination and damage .

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46892 Based on observations, interviews, and record review, the facility failed to ensure that respiratory care was provided consistent with professional standards of practice for 3 of 5 residents (Resident #3, Resident #66, and Resident #19) reviewed for respiratory care. 1. The facility failed to ensure Resident # 3's oxygen was administered as prescribed by the physician at 3 liters via nasal cannula and her nebulizer mask was stored properly. 2. The facility failed to ensure Resident #66's oxygen was administered as prescribed by the physician at 2 liters via nasal cannula. 3. The facility failed to ensure Resident #19's oxygen was placed on 3 liters per nasal cannula as ordered by the physician and her nebulizer mask was stored properly These failures could place residents requiring respiratory care at risk for shortness of breath, respiratory distress, or complications. Findings included: 1. Record review of a face sheet dated 03/12/2025 indicated Resident #3 was an [AGE] year-old female admitted to the facility on [DATE] with diagnoses which included chronic obstructive pulmonary disease (chronic inflammatory lung disease that causes obstructed airflow in the lungs). Record review of Resident #3's Quarterly MDS assessment dated [DATE] indicated she was understood by others and was able to understand others. The MDS assessment indicated Resident #3 had a BIMS score of 14, which indicated her cognition was intact. The MDS assessment indicated Resident #3 required substantial/maximal assistant with toileting and was dependent for showering/bathing and personal hygiene. The MDS assessment indicated Resident #3 received oxygen while a resident in the facility. Record review of Resident #3's Order Summary Report dated 03/11/2025 indicated, may have oxygen at 3 liters per nasal cannula every shift with a start date of 10/21/2024. Record review of Resident #3's care plan with a target date of 04/30/2025 indicated she had oxygen therapy related to COPD and she was at risk for shortness of breath. Resident #3's care plan indicated she may have oxygen at 2-3 liters per nasal cannula, may remove for ADLs, and keep the head of bed elevated for shortness of breath while laying flat. During an observation on 03/10/2025 at 9:40 AM, Resident #3 was in her bed, and she had oxygen via nasal canula at a little bit above 1 lpm. Resident #3's nebulizer mask was on top of her mini fridge exposed to air, unbagged. During an observation on 03/11/2025 at 8:00 AM, Resident #3's nebulizer mask was on the floor uncovered, unbagged. Resident #3's oxygen via nasal cannula was set at 1 lpm. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Record review of a face sheet dated 03/12/2025 indicated Resident #66 was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses which included Alzheimer's disease (progressive disease that destroys memory and other important mental functions) and displaced intertrochanteric fracture of right femur subsequent encounter for closed fracture with routine healing (care following a fracture of the right upper leg). Record review of the Quarterly MDS assessment dated [DATE], indicated Resident #66 was usually understood by others and was usually able to understand others. The MDS assessment indicated Resident #66's BIMS score was 11, which indicated her cognition was moderately impaired. The MDS assessment indicated Resident #66 was dependent on staff for toileting and showering, required substantial/maximal assistance with lower body dressing and personal hygiene, and partial/moderate assistance with oral hygiene and upper body dressing. The MDS assessment did not indicate Resident #66 required oxygen. Record review of Resident #66's Order Summary Report dated 03/11/2025, indicated administer oxygen at 2 liters per nasal cannula may remove for ADLs keep head of bed elevated for shortness of breath while laying flat every shift with a start date of 03/07/2025. Record review of Resident #66's care plan with a target date of 04/13/2025 indicated she had oxygen therapy related to ineffective gas exchange. During an observation on 03/10/2025 at 10:13 AM, Resident #66 was in her bed with oxygen via nasal cannula set between 3-4 lpm. During an observation and interview on 03/11/2025 at 2:01 PM with LVN G, Resident #3's oxygen was at 1 lpm via nasal cannula. Resident #66's oxygen was at 3 lpm via nasal cannula. LVN G said she was not sure what their oxygen was supposed to be set at. When LVN G verified the orders in the electronic health records, she said Resident #3's oxygen was supposed to be set at 3 lpm via nasal cannula and Resident #66's oxygen was supposed to be at 2 lpm via nasal cannula. LVN G said she was responsible for ensuring the residents oxygen was set correctly, and she checked them every morning to ensure they were set as ordered. LVN G said she had checked them that morning (the morning of 03/11/2025) and they were set correctly. LVN G said it was important for oxygen to be administered as ordered to keep the residents oxygenated. LVN G said if the residents were not receiving oxygen as ordered it could lead to respiratory distress and shortness of breath. LVN G said the residents nebulizer masks should be stored in bags. LVN G said she did not know why Resident #3's nebulizer mask was not in a bag or why it was on the floor. LVN G said it was important for the nebulizer masks to be stored in a bag to prevent bacteria and for infection control. During an interview on 03/12/2025 at 3:05 PM, the DON said the nurses should be checking to ensure the oxygen was set according to the physician's order. The DON said the ADON and herself monitored to ensure this was being done. The DON said they conducted rounds at least a couple of times a week and had not noticed any issues. The DON said the oxygen not set as ordered could allow the residents' oxygen saturations to drop, and it could lead to confusion and falls. The DON said nebulizer masks should be bagged after use and in between uses, and the nurse was responsible for ensuring this happened. The DON said if the nebulizer masks were not stored in a bag, they could become unclean, contaminated, and lead to infections. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 03/12/2025 at 3:44 PM, the ADON said anyone going into a resident's room should ensure the residents' nebulizer masks were bagged. The ADON said if the nebulizer masks were not stored in a bag it could result in contamination of the mask and then it would be placed on the resident's face dirty. The ADON said the nurses should be checking the residents' oxygen settings to ensure they were set correctly. The ADON said the oxygen not being set correctly could cause shortness of breath and other issues depending on the resident's disease process. During an interview on 03/12/2025 at 3:49 PM, the RVP said he expected for the nurses to follow the physician's orders. The RVP said the person applying the oxygen was responsible for ensuring the oxygen was at the correct setting. The RVP said it was important for the oxygen to be set as ordered because it was the doctor's request and for the residents to have the best outcomes. The RVP said he expected the staff to store the nebulizer masks properly. The RVP said the nursing department and the department heads were responsible for ensuring this was done. The RVP said it was important for the nebulizer masks to be stored in a bag for cleanliness.Based on observation, interview, and record review, the facility failed to ensure that respiratory care was provided consistent with professional standards of practice for 3 of 4 residents (Resident #3, Resident #19, and Resident #66) reviewed for respiratory care. 1. The facility failed to ensure Resident # 3's oxygen was administered as prescribed by the physician at 3 lpm via nasal cannula. 2. The facility failed to ensure Resident #3's nebulizer mask was stored properly. 3. The facility failed to ensure Resident #66's oxygen was administered as prescribed by the physician at 2 lpm via nasal cannula. These failures could place residents requiring respiratory care at risk for shortness of breath, respiratory distress, or complications. Findings included: 1. Record review of a face sheet dated 03/12/2025 indicated Resident #3 was an [AGE] year-old female admitted to the facility on [DATE] with diagnoses which included chronic obstructive pulmonary disease (chronic inflammatory lung disease that causes obstructed airflow in the lungs). Record review of Resident #3's Quarterly MDS assessment dated [DATE] indicated she was understood by others and was able to understand others. The MDS assessment indicated Resident #3 had a BIMS score of 14, which indicated her cognition was intact. The MDS assessment indicated Resident #3 required substantial/maximal assistant with toileting and was dependent for showering/bathing and personal hygiene. The MDS assessment indicated Resident #3 received oxygen while a resident in the facility. Record review of Resident #3's Order Summary Report dated 03/11/2025 indicated, may have oxygen at 3 liters per nasal cannula every shift with a start date of 10/21/2024. Record review of Resident #3's care plan with a target date of 04/30/2025 indicated she had oxygen therapy related to COPD and she was at risk for shortness of breath. Resident #3's care plan indicated she may have oxygen at 2-3 liters per nasal cannula, may remove for ADLs, and keep the head of bed elevated for shortness of breath while laying flat. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 03/10/2025 at 9:40 AM, Resident #3 was in her bed, and she had oxygen via nasal canula at a little bit above 1 lpm. Resident #3's nebulizer mask was on top of her mini fridge exposed to air, unbagged. During an observation on 03/11/2025 at 8:00 AM, Resident #3's nebulizer mask was on the floor uncovered, unbagged. Resident #3's oxygen via nasal cannula was set at 1 lpm. 2. Record review of a face sheet dated 03/12/2025 indicated Resident #66 was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses which included Alzheimer's disease (progressive disease that destroys memory and other important mental functions) and displaced intertrochanteric fracture of right femur subsequent encounter for closed fracture with routine healing (care following a fracture of the right upper leg). Record review of the Quarterly MDS assessment dated [DATE], indicated Resident #66 was usually understood by others and was usually able to understand others. The MDS assessment indicated Resident #66's BIMS score was 11, which indicated her cognition was moderately impaired. The MDS assessment indicated Resident #66 was dependent on staff for toileting and showering, required substantial/maximal assistance with lower body dressing and personal hygiene, and partial/moderate assistance with oral hygiene and upper body dressing. The MDS assessment did not indicate Resident #66 required oxygen. Record review of Resident #66's Order Summary Report dated 03/11/2025, indicated administer oxygen at 2 liters per nasal cannula may remove for ADLs keep head of bed elevated for shortness of breath while laying flat every shift with a start date of 03/07/2025. Record review of Resident #66's care plan with a target date of 04/13/2025 indicated she had oxygen therapy related to ineffective gas exchange. During an observation on 03/10/2025 at 10:13 AM, Resident #66 was in her bed with oxygen via nasal cannula set between 3-4 lpm. During an observation and interview on 03/11/2025 at 2:01 PM with LVN G, Resident #3's oxygen was at 1 lpm via nasal cannula. Resident #66's oxygen was at 3 lpm via nasal cannula. LVN G said she was not sure what their oxygen was supposed to be set at. When LVN G verified the orders in the electronic health records, she said Resident #3's oxygen was supposed to be set at 3 lpm via nasal cannula and Resident #66's oxygen was supposed to be at 2 lpm via nasal cannula. LVN G said she was responsible for ensuring the residents oxygen was set correctly, and she checked them every morning to ensure they were set as ordered. LVN G said she had checked them that morning (the morning of 03/11/2025) and they were set correctly. LVN G said it was important for oxygen to be administered as ordered to keep the residents oxygenated. LVN G said if the residents were not receiving oxygen as ordered it could lead to respiratory distress and shortness of breath. LVN G said the residents nebulizer masks should be stored in bags. LVN G said she did not know why Resident #3's nebulizer mask was not in a bag or why it was on the floor. LVN G said it was important for the nebulizer masks to be stored in a bag to prevent bacteria and for infection control. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 03/12/2025 at 3:05 PM, the DON said the nurses should be checking to ensure the oxygen was set according to the physician's order. The DON said the ADON and herself monitored to ensure this was being done. The DON said they conducted rounds at least a couple of times a week and had not noticed any issues. The DON said the oxygen not set as ordered could allow the residents' oxygen saturations to drop, and it could lead to confusion and falls. The DON said nebulizer masks should be bagged after use and in between uses, and the nurse was responsible for ensuring this happened. The DON said if the nebulizer masks were not stored in a bag, they could become unclean, contaminated, and lead to infections. During an interview on 03/12/2025 at 3:44 PM, the ADON said anyone going into a resident's room should ensure the residents' nebulizer masks were bagged. The ADON said if the nebulizer masks were not stored in a bag it could result in contamination of the mask and then it would be placed on the resident's face dirty. The ADON said the nurses should be checking the residents' oxygen settings to ensure they were set correctly. The ADON said the oxygen not being set correctly could cause shortness of breath and other issues depending on the resident's disease process. During an interview on 03/12/2025 at 3:49 PM, the RVP said he expected for the nurses to follow the physician's orders. The RVP said the person applying the oxygen was responsible for ensuring the oxygen was at the correct setting. The RVP said it was important for the oxygen to be set as ordered because it was the doctor's request and for the residents to have the best outcomes. The RVP said he expected the staff to store the nebulizer masks properly. The RVP said the nursing department and the department heads were responsible for ensuring this was done. The RVP said it was important for the nebulizer masks to be stored in a bag for cleanliness. 45879 3. Record review of Resident #19's face sheet, dated 03/11/25, indicated an [AGE] year-old female who was admitted to the facility on [DATE] and readmitted [DATE] with diagnoses which included dementia (loss of memory, language, problem-solving, and other thinking abilities that were severe enough to interfere with daily life), chronic obstructive pulmonary disease also known as COPD (a common lung disease causing restricted airflow and breathing problems), Parkinson's (a movement disorder of the nervous system that worsens over time), and high blood pressure. Record review of Resident #19's quarterly MDS assessment, dated 02/06/25, indicated Resident #19 usually understood and was usually understood by others. The MDS assessment indicated she had a BIMS score of 5 indicating she was severely cognitively impaired. Resident #19 required assistance with bathing, toileting, dressing, bed mobility, personal hygiene, and eating. The MDS indicated she required oxygen. The MDS did not indicate any behaviors or refusal of care. Record review of Resident #19's physician's order dated 09/30/24 indicated Oxygen at 3 liters per nasal cannula every shift as needed for shortness of breath. Record review of Resident #19's physician's order dated 05/24/24 indicated Budesonide Inhalation Suspension 0.5 MG/2ML (Budesonide (Inhalation), give 1 dose inhale orally two times a day for shortness of breath. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #19's comprehensive care plan, dated 11/01/23, indicated Resident #19 had shortness of breath related to congestive heart failure. The intervention of the care plan was for staff to administer oxygen as ordered. During an observation on 03/10/25 at 10:32 a.m., Resident #19's oxygen tubing was on the floor and the nebulizer mask was not bagged on the nightstand. During an observation on 03/10/25 at 12:29 p.m., Resident #19 was in the dining room eating lunch with oxygen at 2 liters per nasal cannula. During an observation on 03/11/25 at 9:16 a.m., Resident #19's nebulizer mask was not bagged and was sitting on the nightstand. During an observation and interview on 03/11/25 at 4:04 p.m., LVN A came into Resident #19's room and verified her nebulizer mask was not bagged. He said Resident #19 sometimes moved things around in her room because she was a hoarder. He said Resident #19 probably took the oxygen tubing and the nebulizer mask out of the bag. He said both oxygen tubing and nebulizer mask should be bagged when not in use to prevent infection control issues. During an observation and interview on 03/12/25 at 1:30 p.m., Resident #19 was in her room with her oxygen set at 2 liters via nasal cannula. LVN D came into the room and verified her oxygen was set at 2 liters per nasal cannula. He looked at Resident #19's orders in her electronic medical records and said her orders were for 3 liters of oxygen. LVN D turned Resident #19's oxygen to 3 liters per nasal cannula. He said the failure to have oxygen set at the correct orders could cause respiratory distress . During an interview on 03/12/25 at 2:00 p.m., the DON said the charge nurses were responsible for following the physician's orders. She said the failure to follow the orders could cause respiratory distress. The DON said the charge nurses were responsible for ensuring the oxygen tubing and the nebulizer mask were bagged when not in use. The DON said oxygen tubing should not be on the floor and the nebulizer mask should be bagged for infection control reasons. During an interview on 03/12/25 at 3:32 p.m., the Regional [NAME] President said he expected oxygen tubing and the nebulizer mask to be dated and bagged. He said nurse managers were the overseers of oxygen. He said the floor was not the best place for oxygen tubing or the nebulizer mask because of the potential for infection. Record review of the facility's policy titled, Oxygen Administration, revised February 2025, indicated, .1. Verify that there is a physician's order for this procedure. Review the physician's orders or facility protocol for oxygen administration. 3. Turn on the oxygen. Unless otherwise ordered, the flow of oxygen per Physician orders. 4. Place appropriate oxygen device on the resident (i.e., mask, nasal cannula and/or nasal catheter). 5. Oxygen cannula and tubing will be changed within 7-10 days or if visibly soiled. Store in a covered device (i.e. plastic bag. kangaroo Pouch) between uses. 6. Adjust the oxygen delivery device so that it is comfortable for the resident and the proper flow of oxygen is being administered . 6. Store nebulizer equipment in a covered device (i.e. plastic bag, kangaroo pouch) between uses . (continued on next page)

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	676458	A. Building B. Wing	03/12/2025

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

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the facility policy titled, Administering Medications through a Small Volume (Handheld) Nebulizer, dated August 25, 2022, indicated, Purpose: The purpose of this procedure is to safely and aseptically administer aerosolized particles of medication into the resident's airway. Steps: #26. When equipment is completely dry, store in a plastic bag with the resident's name and the date on it.

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47612 Based on interviews, and record review, the facility failed to ensure that residents who were trauma survivors receive culturally competent, trauma-informed care in accordance with professional standards of practice and accounting for residents' experiences and preferences in order to eliminate or mitigate triggers that may cause re-traumatization of the resident for 1 of 21 residents' (Resident #'s 62) reviewed for trauma-informed care. The facility did not ensure Resident #62 had a trauma screening that identified possible triggers when Resident #62 had a history of trauma. These failures could put residents at an increased risk for severe psychological distress due to re-traumatization. The findings included: Record review of the face sheet, dated 03/12/2025, indicated Resident #62 was a [AGE] year-old female, originally admitted to the facility on [DATE] and readmitted to the facility on [DATE] with diagnoses of anxiety disorder (condition in which a person has excessive worry and feelings of fear, dread, and uneasiness), and dementia (a group of conditions that cause a progressive decline in cognitive abilities, including memory, thinking, reasoning, and problem-solving). Record review of the quarterly MDS assessment, dated 02/25/2025, revealed Resident #62 had a BIMS of score 07, which indicated severe cognitive impairment. The MDS revealed Resident #62 had no behaviors or refusal of care. Record review of the care plan did not address Resident #62 having a history of trauma. Record review of Resident #62's progress notes dated 3/12/2025, indicated an entry by the social worker on 1/27/2025 of a history of trauma /abuse by a family member. During an interview on 03/12/2025 at 2:15 p.m., the Social Worker stated it would not hurt to put Resident #62's history of trauma on the care plan, but she was unsure who was responsible for adding the history of trauma to the care plan. The Social Worker stated it was important for the resident's history of trauma to be on the care plan in case the resident started showing behaviors due to past trauma. The Social Worker stated if the history of trauma was not on the care plan the nurse may not know how to treat the resident. During an interview on 03/12/2025 at 2:22 p.m., the DON stated the Social Worker was responsible for informing the nursing staff of Resident #62's history of trauma so it could be added to the care plan. The DON stated it was important to add the history of trauma to the care plan so the nurses would know how to monitor and assess if the resident had any behaviors related to the past trauma. The DON stated there could be harm to the resident if history of trauma was not care planned and the resident started having behaviors the nurse would need to know to be able to care for the resident. The DON stated she would monitor by reviewing the 24-hour report and during IDT morning meetings. (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 03/12/2025 at 3:04 p.m., the Regional [NAME] President stated he expected the appropriate information to be on the resident's care plan. The Regional [NAME] President stated it was important for the care plan to provide the best individualized care for the residents. Record review of the facility's undated policy titled Trauma-Informed Care indicated . The care plan will be person-centered and include interventions that are individualized and have worked in the past, simple and include triggers that the resident may have .

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45879 Based on observations, interviews, and record review the facility failed to ensure all drugs were only accessible by authorized personnel, for 1 of 6 residents (Resident #57) reviewed for medication storage. The facility did not ensure medication named Breo Ellipta (a combination inhaler used for maintenance treatment of chronic obstructive pulmonary disease (COPD) and asthma in adults) was not left unattended on Resident #57's bedside table on 03/10/25. This failure could place residents at risk of not receiving the therapeutic benefit of medications, harm or misuse of medication, drug diversions, and adverse reactions to medications due to improper storage. Findings included: Record review of Resident #57's face sheet, dated 03/11/25, indicated an [AGE] year-old female who was admitted to the facility on [DATE] with diagnoses which included Parkinson's (a movement disorder of the nervous system that worsens over time), chronic obstructive pulmonary disease also known as COPD (a common lung disease causing restricted airflow and breathing problems), dementia (loss of memory, language, problem-solving and other thinking abilities that were severe enough to interfere with daily life), and high blood pressure. Record review of Resident #57's quarterly MDS assessment, dated 01/10/25, indicated Resident #57 understood and was understood by others. Resident #57's BIMS score was 14, which meant she was cognitively intact. The MDS indicated Resident #57 required help with toileting bed mobility, dressing, transfers, personal hygiene, and eating. Record review of Resident #57's physician orders dated 10/14/25 indicated: Breo Ellipta Inhalation Aerosol Powder breath activated 200-25 MCG/ACT (Fluticasone Furoate-Vilanterol) 1 puff inhale orally one time a day for cough. Record review of Resident #57's comprehensive care plan, dated 01/13/25, indicated she had shortness of breath related to her diagnosis of COPD. The interventions were to administer medication as ordered, encourage sustained deep breaths by using a demonstration (emphasizing slow inhalation, holding and inspiration for a few seconds, and passive exhalation), and to use an incentive spirometer. During an observation and interview on 03/10/25 at 11:08 a.m., Resident #57 had a medication named Breo Ellipta sitting on her bedside table with 18 puffs remaining. CNA C was in the room and verified that the medication was sitting on the bedside table. CNA C said medications were a nurse thing but to her knowledge, no resident should have medication left at the bedside . (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 03/11/25 at 4:55 p.m., LVN A said he was Resident #57's nurse yesterday (03/10/25) and was responsible for administering the Breo Ellipta. He said it took him a long time to administer Resident #57's medication and he was probably called away to do breakfast duty and did not realize he left the medication at the bedside. He said he should have taken the medication out of the room when he left because she could have taken another inhalation, another resident could have gotten it, or it could have come up missing and caused the resident to miss a dose. During an interview on 03/12/25 at 2:00 p.m., the DON said she expected staff not to leave medication at the bedside unattended. The DON said the nurse who gave the medication was responsible for ensuring the resident took his or her medication before leaving the room. She said she did not have any residents who could self-medicate. She said if medications were left at the bedside, then the intended resident would not receive their medication or take an extra dose, or another resident could take a dose. During an interview on 03/12/25 at 3:32 p.m., the Regional [NAME] President said he did not expect medication to be left at the bedside. He said the resident might get an extra dose or other residents were at risk of getting medication that was not ordered for them or even staff. Record review of the facility policy titled, Storage of Medication, revised date of April 2019, indicated, Policy Statement: The facility stores all drugs and biologicals in a safe, secure, and orderly manner. Policy Interpretation and Implementation: #1. Drugs and biologicals used in the facility are stored in locked compartments under proper temperature, light, and humidity controls. #3. The nursing staff is responsible for maintaining medication storage and preparation areas in a clean, safe, and sanitary manner.

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46892 Based on observations, interviews, and record review the facility failed to accommodate residents' food preferences for 1 of 21 residents (Resident #7) reviewed for preference. The facility failed to honor Resident #7's preference for no sausage. This failure could result in a decrease in resident choices, diminished interest in meals, and weight loss. Findings included: Record review of Resident #7's face sheet dated 03/12/2025 indicated she was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses which included fracture with routine healing and protein-calorie malnutrition. Record review of Resident #7's Quarterly MDS assessment dated [DATE] indicated she usually understood others and was usually understood. The MDS assessment indicated Resident #7's BIMS score was a 13, which indicated her cognition was intact. The MDS assessment indicated Resident #7 required supervision or touching assistance with eating. The MDS assessment did not indicate Resident #7 required a mechanically altered diet or a therapeutic diet. Record review of Resident #7's Order Summary Report dated 03/12/2025 indicated she had an order for a regular diet with regular consistency with a start date of 01/31/2025. Record review of Resident #7's care plan date initiated 01/19/2025 indicated she had no known allergies that she would have her medications and diet as ordered. Resident #7's care plan did not address her food preferences. Record review of Resident #7's Diet History and Food Preferences with an effective date of 01/20/2025 did not indicate her dislike for sausage and preference for bacon. Record review of Resident #7's breakfast meal tickets dated 03/10/2025 and 03/11/2025 indicated dislikes sausage, meal note bacon (no sausage), and special notes bacon (no sausage). During an interview on 03/10/2025 at 3:10 PM, Resident #7 said she did not like sausage for breakfast, and she had told the nurses and CNAs several times for a while now (she was unable to provide specific timeframes). Resident #7 said she still received sausage for breakfast. Resident #7 said the nurses and CNAs had written on her meal tickets multiple times that she did not like sausage and wanted bacon. Resident #7 said her roommate had also told them Resident #7 did not like sausage and her roommate shared her bacon with her. (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and interview on 03/11/2025 at 7:57 AM, Resident #7 had sausage on her breakfast tray, and said she did not receive bacon. Resident #7 said she did not like sausage and preferred bacon. Resident #7 said she had already told them she did not want sausage. Resident #7 said, Sausage does not agree with me, they gave me sausage again. During an interview on 03/12/2025 at 2:50 PM, [NAME] L said the nurses had told her Resident #7 did not like sausage and wanted bacon. [NAME] L said she served breakfast and gave Resident #7 bacon, but they were not perfect and sometimes they made mistakes. [NAME] L said the meal tickets noted the residents' dislikes. [NAME] L said it was important for the residents to receive their food preferences for them to be happy, and because if they did not like what they got they would not eat it and they could lose weight. During an interview on 03/12/2025 at 2:57 PM, the Dietary Manager said she completed an assessment on admission to get the residents likes and dislikes. The Dietary Manager said if she was notified of the resident disliking a certain food, she would update the assessment. The Dietary Manager said she also placed the residents' dislikes on their meal tickets. The Dietary Manager said Resident #7 was one of the residents who wrote on her meal ticket she did not like sausage and wanted bacon. The Dietary Manager said she noticed it on Sunday 03/09/2025 and had added it to her meal ticket the following day (03/10/2025). The Dietary Manager said she did not know what happened on 03/11/2025 that Resident #7 received sausage instead of bacon. The Dietary Manager said it was important for the residents to receive the food they liked so they could eat. During an interview on 03/12/2025 at 3:52 PM, the RVP said the dietary manager visited with the residents and based on their food preferences entered them into the system. The RVP said Resident #39's food preference for bacon was updated the next day of when the dietary manager was informed, and the timing was as expected. The RVP said it was important for the food preferences to be updated to provide individualized care to the resident and for them to eat what they enjoyed to keep their caloric intake up. Record review of the facility's policy titled Resident Food Preferences, revised July 2017, indicated, .Upon the resident's admission and as needed, the Dietician or designee will identify a resident's food preferences and document on the Diet History/Food Preference form found in the electronic medical record .

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46892 Based on observations, interviews, and record review, the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment to help prevent the development and transmission of communicable diseases and infections for 2 of 4 residents (Resident #39 and resident #41) reviewed for infection control. 1. The facility failed to ensure contact precautions were started on Resident #39 after a wound culture collected on 03/04/2025 indicated methicillin-resistant staphylococcus aureus (a type of bacteria that many antibiotics do not work on) was detected. 2. The facility failed to ensure CNA F wore PPE while entering Resident #41's room while on contact isolation precautions on 03/10/25. 3. The facility failed to ensure Housekeeper E wore PPE while cleaning Resident #41's room while she was on contact isolation precautions on 03/11/25. 4. The facility failed to ensure CNA B wore PPE while entering Resident #41's room while on contact isolation precautions on 03/11/25. These failures could place residents at risk for cross-contamination and the spread of infection due to a lack of implementation of orders and following contact isolation precautions. Findings included: Record review of a face sheet dated 03/12/2025 indicated Resident #39 was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses which included laceration without foreign body left foot, laceration without foreign body of right lesser toe(s) without damage to nail, laceration without foreign body of right great toe without damage to nail, laceration without foreign body, left ankle, and laceration without foreign body, right lower leg. Record review of Resident #39's Comprehensive MDS assessment dated [DATE] indicated she was able to understand others and was understood. The MDS assessment indicated Resident #39 had a BIMS score of 09, which indicated her cognition was moderately impaired. The MDS assessment indicated Resident #39 required partial/moderate assistance with dressing, showering/bathing self, personal hygiene, and substantial/maximal assistance with toileting. The MDS assessment indicated Resident #39 had other open lesion(s) on the foot, skin tear(s), and received application of nonsurgical dressings and dressings to feet. Record review of Resident #39's Order Summary Report dated 03/11/2025 indicated: nursing intervention: implement and maintain enhanced barrier precautions when performing high contact care activities with a start date of 02/27/2025. Clindamycin (antibiotic) 300 mg by mouth three times a day for wound infection for 10 days with a start date of 03/05/2025. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ciprofloxacin (antibiotic) 250 mg by mouth two times a day for wound infection for 10 Days with a start date of 03/06/2025. Clobetasol Propionate External Gel 0.05 % apply to right shin, left posterior ankle topically one time a day for wound healing cleanse with normal saline, pat dry, apply gel, apply xeroform, cover with clean dry dressing with a start date of 03/05/2025. Record review of Resident #39's care plan revised 03/07/2025 indicated, she required EBP related to being at increased risk for MDRO acquisition due to wound to lower extremity. Interventions included a private room was not required, allowed to attend group activities, do not wear the same gown and gloves for the care of more than the single patient care post clear signage on the door or wall outside of the room indicating the type of precautions and required PPE, Provide patient standard precautions using gowns and gloves during dressing, bathing, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device care or use and wound care. The resident was on antibiotic therapy related to lower extremity cellulitis (infection of the skin and tissue) and had skin tears of the right lower extremity related to scratching herself. Interventions included if a skin tear occurred treat per facility protocol and notify the MD and family. The resident had actual impairment to skin integrity of the left lower extremity related to eczema and fragile skin follow facility protocols for treatment of injury. Record review of Resident #39's wound culture collection date: 03/04/2025, indicated, methicillin resistant staphylococcus aureus was detected. During an observation and interview on 03/11/2025 at 4:50 PM, Resident #39 had an EBP sign on her door. LVN G said Resident #39 was on an antibiotic for her wound, but she did not know which wound that the treatment nurse had received the orders for the wounds and put the EBP in place. During an interview on 03/11/2025 at 4:53 PM, the Wound Care Nurse said Resident #39's wound infection was in her left posterior (back) ankle. The Wound Care Nurse said when wound culture results were received, she notified the wound doctor, and the wound doctor gave recommendations. The Wound Care Nurse said the wound doctor and the facility's NP discussed the results and orders were provided. The Wound Care Nurse said Resident #39 was on EBP not on contact precautions. The Wound Care Nurse said she was a nurse and could determine if a resident required contact precautions. The Wound Care Nurse said when she reviewed Resident #39's wound culture results she did not notice any bacteria that required contact precautions, and the only order she received from the wound care doctor was an antibiotic. The Wound Care Nurse said she did not remember the bacteria on Resident #39's wound culture that she would review the wound culture results and let me know if Resident #39 required contact precautions. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 03/11/2025 at 5:39 PM, the DON said she had called the wound care doctor because they did depend on the physician to give them orders for antibiotics and anything that went along with the wound culture results. The DON said the wound care doctor said, I leave it up the primary care team, NP and MD to determine if any precautions are necessary, regarding if Resident #39 needed to be on contact precautions. The DON said the NP had not addressed the wound culture results because another physician had ordered the wound culture. The DON said she had reviewed the wound culture results when they received them and had not noticed the MRSA. The DON said she looked at it again today (03/11/2025), and she was not able to interpret anything to indicate Resident #39 required contact precautions that she had to google it to interpret the results. The DON said Resident #39 should be on contact precautions because the wound culture identified a type of MRSA. During an interview on 03/12/2025 at 3:09 PM, the DON said the wound physician ordered the wound culture on Resident #39's wound, and they notified him of the results since he was the ordering physician. He prescribed an antibiotic and assumed the PCP would review the wound culture as well. The DON said as the infection preventionist she reviewed the wound culture results and never got MRSA from the results. The DON said she could not write orders for contact precautions. The DON said Resident #39 not being on contact precautions was a risk of infection spreading to other residents or staff. During an interview on 03/12/2025 at 3:52 PM, the RVP said he expected the physician's orders to be followed. The RVP said the infection preventionist was responsible for ensuring the proper isolation measures were in place. The RVP said it was important for the proper isolation measures to be implemented to limit the spread of infection. During an interview on 03/12/2025 at 4:13 PM, the Wound Care Doctor said when he ordered a wound culture he was contacted with the results, and then his recommendations went to the Medical Director for his recommendations to be approved. The Wound Care Doctor said he was a consultant, and the primary care physician should follow up to implement the necessary isolation precautions. The Wound Care Doctor said as far as he knew the facility was responsible for implementing isolation precautions. The Wound Care Doctor said placing someone on contact isolation was a facility driven protocol. During an attempted phone interview on 03/12/2025 at 4:24 PM, the Medical Director did not answer the phone. 45879 2. Record review of Resident #41's face sheet, dated 03/11/25 indicated he was a [AGE] year-old female admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included respiratory failure (a serious medical condition where the lungs are unable to adequately exchange oxygen and carbon dioxide in the blood), urinary tract infection also known as UTI (is an infection of the urinary tract, which includes the kidneys, bladder, ureters, and urethra), Chronic obstructive pulmonary disease also known as COPD (a common lung disease causing restricted airflow and breathing problems), and stroke. Record review of Resident 41's admission MDS assessment, dated 02/14/25, indicated Resident #41 understood and was understood by others. Resident #41's BIMS score was 15 indicating she was cognitively intact. The MDS indicated Resident #41 required assistance with his transfers, toileting, dressing, hygiene, and set up for eating. The MDS indicated she was on an antibiotic. (continued on next page)

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	03/12/2025

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.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #41's electronic medical records revealed a urinalysis dated 03/04/25 which detected Methicillin-Resistant Staphylococcus Aureus also known as MRSA (a bacteria that has become resistant to some common antibiotics. It can cause an infection that can spread from one person to another). Record review of Resident #41's physician's order dated 03/04/25, indicated: Macrobid 100mg, give 1 capsule by mouth two times a day related to Urinary tract infection for 7 days. Record review of Resident #41's Physician order dated 03/05/25, indicated Contact isolation precautions in place related to MRSA in urine every shift for UTI until 03/12/202. Record review of Resident #41's comprehensive care plan dated 03/05/25 indicated Resident #41 had a UTI. The intervention was for staff to use contact isolation and give antibiotic therapy as ordered. During an observation on 03/10/25 at 3:09 p.m., a contact isolation sign was noted on Resident #41's door. CNA F walked into Resident #41's room to give him some ice/water without applying her gloves or gown. During an interview on 03/10/25 at 3:09 p.m., CNA F said after she went into Resident #41's room without any PPE. She said she did not touch her, so she said she did not believe she had to wear a gown or gloves. She said she only needed to wear PPE (gown and gloves) if she was providing care to prevent the spread of infection. She said she was aware Resident #41 was on contact isolation for her urine. During an observation on 03/11/25 at 8:24 a.m., CNA B entered Resident #41's room without any gloves or gown to deliver her breakfast tray and came back into the hallway and continued to pass trays to other residents. During an observation and interview on 03/11/25 at 10:04 a.m., Housekeeper F was cleaning Resident #41's room without a gown on. She said she was not aware she needed to wear anything except gloves. She said she could see where this resident might touch something because she does go to the bathroom herself. She said she should have worn a gown and gloves to prevent the spread of infection. During an interview on 03/11/25 at 1:42 p.m., CNA B said she went into Resident #41's room to pass her breakfast with no gown or gloves on and realized afterward she was doing it incorrectly. She said she was aware Resident #41 was on contact precautions for MRSA in her urine. She said she could spread her infection if she or other staff was not wearing gowns and gloves while in the room. She said she went in and told Resident #41 the correct way staff should be coming into her room. During an interview on 03/11/25 at 4:18 p.m., LVN A said he was the charge nurse for resident #41. He said she was on contact precautions for MRSA in her urine. LVN A said staff should have on a gown and gloves when entering Resident #41's room. He said he thought the staff were only thinking about EBP (Enhanced Barrier precautions) and not contact precautions when they were entering Resident #41's room. He said if staff were not wearing PPE they could spread the infection to others. (continued on next page)

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	03/12/2025

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

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 03/12/25 at 2:00 p.m., the DON said she expected all staff to follow the guidelines on the sign posted on the door. She said the staff were aware of Resident #41 being on contact precautions by the sign on the door and the setup outside the door. She said she made routine rounds to ensure staff were following the guidelines and had given several in-services on isolation. She said they should be wearing the proper PPE (gown and gloves) to protect themselves and to keep the spread of infection from other residents. During an interview on 03/12/25 at 3:32 p.m., the RVP said when a resident was on contact isolation staff should wear gowns and gloves when entering the room. He said the DON was the overseer of infection control. The RVP said staff should ensure they had on the proper PPE to protect themselves, the residents, and to prevent the spread of infection. Record review of the facility's policy titled, Infection Prevention and Control Program, revised August 2016, indicated, .The infection prevention and control program is coordinated and overseen by an infection prevention specialist (infection preventionist) . Prevention of Infection a. Important facets of infection prevention include: (1) identifying possible infections or potential complications of existing infection; (2) instituting measures to avoid complications or dissemination . (6) implementing appropriate isolation precautions when necessary . Record review of the facility's policy titled, Isolation-Categories of Transmission-Based Precautions, revised September 2022, indicated, Transmission-based precautions are initiated when a resident develops signs and symptoms of a transmissible infection; arrives for admission with symptoms of an infection; or has a laboratory confirmed infection; and is at risk of transmitting the infection to other residents . 5. When a resident is placed on transmission-based precautions, appropriate notification is placed on the room entrance door and on the front of the chart so that personnel and visitors are aware of the need for and the type of precaution. a. The signage informs the staff of the type of CDC precaution(s), instructions for use of PPE, and/or instructions to see a nurse before entering the room. b. Signs and notifications comply with the resident's right to confidentiality or privacy .Contact Precautions 1. Contact precautions are implemented for residents known or suspected to be infected with microorganisms that can be transmitted by direct contact with the resident or indirect contact with environmental surfaces or resident-care items in the resident's environment . 3. Contact precautions are used for residents infected or colonized with MDROs in the following situations: a. When a resident has wounds, secretions, or excretions that are unable to be covered or contained, and b. On units or in facilities where, despite attempts to control the spread of the MDRO, ongoing transmission is occurring .