STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676469	A. Building B. Wing	02/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Premier Snf of Alice	800-A Coyote Trail Alice, TX 78332

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 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** 46038 Based on observations, interviews, and record review the facility failed to develop and implement a comprehensive person-centered care plan for each resident that included measurable objectives and timeframes to meet a residents medical, nursing, mental, and psychosocial needs, for 2 (Resident #5 and Resident #44) of 12 Residents reviewed for care plans in that: 1. The facility failed to implement a comprehensive person-centered care plan for Resident #5 to maintain the call light within reach of Resident #5. 2. The facility failed to ensure Resident #44's foley catheter ordered on 11/27/24 was care planned. This deficient practice could place residents at an increased risk of decline, and diminished quality of life. The findings included: 1. Record review of Resident #5's face sheet dated 02/03/25 revealed a [AGE] year-old male with an admitted [DATE]. Pertinent diagnoses included unspecified dementia, traumatic subdural hemorrhage (bleeding between the brain and the skull), and unspecified psychosis. Record review of Resident #5's comprehensive MDS dated [DATE] section C, cognitive function, stated Resident #5's BIMS score was 99, which indicated the resident was unable to complete the interview. Section GG, functional abilities, scored Resident #5 as a 1 (Dependent - Helper does ALL of the effort. Resident does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the resident to complete the activity) for eating, oral hygeine, toileting hygeine, shower/bathe self, upper body dressing, lower body dressing, putting on/taking off footwear, and personal hygeine. Record review of Resident #5's care plan revealed the focus [Resident #5] has impaired communication due to impaired cognition and unclear speech initiated on 03/01/21 and revised on 05/12/21. One Intervention listed associated with the focus included: Ensure/provide a safe environment: Call light in reach, Adequate low glare light, Bed in lowest position and wheels locked, Avoid isolation initiated on 03/01/21. (continued on next page)

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

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation inside Resident #5's room and interview on 02/03/25 at 9:36 AM, Resident #5's call light was hung up on the wall, out of reach of Resident #5. Resident #5 was not interviewable. During an observation inside Resident #5's room on 02/03/25 at 1:20 PM, Resident #5's call light was hung up on the wall, in the same position it was in during the previous observation. In an interview with CNA A on 02/03/25 at 1:24 PM, CNA A stated a resident's call light should be within arms reach or clipped onto the bed. CNA A stated the staff went in Resident #5's room frequently. CNA A stated Resident #5 was not able to get up and walk around. CNA A stated Resident #5 can only move around in bed a little bit. This state surveyor and CNA A walked into Resident #5's room and CNA A stated Resident #5's call light was currently on the wall. CNA A stated Resident #5 will swing his call light around sometimes. CNA A stated they will sometimes put it out if reach for a few minutes and redirect him from swinging it around, before putting his call light back within reach. CNA A stated it was important for residents to be able to reach their call light in case they needed assistance going to the bathroom or if they needed anything. In an interview with LVN B on 02/03/25 at 1:31 PM, LVN B stated residents should have their call light within arm ' s reach. LVN B stated she was in Resident #5's room approximately 30 minutes ago and his call light was draped over the back of his bed at that time. LVN B stated Resident #5 had a family member with him in his room at that time. LVN B stated Resident #5's call light was within reach as well during her morning rounds around 6:30 AM. LVN B stated she had not seen Resident #5 swing his call light around before but had heard about it from other CNAs and nurses. This state surveyor and LVN B walked into Resident #5's room and LVN B stated Resident #5's call light was not currently within reach. LVN B stated it was important for residents to be able to reach their call lights in case they needed anything from staff. In an interview with the DON on 02/03/25 at 4:45 PM, the DON stated the call light should always be within reach of the resident unless otherwise stated. The DON stated she was not aware of any residents in the facility that should not have their call light within reach. The DON stated the only signaling system residents used in the facility were call lights. The DON stated she had never heard of Resident #5 swinging his call light around. The DON stated she had not heard of any issues with Resident #5 regarding his call light. The DON stated it was important for residents to have their call lights within reach so they could voice their needs if they had any. 2. Record review of Resident #44's face sheet date 2/4/25 reflected an [AGE] year-old-female with an original admitted [DATE] and a re-admitted [DATE]. Diagnosis included chronic obstructions pulmonary disease (characterized by persistent respiratory symptoms like progressive cough and breathlessness) and type two diabetes (insufficient insulin production in the human body). Record review of Resident #44's orders dated 11/27/24 reflected: Urinary Foley Catheter 20F/10cc to gravity drainage every shift related to obstructive and reflux uropathy (blockage in your urinary tract). Record review of Resident #44's care plan initially dated 8/23/24 did not reflect foley care. Record review of Resident #44's Admission/Medicare MDS dated [DATE] reflected a BIMS of 14 (cognition intact) and indicated the resident had an indwelling catheter. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 02/04/25 at 02:47 PM LVN C stated she was unable to locate Resident #44's foley catheter care plan. LVN C stated Resident #44's foley catheter should have been care planned to ensure foley catheter care was being done and so direct care staff could monitor for infection. LVN C stated Resident #44's foley catheter instructions were on the medication administration record and treatment administration record. In an interview on 02/04/25 at 02:52 PM the MDS Coordinator stated Resident #44's foley care was not on the care plan. The MDS Coordinator stated it should have been care planned since it was part of Resident #44's plan of care. The MDS Coordinator stated she was not sure why foley care was not care planned. The MDS Coordinator stated it was a team effort to make sure the care plans are not overlooked and accurate. In an interview on 02/04/25 03:16 PM the DON stated Resident #44's foley should be care planned to ensure the proper plan of care was in place for Resident #44 and so staff were aware of the foley being in place. The DON stated it was a team effort to ensure the care plans are up to date and Resident #44's foley care plan was over looked. Record review of the facility's Comprehensive Care Planning policy not dated stated: The facility will develop and implement a comprehensive person-centered care plan for each resident consistent with the resident rights that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The facility will establish, document and implement the care and services to be provided to each resident to assist in attaining or maintaining his or her highest practicable quality of life. The resident's care plan will be reviewed after each Admission, Quarterly, Annual and/or Significant Change MDS assessment, and revised based on changing goals, preferences and needs of the resident and in response to current interventions. 50039

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50969 Based on observation, interview, and record review, the facility failed to review and revise the care plans for 1 of 5 residents (Resident #232) whose care plans were reviewed, in that: The facility failed to ensure Resident #232's care plan was revised to accurately reflect current urinary or foley catheter status. These failures could place residents at risk of receiving inadequate individualized care and services. Findings included: Record review of Resident #232's face sheet revealed an [AGE] year-old male with an admitted [DATE]. Record review of Resident #232's Comprehensive MDS dated [DATE] revealed Resident #232 was unable to respond or answer questions, or rarely or never understood, so the brief interview for mental status was not performed. MDS also reflected Resident #232 was dependent with toileting hygiene, oral hygiene, showering/bathing and dressing. Record review of Resident #232's care plan revealed resident was care planned for an indwelling catheter on 1/14/25, and it was revised on 2/4/25 to still show indwelling catheter with 7 different interventions to meet urinary and catheter goals. Record review of Resident #232's physician orders revealed Foley catheter and Foley catheter care discontinued on 1/16/25. Record review of Resident #232's progress notes dated 1/13/25 revealed Resident was admitted from the hospital with the foley catheter. No other progress notes make a reference to having or removing a foley catheter. In an observation on 2/3/25 at 4:40 PM, Resident #232 was observed lying in bed with feeding tube attached and family at bedside. He would not wake to answer questions. No Foley catheter was observed. In an interview on 2/3/25 at 4:40 PM, Resident #232's daughter stated that her dad did have a foley catheter, but they removed it not long after he was admitted to the facility. In an interview on 2/4/25 at 12:12 PM with the Regional Nurse Consultant, she stated that care plans were updated typically by either the DON, ADON or MDS nurse. In an interview on 2/4/25 at 5:05 PM the DON stated that per the physician's orders, the foley catheter was discontinued on 1/16/25, and catheter and urinary status should have been removed from the care plan, especially since it was revised by someone today. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 2/5/25 at 9:29 AM with the Administrator, he stated that the DON normally initiates the care plans, then they were reviewed, revised, or updated by anyone on the Interdisciplinary Team. He stated that if care plans were not implemented or revised correctly, resident could end up getting improper care. Record Review of the Care Plan Policy, undated, revealed each resident will have a person-centered comprehensive care plan developed and implemented to meet his other preferences and goals, and address the resident's medical, physical, mental, and psychosocial needs. The resident's care plan will be reviewed after each admission, quarterly, annual and/or significant change MDS assessment, and revised based on changing goals, preferences and needs of the resident and in response to current interventions.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50969 Based on observations, interviews, and record reviews, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safely for 1 of 1 kitchen reviewed for sanitation. The facility failed to properly label and date open, shelf stable food. The facility failed to dispose of expired shelf stable and refrigerated food. The facility failed to ensure items were stored properly in a refrigerator instead of on a pantry shelf. The facility failed to ensure the large containers of cooking oil were free from cracks or holes and not leaking on the floor. The facility failed to maintain and assure all chemicals in the kitchen area were labeled appropriately. These failures could place residents at risk of foodborne illnesses, as well as place residents and staff at risk for falls and injuries. Findings were: Observations and initial tour of the kitchen on [DATE] at 8:10 AM revealed a half-used jug of lemon juice labeled as refrigerate after opening was being kept on a pantry shelf; a large container of cooking oil on a bottom shelf in pantry that had leaked all over the floor and under shelving; an opened meat product, thawing in bloody water, past the hand written expiration date; three Ziploc bags of dry goods that were all past the hand written expiration date. Observation on [DATE] at 8:25 AM of the supply closet in the kitchen that houses the cleaners and chemicals revealed a large spray bottle with a light-yellow liquid or chemical inside it. Liquid or chemical had a very strong odor, and there was no label or writing on the bottle. In an interview on [DATE] at 8:25 AM with the Dietary Manager, he stated the unlabeled bottle had Clorox cleaner in it, and it should have been labeled or discarded. In an interview on [DATE] at 8:29 AM, housekeeping stated that labels should be put on the bottles by whoever pours the chemical into the bottle. She stated that it was not safe to have unlabeled chemicals sitting around because staff could use them without knowing what they were using, or a resident could get ahold of it and really hurt themselves if they drank it or got it on their skin. She also stated that it was not safe to leave spills, whether oil or something else, on the floor as someone could slip in it and hurt themselves. She stated it should be cleaned up as soon as the spill or mess was noticed. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview with the Dietary Manager on [DATE] at 08:55 AM, he stated serving expired food could cause residents to become ill, and If items were not being refrigerated like they should, this could also cause residents to become ill. He also stated that the oil had been leaking, and needed to be transferred to a different container and cleaned off the floor so an accident did not occur. He also stated that the person who transferred the chemical should have added the labels to the bottle, and if a chemical was not labeled appropriately, it could be hazardous if used for something else or if a resident got ahold of the chemical, it could cause harm to them. He stated that he was ultimately responsible for things being labeled or disposed of appropriately in the kitchen. In an interview with the Dietary Aide on [DATE] at 09:10 AM, she stated if food was used past the expiration date it could cause the residents to get sick. She also stated if things were not stored properly, they could go bad, and the residents could get sick from this as well. She also stated the person who opened and poured chemicals into a bottle was the person who would label the chemicals. She stated the staff or manager needed to dispose of the chemicals since there was no label or you could get it confused with other things. She also stated that a resident could have drunk the chemical or gotten it on their skin not knowing what it was, and it could have harmed them, and in regard to the oil all over the floor, whoever saw or noticed the oil spilled in the floor should have attended to it and cleaned it up, but that the Dietary Manager was ultimately responsible for everything in the kitchen. In an interview with the Administrator on [DATE] at 9:29 AM, he stated that the person who transferred the chemicals should have labeled it, but the Dietary Manager was ultimately responsible for everything in the kitchen, including labeling and discarding chemicals. He also stated that they do not have a policy regarding labeling chemicals or keeping chemicals labeled. He stated he was told that they teach and preach to label chemicals, but they do not have a specific policy for it. He also stated the Dietary Manager was ultimately responsible for getting rid of any expired food, and that serving expired food to the residents could cause them to become sick. He also stated that storing food improperly could cause it to go bad and could cause sickness as well if served; The Administrator also stated that the Dietary Manager was responsible for cleaning the oil off the kitchen floor, and if not cleaned up, someone could slip and fall. In an interview with the DON on [DATE] at 09:18 AM, she stated that serving expired food to the residents could cause them to get sick, and it was all kitchen staff's job to discard of expired food, but it was ultimately the Dietary Manager's responsibility to check to see if anything was expired. She also stated if food items or products were being stored improperly and served to the residents, this could also have caused them to get sick. The Dietary manager would be ultimately responsible for making sure if something was not labeled, it was discarded. The DON stated that the person who transferred the chemicals into the bottle should have labeled the bottle. If they did not label the bottle a resident could get injured or have poisoning if they had ingested the chemical. She stated the dietary manager was ultimately responsible for making sure something was labeled or was discarded, as well as should keep the oil contained, and the floor cleaned up because someone could slip and fall and become injured. Record review of the Food Storage and Supplies policy from the Dietary Services Policy and Procedure Manual 2012 revealed all facility storage areas will be maintained in an orderly manner that preserves the condition of food and supplies. We will ensure storage areas were clean and organized. If perishable food items were not stored at the proper temperature, spoilage bacteria could grow faster than anticipated and food becomes spoiled and should not be served. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of an email dated [DATE] at 10:38 AM from the Director of Environmental Services revealed they teach and preach to label chemicals, but there was no policy.