STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676499	A. Building B. Wing	09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Springtown Park Rehabilitation and Care Center	201 Williams Ward Rd. Springtown, TX 76082

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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 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50133 Based on interview and record review, the facility failed to ensure each resident was informed before, or at the time of admission, and periodically during the residents stay, of services available in the facility and of changes for those services, which included changes for services not covered under Medicare/Medicaid or by the facility's per diem rate for 2 of 3 residents (Resident #60, and #98) reviewed for Medicare/Medicaid coverage. The facility failed to ensure Residents #60 and #98 were given a completed SNF ABN (a notice given to Medicare beneficiaries to transfer financial liability to the beneficiary before the SNF provides an item or service that would usually be paid for by Medicare, but Medicare was not likely to provide coverage because care was not medically reasonable and necessary, or was custodial in nature) when discharged from skilled services at the facility prior to covered days being exhausted. This failure could place residents at risk for not being aware of changes to provided services. Findings included: 1. Record review of Resident #60's electronic face sheet dated 09/26/24 revealed resident was a [AGE] year-old female who was admitted on [DATE] with diagnoses that include: muscle wasting and atrophy, muscle weakness, acute respiratory failure with hypoxia (lung disease resulting in lack of oxygen), abnormalities of gait. Record review of the SNF Beneficiary Protection Notification Review indicated Resident #60 received Medicare Part A Skilled Services on 6/22/24 and her last covered day of Part A services was 8/16/24. The SNF Beneficiary Protection Notification Review indicated the facility/provider did not document on CMS 10123-NOMNC form which covered Medicare Part A service was ending. 2. Record review of Resident #98's electronic face sheet dated 09/26/24 revealed the resident was a [AGE] year-old female who was originally admitted on [DATE] with diagnoses that include: muscle weakness, cerebral infarction (reduced blood flow to brain), chronic respiratory failure with hypoxia (decreased oxygen), unspecified asthma. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the SNF Beneficiary Protection Notification Review indicated Resident #98 received Medicare Part A Skilled Services on 06/20/24 and her last covered day of Part A services was 08/23/24. The SNF Beneficiary Protection Notification Review indicated the facility/provider initiated did not document on CMS 10123-NOMNC form which covered Medicare Part A service was ending. During an interview on 09/26/24 at 02:49 PM the MDS nurse stated the NOMNC form wasn't completely filled out for Residents #60 and #98. The MDS nurse further stated, That's why you complete an ADN. The MDS nurse explained the NOMNC form was used when Medicaid part A services are discontinued or end. She further explained that the ADN form was used for a payor change. She continued to deny the form wasn't completed correctly and stated that I will get with my corporate on that. During an interview on 9/26/24 at 3:15 PM the MDS nurse stated that she spoke with her corporate nurse and the NOMNC form should be completed in its entirety and stated that she did not have the two reviewed filled out completely. She stated the error happened due to receiving a new form 8/3/24 and she was not aware it needed to be completed. She further stated that incomplete forms could lead to a resident not being aware of actual services that were ending. The MDS Nurse stated that she was responsible for NOMNC forms. Review of Form Instructions for the Notice of Medicare Non-Coverage (NOMNC) CMS-10123 revealed the form must include [in part]: THE EFFECTIVE DATE YOUR {INSERT TYPE} SERVICES WILL END: {Insert Effective Date}: Fill the type of services ending, {home health, skilled nursing, comprehensive outpatient rehabilitation services, or hospice} and the actual date the service will end.

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42852 Based on observations, interviews and record reviews, the facility failed to ensure they followed professional standards of practice in accordance with physician orders and facility policy for care of midline for 3 (Residents #13, #349, #354) of 4 residents reviewed for parenteral and intravenous care. The facility failed to assess the midline intravenous catheter (an intravenous catheter that is suitable for long term infusion therapy) dressing on Resident #13. Dressing was observed as soiled and dislodged before flush being performed. The facility failed to change the midline intravenous catheter (an intravenous catheter that is suitable for long term infusion therapy) dressing on Resident #349 for more than 7 days. The facility failed to change the midline intravenous catheter (an intravenous catheter that is suitable for long term infusion therapy) dressing on Resident #354 for more than 7 days. These failures placed the residents at risk of complications with their midlines needed for infusion therapy. Findings included: Resident #13 Review of Resident #13's face sheet dated 09/24/2024 revealed she was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses of Sepsis , (infection of the blood) Pneumonia, and Urinary Tract Infection. Review of Resident #13's MDS dated [DATE] revealed the resident had BIMS (Brief Interview Mental Status) of 2 which suggest severe cognitive impairment . Review of Resident #13's physician's orders dated 09/24/2024 revealed an order 09/04/2024 intravenously for antibiotics of Ertapenem Sodium Solution 1 Gram intravenously one time a day for urinary tract infection for 10 days from 09/18/2024 thru 09/28/2024. Record review of Resident # 13's progress note dated 09/24/2024 revealed the midline was removed and replaced 09/24/24 due to occlusion. Observation and interview on 09/24/2024 at 4:24 pm, Resident # 13's midline dressing site was wet and not sealed. The DON said it needed to be changed due to being saturated and not secured. (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation and interview 09/24/2024 at 4:30 pm with LVN A revealed Resident #13's midline site to right arm was flushed by LVN A before checking infusion site. Site was dripping around soiled dressing covering midline insertion site. Post flush of midline dressing caused Resident #13's face to grimace. LVN A stated post flush, midline was occluded and would need to be changed. She said she did not look at site until flush was injected. Resident #349 Record review of Resident # 349's face sheet dated 09/24/2024 revealed she was a [AGE] year-old-female admitted to services on 09/17/2024 with diagnosis of Metabolic Encephalopathy (which happens due to organ dysfunction) and Extended Spectrum Beta Lactamase (ESBL) Resistance which is a type of enzyme that is produced by certain bacteria, making resistance to certain antibiotics which cause urinary tract infection difficult to treat (give medical care or attention to). Record review of Resident # 349's Care Plan dated 9/17/2024 revealed the resident's cognition was alert, cognitively intact. Resident was admitted to service for IV medications. Record review of #349's Order summary report dated 09/24/2024 revealed order for midline dressing change once a week and as needed if dressing becomes soiled. Record review Resident # 349's Medication Administration Record under Schedule for Sep 2024 revealed, Changed Midline Dressing once a week and PRN if becomes soiled. Observation and interview on 09/23/2024 at 12:10 PM revealed Resident # 349 had a single lumen midline to left arm with a dressing dated 9/13/2024. Dressing edges were not intact, and tape was discolored. Resident #349 stated the same dressing had been on since insertion. Resident #354 Review of Resident # 354's face sheet dated 9/24/2024 revealed she was an [AGE] year-old female admitted to facility on 09/16/2024 for metabolic encephalopathy (a change in how a brain works due to an underlying condition) and sepsis with bone infection to right ankle, foot which is resistance to multiple antimicrobial drugs. Review of Resident # 354's physician's orders dated 9/24/2024 revealed an order in part: May change Midline dressing every seven days or as indicated for soiled or damaged dressing. Change stabilization device and injection caps with each dressing change. As needed for soiled or damaged dressing. Observation on 09/23/2024 at 11:59 AM revealed Resident #354's midline to left arm with dressing covering site dated 09/11/2024. Interview 09/24/24 @ 3:30 PM with LVN A. She said, usually the nurse on 6am-2pm shift changed the midline dressing, but the 6am-2pm shift nurse has been off a few days. LVN A said she did change dressing for Resident #354 that morning (9/24/24) and the previous dressing was dated 9/13/24. She stated that upon admission they add 7 days from date of admission not date of dressing for dressing to be changed. She further stated she had IV training at hospital. (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 09/24/24 at 3:33PM with the DON, she said a midline dressing should be changed every 7 days or PRN as needed. The DON said Charge nurses were responsible for changing the dressings and the residents should have had orders that would show up on the MAR when the dressings needed to be changed. Possible failures to change the dressings on the midlines could cause infections at the infusion sites. Review of the facility's current Midline Dressing Changes policy and procedure Level III, dated April 2016: In-part: General Guidelines 1. Change midline dressing 24 hours after insertion, every 5-7 days, or if it is wet, dirty, not intact, or compromised in any way. Documentation 1. The following information should be recorded in the resident's medical record: (in-part) a. Date and time dressing was changed. b. Location and objective description of insertion site. c. Any complications, interventions that were done. Reporting 2. Intervene as necessary. Review on 09/26/2024 of the Guidelines for the Prevention of Intravascular Catheter-Related Infections at: https://www.cdc.gov/infectioncontrol/guidelines/bsi/recommendations revealed evidenced based recommendations for the preparation, insertion, administration, maintenance, and discontinuance of the IV as well as prevention of infection at the site to the extent possible.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50133 Based on observation, interview, and record review the facility failed to ensure that a resident who needed respiratory care, was provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences for 1 of 1 resident (Residents #12's) reviewed for respiratory care. 1. The facility failed to ensure Residents #12's nasal cannula was kept in a bag while not in use. These failures could place residents at risk for infections and transmission of communicable diseases. The findings included: 1. Record review of Resident #12's face sheet, dated 09/26/2024, reflected an [AGE] year-old female, who was admitted to the facility on [DATE]. Resident #12 had diagnoses which included Congestive Heart Failure (heart cannot pump blood efficiently enough to supply the body), Shortness of breath, Depression, Anxiety, chronic obstructive pulmonary disease (a lung disease that blocks airflow and makes it difficult to breathe). Record review of Resident #12's annual MDS assessment, dated 01/02/2024, reflected a BIMS score of 00, which indicated severe cognitive impairment. Section I: Active diagnosis reflected chronic pulmonary disease, or chronic lung disease. Section O: Respiratory Treatments was marked for Oxygen Therapy. Record review of Resident #12's quarterly Care Plan, 06/17/2024, reflected a care plan for has COPD (obstructive pulmonary disease) - Oxygen at 3 liters per minute continuously to keep oxygen saturation above 90%. The Care Plan did not have an intervention regarding when the oxygen tubing needed to be changed. Record review of Resident #12's Physician's Orders, dated 09/26/2024, reflected an order for Oxygen at 3 liters per minute via nasal cannula to maintain 02 saturation above 90%. Change oxygen and nebulizer tubing weekly. In an observation on 09/23/2024 at 10:30 AM revealed Resident #12 was sitting in the dayroom in her wheelchair. Her nasal cannula was uncovered and hanging over the bed rail in her room with the nose prongs on the floor. In an observation and interview on 09/24/2024 at 10:45 AM, during morning rounds, revealed Resident #12 was sitting in her wheelchair in her room and her nasal cannula was uncovered and hanging over the concentrator in her room with the nose prongs on the floor. Attempted to interview Resident #12 regarding the oxygen tubing, however she very confused and unable to answer. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an Interview on 09/26/2024 at 3:10 PM the DON stated oxygen tubing was changed weekly based on the resident's orders, or as needed if the tubing become contaminated or occluded. The DON said oxygen tubing and the humidifier bottle should be changed per doctor's orders and the nasal cannula should have been stored in a plastic bag when not in use to prevent cross contamination and infection. He. The DON said the charge nurses were responsible for seeing that it was done. In an Interview on 09/26/2024 at 4:00 PM the Administrator stated the resident care was handled by the nursing department and nasal cannulas should be put in a plastic bag when not in use. Policy requested from the DON on 09/26/2024 at 3:10 PM. Policy requested from the ADM on 09/26/2024 at 4:00 PM. No policies given.

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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. 50133 Based on observation, interview, and record review the facility failed to ensure that drugs and biologicals used in the facility were secured and stored in accordance with current accepted professional principles for 1 Treatment Cart observed for medication storage. The facility did not ensure the Treatment Cart was locked and secured. This failure could place the residents at risk of gaining access to unlocked medications not prescribed to them. Findings included: Observation on 9/24/24 at 1:19 PM revealed the treatment cart was parked in the 200 hallway with a resident within 6 feet of the opened, unsecured cart. The cart lock was popped out, and all drawers were able to be opened. No nurse was in sight of the cart. Present in cart were medicated dressings, prescription ointments and creams, over the counter creams, antifungal creams, Iodine swab sticks, adhesive remover, and wound cleanser. In an interview on 09/24/2024 at 1:24 ADON B stated that her expectation was for carts to be locked if nurse walks away from the cart. ADON B further stated that lack of ensuring cart security could lead to adverse outcomes due to residents being able to get into the cart. ADON B also stated the person responsible for cart security is the nurse assigned to cart with keys. ADON B stated that she is also responsible and should be observing to ensure cart is secure. In an interview on 9/24/2024 at 1:28 PM the Wound Care Nurse stated the treatment cart is to be always locked when not in use or directly in her sight to prevent residents accessing cart items that could harm them. The Wound Care Nurse further stated that it was her responsibility to ensure the treatment cart was locked. In an interview with the DON on 9/24/24 at PM revealed her expectation is for treatment cart to be locked if not in use by the nurse. The DON also stated if the cart is not locked residents could get into the cart and have access to contents of the cart. The DON further stated that nurse who receives the cart is responsible for making sure it is secure. The DON continued stating that it is the DON's responsibility to observe cart security. In an interview on 9/24/24 ADM at 4:08 PM the ADM stated that medication carts security should follow policy. The ADM that he could not speculate outcome regarding effect of unsecured cart. Record review of policy Storage of Medication dated 2001 revealed the following [in-part]: 8. Compartments (including, but not limited to, drawers, cabinets, rooms, refrigerators, carts and boxes) containing drugs and biologicals are locked when not in use. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	9. Unlocked medication carts are not left unattended.

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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. 44722 Based on observations, interviews, and record reviews the facility failed to properly store, prepare, distribute, and serve food in accordance with professional standards for food service safety for 1 of 1 kitchen reviewed. The facility failed to ensure foods were labeled properly in the refrigerator and the freezer. The facility failed to ensure food that had spoiled was discarded timely. The facility failed to ensure that staff performed hand hygiene while preparing food. These failures could place residents that eat out of the kitchen at risk for food borne illnesses. The findings included: During an observation on 09/23/24 between 9:40 AM and 10:15 AM, in the kitchen, revealed: Refrigerator #1 1. An open box, that contained 15 individually wrapped uncrustable peanut butter and jelly sandwiches, that were unthawed. The box had a manufacturer label that reflected keep frozen and did not have a date when opened and/or removed from the freezer. 2. One green bell pepper with a black soft spot on the top on the green pepper. Freezer #1 1. A plastic bag that contained garlic bread, out of the original container, that was not labeled with contents of package or with an open or use by date. 2. A plastic bag that contained cookie dough, out of the original container, that was not labeled with contents in package or with an open or use by date. During an interview on 09/23/2024 at 10:15 AM the DM stated items that had been removed from the original container should have been labeled with an item description and an open date. The DM stated if the manufacturer directions said to keep frozen then the item should have been kept frozen. The DM stated she was not sure how long the uncrustables had been out of the freezer. During an observation on 09/23/2024 between 11:30 AM and 12:15 PM revealed the DA exited the kitchen and returned to the kitchen pushing a cart. The DA failed to wash her hands when entering the kitchen. The DA emptied the container and refilled the container with ice. The DA failed to wash her hands before and after switching between preparing food The DM failed to wash her hands numerous times after touching her face, glasses and changing between tasks and assisting the cook. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 09/26/24 at 4:03 PM the DM stated her expectation was that food items be discarded per policy, and food times should have be labeled with an open date and/or use by date, item and description. The DM stated the affect could have been residents received food that was spoiled or the wrong food. The failure was staff got in a hurry and new staff. The DM stated her expectation was that staff perform hand hygiene every time they changed tasks, touched their face or glasses. The DM stated she was responsible for monitoring staff. The DM stated residents could have been affected by bacteria which could have led to residents getting sick. The DM stated what led to failure was staff was nervous and new staff. During an interview on 09/26/2024 at 4:45 Pm the ADM stated he expected staff to follow the polices for hand hygiene and labeling food. The ADM stated the DM was responsible to monitor the kitchen. The ADM stated he would not speculate to what led to the failures in the kitchen. Record review of the facility policy titled, Hand Washing dated 2021 revealed: Hands and exposed portions of arms (or surrogate prosthetic devices) should be washed immediately before engaging in food preparation. When to wash hands: a. When entering the kitchen at the start of a shift. b. After touching bare human body parts other than clean hands and wrists. c. After using the restroom .f. After handling soiled equipment or utensils. g. During food preparation, as often as necessary to remove soil or contamination and to prevent cross contamination when changing tasks .j. After engaging in other activities that contaminate the hands. Record review of the facility policy titled, Food Receiving and Storage dated July 2014 revealed: All foods stored in the refrigerator or freezer will be covered, labeled and dated (useby).