STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	745002	A. Building B. Wing	08/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Kent County Nursing Home	1443 North Main Jayton, TX 79528

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 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** 49305 Based on interview and record review, the facility failed to ensure that the comprehensive care plan was reviewed and revised by the interdisciplinary team after each assessment for 1 of 16 residents (Resident #27) reviewed for care plans. The facility failed to ensure Resident #27's care plan reflected the resident's current code status. This failure could place residents at risk of not receiving appropriate care to meet their current needs. Findings include: Resident # 27: Record review of a facility face sheet for Resident #27 dated [DATE] indicated that she was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses that included the following: personality disorder (mental health condition where people have a lifelong pattern of seeing themselves and reacting to others in ways that cause problems), anemia (not having enough healthy red blood cells or hemoglobin to carry oxygen to the body's tissues), anodontia (complete absence of teeth), muscle weakness-unspecified (lack of muscle strength), underweight, and other reduced mobility. Record review of Resident #27's Quarterly MDS (Minimum Data Set assessment) assessment dated [DATE], revealed under Section C Cognitive Patterns, a BIMS score of 11 indicating the resident was moderately cognitively impaired. Record review of physician orders dated [DATE] for Resident #27 indicated a Code Status of DNR. Record review of Resident #27's Out of Hospital Do Not Resuscitate (OOH-DNR) form dated [DATE] revealed it was completed by a qualified relative, signed by a physician, and signed by two witnesses. (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #27's care plan dated [DATE] with a revision date of [DATE] revealed a care plan focus of Full Code with a goal that stated, residents wishes will be honored, and the intervention stated Resident wishes will be respected and acted upon. CPR will be performed if need arises. During an interview on [DATE] at 11:55 AM, the ADMIN and the DON stated ADON is responsible for ensuring care plans were completed and updated accurately. The ADMIN stated the ADON was not working on this day and was unavailable for interview. The ADMIN stated the ADON was the MDS nurse as well. The ADMIN stated the ADON was having trouble keeping up with the care plans. The ADMIN stated the contracted personnel were not located in the facility. The ADMIN stated Resident #27 had a code status of DNR. The DON confirmed this. The ADMIN and DON both stated they were unaware the care plan for Resident #27 indicated a code status of Full Code (medical directive that instructs a patient's healthcare team to perform all possible measures to save the patient's life in the event of a medical emergency). The ADMIN and the DON were unsure why Resident # 27's care plan did not reflect an accurate code status. The ADMIN stated the ADON should have received training on completing and updating care plans at some point, but he was unsure of when that occurred. The ADMIN stated the ADON received ongoing training on how to complete and update care plans and she should have known these updates were needed. The ADMIN stated updating care plans when changes occur was included in the facility's policy related to care plans. The ADMIN stated the facility had an MDS and care plan consultant that monitored the completion of care plans to help ensure they are completed and updated, but he was unsure why these updated were not completed. The ADMIN stated he could not guess what the potential negative outcome could be for the residents' care plans not reflecting an accurate code status, as he stated there are too many variables to consider. The ADMIN stated there was a reason the process exists to protect the residents and to promote the highest quality of care. The DON stated the final wishes of a resident could be missed if the care plans do not reflect an accurate code status for the residents. The DON stated there were a lot of variables, but the care plan wishes of the residents could be missed if their care plans were not accurate. Record review of the facility policy, Care Plans, Comprehensive Person-Centered, Revised [DATE], revealed the following documentation: Policy Statement A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. Policy Interpretation and Implementation 1. The interdisciplinary team (IDT), in conjunction with the resident and his/her family or legal representative, develops and implements a comprehensive, person-centered care plan for each resident. 2. The comprehensive, person-centered care plan is developed within seven (7) days of the completion of the required MDS assessment (Admission, Annual or Significant Change in Status), and no more than 21 days after admission. 7. The comprehensive, person-centered care plan: (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	e. Reflects currently recognized standards of practice for problem areas and conditions. 11. Assessments of residents are ongoing and care plans are revised as information about the residents and the residents' conditions change. 12. The interdisciplinary team reviews and updates the care plan: a. when there has been a significant change in the resident's condition; b. when the desired outcome is not met; c. when the resident has been readmitted to the facility from a hospital stay; and d. at least quarterly, in conjunction with the required quarterly MDS assessment.

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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** 49927 Based on interview and record review, the facility failed to ensure that the comprehensive care plan was reviewed and revised by the interdisciplinary team after each assessment for 1 of 16 residents (Resident #31) reviewed for care plans. The facility failed to ensure Resident #31's care plan reflected the resident's current code status. This failure could place residents at risk of not receiving appropriate care to meet their current needs. Findings include: Resident # 31: Record review of a facility face sheet for Resident #31 dated [DATE] indicated that she was an [AGE] year-old female admitted to the facility on [DATE] with diagnoses that included the following: vascular dementia (problems with reasoning, planning, judgment, memory and other thought processes caused by brain damage from impaired blood flow to your brain), facial weakness following other cerebrovascular disease, major depressive disorder (mood disorder that causes a persistent feeling of sadness and loss of interest), generalized anxiety disorder (mental health condition that causes fear, a constant feeling of being overwhelmed and excessive worry), essential primary hypertension (abnormally high blood pressure that's not the result of a medical condition), and chronic atrial fibrillation, unspecified (irregular and often very rapid heart rhythm). Record review of Resident #31's Quarterly MDS (Minimum Data Set) assessment dated [DATE], revealed under Section C Cognitive Patterns, a BIMS score of 13 indicating the resident was slightly, cognitively impaired. Record review of physician orders dated [DATE] for Resident #31 indicated a Code Status of DNR. Record review of Resident #31's Out of Hospital Do Not Resuscitate (OOH-DNR) form dated [DATE] revealed it was completed by a qualified relative, signed by a physician, and signed by two witnesses. Record review of Resident #31's care plan dated [DATE] with a revision date of [DATE] revealed a care plan focus of Full Code with a goal that stated residents wishes will be honored, and the intervention stated, Resident wishes will be respected and acted upon. CPR will be performed if need arises. (continued on next page)

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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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on [DATE] at 11:55 AM, the ADMIN and the DON stated ADON is responsible for ensuring care plans were completed and updated accurately. The ADMIN stated the ADON was not working on this day and was not available for interview. The ADMIN stated the ADON was the MDS nurse as well. The ADMIN stated the ADON was having trouble keeping up with the care plans. The ADMIN stated the contracted personnel were not located in the facility. The ADMIN stated Resident #31 had a code status of DNR. The DON confirmed this. The ADMIN and DON both stated they were unaware the care plan for Resident #31 indicated a code status of Full Code (medical directive that instructs a patient's healthcare team to perform all possible measures to save the patient's life in the event of a medical emergency). The ADMIN stated Resident #31 was previously a Full Code status but was changed to DNR once she was placed on Hospice services. The ADMIN stated this change should have been updated on Resident #31's care plan as soon as the change was effective. The DON stated the change should have been updated on the care plan immediately. The ADMIN stated the ADON should have received training on completing and updating care plans at some point, but he was unsure of when that occurred. The ADMIN stated the ADON received ongoing training on how to complete and update care plans and she should have known these updates were needed. The ADMIN stated updating care plans when changes occur was included in the facility's policy related to care plans. The ADMIN stated the facility had an MDS and care plan consultant that monitored the completion of care plans to help ensure they are completed and updated, but he was unsure why these updated were not completed. The ADMIN stated he could not guess what the potential negative outcome could be for the residents' care plans not reflecting an accurate code status, as he stated there are too many variables to consider. The ADMIN stated there was a reason the process exists to protect the residents and to promote the highest quality of care. The DON stated the final wishes of a resident could be missed if the care plans do not reflect an accurate code status for the residents. The DON stated there were a lot of variables, but the care plan wishes of the residents could be missed if their care plans were not accurate. Record review of the facility policy, Care Plans, Comprehensive Person-Centered, Revised [DATE], revealed the following documentation: Policy Statement A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. Policy Interpretation and Implementation 1. The interdisciplinary team (IDT), in conjunction with the resident and his/her family or legal representative, develops and implements a comprehensive, person-centered care plan for each resident. 2. The comprehensive, person-centered care plan is developed within seven (7) days of the completion of the required MDS assessment (Admission, Annual or Significant Change in Status), and no more than 21 days after admission. 7. The comprehensive, person-centered care plan: e. Reflects currently recognized standards of practice for problem areas and conditions. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	11. Assessments of residents are ongoing and care plans are revised as information about the residents and the residents' conditions change. 12. The interdisciplinary team reviews and updates the care plan: a. when there has been a significant change in the resident's condition; b. when the desired outcome is not met; c. when the resident has been readmitted to the facility from a hospital stay; and d. at least quarterly, in conjunction with the required quarterly MDS assessment.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 41480 Based on observation, interview, and record review, the facility failed to ensure all drugs and biologicals were stored properly for 1 of 2 medication carts (medication cart for hall 100-200) in that: 1. The medication cart assigned to hall 100-200 contained expired medications. This failure could place residents at risk of not receiving prescribed medications as ordered, receiving medications that are less effective or have altered composition, and drug diversions. The findings included: Observation on 08/28/24 at 01:20 PM of the medication cart for hall 100-200 with LVN B, reflected expired medications were found on the cart. Medications included: Lactulose liquid 10 G/15 ml with an expiration date of 05/24, Senna Plus with an expiration date of 06/24, and Melatonin 1 mg with an illegible manufacturer's expiration date and a date of 07/24 hand-written on the bottle. Expired dates for Lactulose liquid and Senna Plus were verified with LVN B. The expiration date on the Melatonin bottle could not be determined by LVN B. These medications were removed from the cart for destruction by LVN B. During an interview on 08/28/24 at 01:24 PM with LVN B, she stated she was not sure why there were expired medications on the cart. She stated it was the responsibility of the charge nurses to check the carts for expired medications and remove any expired medications for destruction. She stated the medication carts were usually checked weekly for expired medications. LVN B stated she had been trained on proper medication storage through in-services conducted at the facility. During an interview on 08/30/24 at 11:14 AM with the DON, she stated nursing staff and medication aides were responsible for checking medication carts for expired medications. The DON stated she had conducted staff training quarterly and as needed on proper medication storage, including assuring all medications were within the manufacturer's date. The DON stated it was her expectation that staff follow policy and procedure for compliance and the best possible outcome for residents. She stated a potential negative outcome for failure to remove expired medications from the cart would be that residents could get sick or be harmed from being administered an expired medication. During an interview on 08/30/24 at 11:32 AM with the ADM, he stated medication aides, charge nurses and nursing administration were responsible for checking medication carts for expired medications. He stated nursing administration was responsible to conduct staff training on proper medication storage. The ADM stated it was his expectation that staff check medication dates prior to administering medications and that there should be a systemic process to assure proper medication storage. He stated he could not give a potential negative outcome for a resident being given an expired medication because he was not medically trained. He stated there was a reason for expiration dates on medications and the administration of medications should be done for the good of the resident. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of facility provided policy labeled, Medication Labeling and Storage, dated 2001, revealed: Policy Statement: The facility stores all medication and biologicals in locked compartments under proper temperature, humidity and light controls. Only authorized personnel have access to keys. Policy Interpretation and Implementation: Medication Storage 1. Medications and biologicals are stored in the packaging, containers or other dispensing systems in which they are received. Only the issuing pharmacy is authorized to transfer medications between containers. 2. The nursing staff is responsible for maintaining medication storage and preparation areas in a clean, safe, and sanitary manner. 3. If the facility has discontinued, outdated, or deteriorated medications or biologicals, the dispensing pharmacy is contacted for instructions regarding returning or destroying these items. Medication Labeling 4. For over the counter (OTC) medications in bulk containers (if permitted by state law) the label contains: a. the medication name; b. strength; c. quantity; d. accessory instructions; e. lot number; and f. expiration date (if applicable).

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 41480 Based on observation, interview, and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety in 1 of 1 dining rooms reviewed for dietary services, in that: The facility failed to ensure foods were served under sanitary conditions. These failures could place residents at risk for food contamination and foodborne illness. The findings included: The following observations were made on 08/28/24 at 12:25 PM during observation of dining services: LVN A took a resident's tray and placed items on the table in front of the resident. LVN A picked up the bread roll with a bare hand and using a fork, separated the bread roll and applied butter. She placed the bread roll back on the resident's plate using a bare hand. During an interview on 08/28/24 at 01:40 PM with LVN A, she stated I did pick up resident's bread roll and used fork to separate roll to butter his roll. She stated she normally used the resident's fork and knife, but the resident does not have a knife because he likes to cut things. She stated she should have used a glove to pick up the residents' food. She stated, that is just me screwing up, plain and simple. She stated the potential negative outcome of touching food with bare hands could be making the resident sick. She stated she had been trained to not touch residents' food with bare hands. During an interview on 08/30/24 at 10:35 AM with the ADM, he stated food should not be touch by bare hands while serving to residents. He stated he is not sure who trains the staff. He stated the potential negative outcome was most of the time nothing going to happen, but food borne illness is a thing and that is why we take precautions. During an interview on 08/30/24 at 11:42 AM the DON she stated there is no new staff and all staff should be trained on food handling. She stated she is not sure who trains staff. She stated they were probably trained by the DON or DM. She stated food should never be touched with bare hands. She stated the potential negative outcome could be cross contamination and could make residents sick or cause death because our population is very elderly. Record review of the facility policy, titled General Food Preparation and Handling, dated 2010, revealed the following: Policy: Food items will be prepared to conserve maximum nutritive value, develop, and enhance flavor and free of injurious organisms and substances. Procedure: . (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. h. Food will be prepared and served with clean tongs, scoops, forks, spoons, spatulas, or other suitable implements to avoid manual contact of prepared foods .