| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 745021 | A. Building<br>B. Wing | 05/07/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Lindale Specialty Care Center | 13905 Fm 2710<br>Lindale, TX 75771 |

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 0655<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44637<br><br>Based on interview and record review, the facility failed to develop and implement a baseline care plan within 48 hours of admission that included the instructions needed to provide effective and person-centered care of the resident that meets professional standards of quality care for 2 of 6 residents (Resident #1 and Resident #2) reviewed for baseline care plans.<br><br>The facility failed to ensure Resident #1 and Resident #2 had baseline care plans completed within 48 hours of admission.<br><br>This failure could place newly admitted residents at risk of receiving inadequate care and services.<br><br>Findings included:<br><br>1. Record review of the face sheet dated 5/7/24 indicated Resident #1 was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses including heart failure, muscle weakness, diabetes, hypertension (elevated blood pressure), and difficult walking.<br><br>Record review of the MDS dated [DATE] indicated Resident #1 admitted to the facility on [DATE]. The MDS indicated Resident #1 was understood by others and usually understood others. The MDS indicated Resident #1 had a BIMS of 07 and was moderately cognitively impaired.<br><br>Record review of the baseline care plan dated 2/8/24 indicated sections including activities of daily living, fall/safety/restraints/alarms, nutrition, pain, skin, sensory needs, elimination, infection, anticoagulant therapy, treatment(s)/procedures, and physician orders theses sections were not filled out for Resident #1. The baseline care plan for Resident #1 was not locked or signed.<br><br>2. Record review of the face sheet dated 5/7/24 indicated Resident #2 was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses including dementia, weakness, atrial fibrillation (an irregular, often rapid heart rate that commonly causes poor blood flow), chronic obstructive pulmonary disease (a group of lung diseases that block airflow and make it difficult to breathe, and hypertension.<br><br>Record review of the MDS dated [DATE] indicated Resident #2 admitted to the facility on [DATE].<br><br>(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 0655<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on 5/3/24 at 1:37 pm the DON said Resident #2 did not have a baseline or comprehensive care plan. The DON said the facility had an action plan related to baseline care plans.<br><br>Record review of an action plan dated 2/21/24 indicated the facility had a problem regarding baseline care plans not being opened, completed, and a copy given to the resident or resident representative withing 48 hours of admission. The action plan indicated the goal was for baseline care plans would be completed within 48 hours of admission and a copy given to the resident or resident representative.<br><br>During an interview on 5/7/24 at 10:56 a.m. MDS Coordinator B said she started at the facility approximately 2 weeks ago but had gone on vacation for a week after starting at the facility. MDS Coordinator B said the MDS Coordinators are responsible for opening and starting the baseline care plan. MDS Coordinator B said the treatment nurse, activities, dietary, and social services have parts to complete in the baseline care plans. MDS Coordinator B said the importance of the baseline care plan showed what level of assistance a resident needed, what a resident's functional status was, and if a resident had a specialized diet on admission. MDS Coordinator B Coordinator said a baseline care plan should be completed within 48 hours.<br><br>During an interview on 5/7/24 at 11:05 a.m. the DON said the MDS Coordinator was responsible for ensuring baseline care plans were completed within 48 hours of admission. The DON said the MDS was responsible for opening the care plan and then reviewing and ensuring every section was completed by the departments accurately. The DON said the importance of a baseline care plan was so staff knew how to take care of the resident, so the family, resident, and staff were on the same page to know what the resident's needs were and how the facility was going to meet them.<br><br>Record review of the facility's Care Plans-Baseline policy dated 2/2023 indicated, The facility will develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards. The baseline care plan will: a. Be developed within 48 hours of a resident's admission. B. Include the minimum healthcare information necessary to properly care for a resident including, but not limited to: i. Initial goals based on admission orders. ii. Physician orders. iii. Dietary orders. iv. Therapy services. v. PASARR recommendation, if applicable .An administrative nurse shall verify within 48 hours that a baseline care plan has been developed . |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44637<br><br>Based on interview and record review the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights for 2 of 6 (Resident #1 and Resident #2) residents reviewed for care plans,<br><br>The facility failed to ensure Resident #1's code status was properly care planned.<br><br>The facility failed to ensure Resident #2 had a care plan completed.<br><br>This failure could place the residents at increased risk of not having their individual needs met and a decreased quality of life.<br><br>Findings Included:<br><br>1. Record review of the face sheet dated 5/7/24 indicated Resident #1 was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses including heart failure, muscle weakness, diabetes, hypertension (elevated blood pressure), and difficult walking.<br><br>Record review of the MDS dated [DATE] indicated Resident #1 admitted to the facility on [DATE]. The MDS indicated Resident #1 was understood by others and usually understood others. The MDS indicated Resident #1 had a BIMS of 07 and was moderately cognitively impaired.<br><br>Record review of the physician orders dated 5/7/24 indicated Resident #1 had an order for Code Status: DNR starting 3/25/24.<br><br>Record review of an Out-Of-Hospital Do-Not-Resuscitate Order dated 3/23/24 indicated Resident #1 DNR was effective 3/23/24.<br><br>Record review of the care plan dated 3/13/24 indicated Resident #1 wished to be a full code.<br><br>2. Record review of the face sheet dated 5/7/24 indicated Resident #2 was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses including dementia, weakness, atrial fibrillation (an irregular, often rapid heart rate that commonly causes poor blood flow), chronic obstructive pulmonary disease (a group of lung diseases that block airflow and make it difficult to breathe, and hypertension.<br><br>Record review of the MDS dated [DATE] indicated Resident #2 admitted to the facility on [DATE].<br><br>Record review of Resident #2s clinical record from 4/19/24 to 5/7/24 revealed there was no care plan completed.<br><br>(continued on next page) |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on 5/7/24 at 9:44 a.m. LVN A said the baseline and comprehensive care plans were completed in the care plan meeting. LVN A said the code status in the orders and in the care plan, should definitely be the same. LVN A said it was important that the code status in the orders and care plan be the same to ensure there was no confusion regarding what a resident's code status was.<br><br>During an interview on 5/7/24 at 10:56 a.m. MDS Coordinator B said she started at the facility approximately 2 weeks ago but had gone on vacation for a week after starting at the facility. MDS Coordinator B said the comprehensive care plan should be completed within 14 days of admission. MDS Coordinator B said the comprehensive care plan and orders for code status should be the same. MDS Coordinator B said the importance of the code status in the orders and in the care plan, being the same was so in the event of a resident becoming unresponsive, with no heartbeat, and not breathing staff would know what the resident's wishes were and how to proceed with the resident's care.<br><br>During an interview on 5/7/24 at 11:05 a.m. the DON said the comprehensive care plan should be completed within 7-10 day of a resident admitting to the facility. The DON said the code status in the comprehensive care plan should be the same as the code status in the orders. The DON said the importance of a comprehensive care plan was so facility staff knew what the needs of a resident were and what the resident and facility expected of the needs being provided for. The DON said the importance of the code status in the care plan being the same as the code status in the orders was to ensure staff knew how to care for a resident in the event of the resident becoming unresponsive, with no heartbeat, and not breathing.<br><br>Record review of the facility's Comprehensive Care Plans policy dated 7/2022 indicated, It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with residents rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychological needs that are identified in the resident's comprehensive assessment .The comprehensive care plan will be developed within 7 days after the completion of the comprehensive MDS . |