STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455957	A. Building B. Wing	01/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Santa Fe Health & Rehabilitation Center	1205 Santa Fe Dr Weatherford, TX 76086

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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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41871 Based on interview and record review, the facility failed to ensure the resident's right to formulate an advance directive for 1 of 3 residents (Resident #44) reviewed for enactment of advance directives. The facility failed to ensure Resident #44 had the Out of Hospital Do Not Resuscitate (OOH-DNR) documentation in his electric record. This failure could put residents at risk of not having their OOH-DNR honored, resulting in receiving medical treatment they did not desire. The findings included: Record review of Resident #44's face sheet dated [DATE] revealed a [AGE] year-old male who was admitted to the facility on [DATE] with the primary diagnosis of dementia (a group of symptoms that affects memory, thinking and interferes with daily life). Record review of Resident #44's Care Plan, last revised on [DATE], revealed resident was a DNR. Record review of Resident #44's Physician Order Summary, dated [DATE], revealed the order DNR. Record review of Resident #44's electric record failed to have the Out of Hospital Do Not Resuscitate (OOH-DNR) documentation. In an interview on [DATE] at 10:57 AM, the MDS Coordinator looked in Resident #44's electronic records and said the advance directive was not in his documentation. In an interview on [DATE] at 2:08 PM, the Social Worker said it was her responsibility to ensure documentation of advanced directives were in the resident's electronic record. The Social Worker said she was recently hired, and she did not know why the OOH-DNR was not in Resident #44's electronic record. She said she would immediately get the required documentation completed. The Social Worker said a potential negative outcome would be Resident #44's end of life wishes might not get honored. Record review of facility policy Advanced Directives/Advanced Care Planning, dated as revised on , d+[DATE] revealed the following [in part]: (continued on next page)

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

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Policy: It is the policy of this facility to recognize two fundamental rights of a person, the right to live and to continue treatment and the right to refuse or terminate unwanted treatment. This facility will honor a resident's wishes and advanced directives pertaining to his/her own medical treatment, including wishes to withhold treatment. Fundamental Information: Advanced directives include written instructions about care and treatment and include such documents as Directive to Physician (Living Will), Durable Power of Attorney for Health Care, Directive to Physician, Family and Surrogates, Out of Hospital DNR, and instructions for no CPR. All of these directives are recognized by state law. Procedure: Upon admission, significate changes or condition and periodic care plan reviews, the Social Service Director reviews each resident end of life care plan and revises as indicated.

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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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 14408 Based on interview and record review, the facility failed to ensure the MDS assessment accurately reflected the resident's status for 1 of 2 residents (Resident #27) whose records were reviewed for resident assessment, in that: Resident #27 had a PASRR evaluation dated 2/18/2020 which documented he was positive for mental illness. His annual MDS assessment dated [DATE] documented he had no Level II PASRR conditions. This failure placed the resident at risk for not receiving mental health services as needed. The findings included: Review of Resident #27's Admission Record, dated 1/24/2024, revealed a [AGE] year-old male admitted to the facility on [DATE]. His diagnoses included: post-traumatic stress disorder (mental health condition that develops following a traumatic event characterized by intrusive thoughts about the incident, recurrent distress/anxiety, flashback and avoidance of similar situations); bipolar disorder (mental health condition that causes extreme mood swings that include emotional highs - mania or and lows - depression); anxiety disorder; and major depressive disorder, recurrent (mood disorder that causes a persistent feeling of sadness and loss of interest). Review of Resident #27's annual MDS assessment, dated 9/14/2023, revealed no documentation of Level II PASRR conditions and the item for mental illness was not selected. Review of Resident #27's PASRR Level I screening, dated 2/14/2020, revealed an indication of MI. Review of Resident #27's PASRR Evaluation for MI, dated 2/18/2020, revealed he met the PASRR definition of MI and was PASRR positive for mental illness. Review of the PASRR quarterly IDT meeting notes, dated 12/18/2023, revealed Resident #27 received PASRR specialized services including community attendant services, individual skills training, medication training, and routine case management. During an interview and record review on 1/25/24 at 11:18 AM, the MDS Coordinator reviewed Resident #27's annual MDS, dated [DATE], for the sections for PASRR. She stated she had coded them wrong and Section A1500 should have been answered yes and Section A1510 should have selected A. mental illness. She stated she would do a correction for the annual MDS assessment. The MDS Coordinator stated there was not a facility policy for MDS completion and accuracy and she went by the instructions in the RAI manual.

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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 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41871 Based on interview, and record review, the facility failed to ensure individuals with mental disorders were evaluated and received care and services in the most integrated setting appropriate to their needs for 1 of 2 residents (Resident #76) reviewed for PASRR Level 1 screenings. The facility did not correctly identify Resident #76 as having a mental illness and did not complete a new PASRR Level One Screening. This failure could place residents at risk of not being evaluated for PASRR services . The findings include: Record review of Resident #76's face sheet, dated 01/24/2024, revealed a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #76's had admitting diagnosis of bipolar disorder (a mental health condition that causes extreme mood swings that include emotional highs and lows). Record review of the Resident #76's Admission MDS assessment, dated 11/19/2023, revealed resident had a BIMS score of 13, which indicated moderate cognitive impairment. Resident #76 had an active diagnosis of Manic Depression (bipolar disorder) and received antipsychotic medication. Record review of Resident #76's Care Plan, last revised on 11/20/2023, revealed the care plan: Resident #76 uses psychotropic medications. Record review of Resident #76's PASRR Level One Screening Forms, dated 11/10/2023, revealed he did not have a primary diagnosis of dementia. It revealed he was negative for mental illness, intellectual disability, or developmental disability. The form had not been updated. In an interview on 01/24/2024 at 1:38 PM, the Social Worker stated she just started on 11/27/2023 and was responsible for the PASRR process. She was not here when Resident #76 was admitted but his should have been updated at admission to reflect his diagnosis of bipolar disorder. She said the resident might not receive services he was entitled to. In an interview on 01/24/24 at 1:43 PM, the MDS Coordinator said she was responsible for PASRR screenings at the time of the resident's admission due to there being no social worker. Resident #76's PASRR should have been updated at the time of admission but it was missed. Record review of the facility policy Preadmission and Screening Resident Review (PASRR) Rules Guidelines, last revised on 07/2023, revealed the following [in part]: Guideline: It is the intent of Advanced Health Care Solutions to meet and abide by all State and Federal regulations that pertain to resident Preadmission and Screening Resident Review (PASRR) rules. Purpose: the purpose of the guideline is to direct the user through the PASRR procedure. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procedure: If positive .the Social Worker or designee enters the positive PL1 into the Simple LTC Portal.

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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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42852 Based on observation, interviews, and record review, the facility failed to ensure that residents were free of a med error rate of 5% or greater (8%) for 2 (Residents #300 and #49) of 6 residents reviewed for medication administration. 1. The facility failed to ensure RN F primed (removing air bubbles from the needle to ensure that the needle is open and working) insulin pen for Resident #300 before administering Lantus insulin. 2. The facility failed to ensure RN G primed the insulin pen for Resident #49 before administering Novolog insulin. 3. The facility had a 8% medication error rate based on 2 errors out of 25 opportunities, which involved 2 of 6 residents reviewed for pharmacy services. This failure placed residents at risk of incorrect doses of medications. Findings included: 1. Resident #300 Record review of Resident #300 Admission Record dated 01/25/24 revealed a [AGE] year-old female with admitted [DATE]. Resident had an active diagnosis list that included a Primary diagnosis of Diabetes Mellitus. She did not have a BIMS score due to being a new admission. Record review of Resident #300's Physician Orders dated 01/23/24 revealed an order for HumaLOG Injection Solution 100 UNIT/ML Inject 50 units subcutaneously before meals related to TYPE 2 DIABETES MELLITUS In an observation on 01/24/24 at 11:55 AM, RN F checked Resident #300 blood glucose and obtained a reading of 164. RN F gave Resident #30 50 units of Humalog KwikPen without priming the insulin pen prior to administering the medication. 2. Resident #49 Record review of Resident # 49's Admission Record dated 01/25/24 revealed a was a [AGE] year-old male admitted to facility on 12/22/20 with a BIMS of 11 (mild cognitive impairment) diagnosis of Insulin dependent Type 2 Diabetes Mellitus with unspecified complications. Record review of Resident #49's Physician Orders dated 01/25/24 an ordered on 11/30/23 revealed: Humalog KwikPen Solution Pen-injector 100 UNIT/ML (Insulin Lispro) inject as per sliding scale (BLOOD SUGAR): if 200-250+= 2 UNITS, IF 251-300=4 UNITS; 301-350=6 UNITS GREATER THAN 350 GIVE 8 UNITS AND NOTIFY PROVIDER subcutaneously two times a day related to TYPE 2 DIABETES MELLITUS DUE TO UNDERLYING CONDITION WITH OTHER UNSPECIFIED COMPLICATIONS with a start date of 11/30/24. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an observation on 01/24/24 at 3:55 PM with RN G, Resident # 49 received insulin of 6 units and received Humalog KwikPen Solution 100 UNIT/ML without the needle being primed. In an interview on 01/24/24 at 3:57 PM with RN G said, she had never been educated on priming insulin pens. G stated that failure could affect residents to receive wrong dose each time. In an interview on 01/24/24 at 3:55 PM, the RC said her expectation for nurses was to prime insulin pens per facility policy. She said the adverse outcome for residents could be not getting the correct dose of insulin and increased blood sugar. In an interview on 01/24/24 at 4:00 PM with the DON, he said any resident that received insulin via an insulin pen, the pen should always be primed. He said the failure could cause a resident to not receive the correct dose of insulin. Record review of facility's policy titled Insulin Pen Administration revised October 2020 revealed [in part]: Point the needle up. Tap the insulin cartridge to force any air bubbles to the top. Dial the 2-units used to Prime pen before each injection (This releases a small amount of insulin into the pen to help get rid of air bubbles that may be in the pen).

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 14408 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 kitchen reviewed for food and nutrition services The facility failed to prevent the following: 1. Vinyl mesh liner was used to cover stainless steel surfaces on shelves and in drawers. 2. Floor tile grout was soiled with a dark colored build-up and dried food throughout the kitchen. 3. The interior surface of the microwave oven was soiled with dried food and grease. 4. The three-door freezer unit for storing breakfast foods and desserts had a temperature above zero and food items were not frozen solid. 5. The sink for the garbage disposal leaked and a bucket was on the floor beneath it to catch dripping water. 6. Floor tiles were missing near the dish machine. These failures could place residents at risk for foodborne illness, compromised nutritional health status, and being served food items that may be contaminated. The findings included: Observations on 1/22/24 at 10:45 AM, during the initial tour of the dietary department, revealed the following: - mesh liner was on the shelves beneath the microwave counter, food processor counter, and center island food preparation counter; - mesh liner was on the bottom surface of three stainless steel drawers used for storing cooking utensils; - the interior surface of the microwave oven was soiled with dried splattered food and grease; - dark colored grease streaks and drips were on the front exterior surface of the oven door; - the manual can opener was soiled with dried food; - plastic storage container lids were soiled with dust and food crumbs in the non-perishable food storage room; (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	- floor tile grout was soiled with a dark colored build-up and dried food throughout the kitchen. Observation and interview on 1/22/24 at 11:08 AM revealed a freezer unit with three locked doors was located against a wall outside the kitchen in the area leading to the dining room. The Dietary Supervisor unlocked the first door for the breakfast food freezer and the thermometer inside registered 11 degrees F. The middle door for desserts was unlocked and thermometer inside registered 21 degrees F; the containers with ice cream and sherbet were not frozen solid. The exterior unit dial thermometer registered 21 degrees F. The Dietary Supervisor threw the soft sherbet and ice cream in a trash can. A stainless steel rectangular pan was covered with plastic wrap on the top shelf in freezer. The plastic wrap was blowing due being close to the fan at the top and a corner of plastic fell into the pan. The it Dietary Manager stated it was jello and attempted to cover the pan with the plastic wrap, which then fell into the center of the pan. The Dietary Manager removed the pan of red colored liquid from the freezer. She instructed a nearby staff member to tell the Administrator the freezer unit was not working. The exterior stainless steel surface of the freezer unit soiled with dried and smeared food particles. A temperature log was in a plastic sheet holder on the side of the freezer unit. The temperature log had documented temperatures for morning and evening on 1/22/24, and the morning of 1/23/24 was documented as 2 degrees F. The Dietary Manager stated the weekend cook had initialed the temperature log for 1/22/24. She stated the staff had been off by one day all month. Observation on 1/22/24 at 11:15 AM revealed the Maintenance Director was standing on a step ladder by the freezer unit against the wall outside the kitchen. He checked the top of the breakfast and dessert freezer and stated a paper had been above the filter. He stated he had removed the paper and the temperature of the freezer was already coming down. He stated he would check the freezer temperature again later today. Observation on 1/22/24 at 11:20 AM revealed the beverage station counter in the dining room had a water and ice dispenser machine. The exterior stainless steel surface was spotted with dry water drop stains. Observation on 1/24/24 at 11:35 AM revealed the garbage disposal sink leaked in the bottom left-hand corner and a bucket had been placed on the floor beneath it to catch the dripping water. Floor tiles were missing and had been covered with a towel and rubber mat in front of the garbage disposal to prevent a trip hazard. Review of the facility's Food and Nutrition Services Policy and Procedure Manual - Equipment Cleaning Procedures, dated 10/2005 and revised 12/31/2017, revealed [in part]: Policy It is the policy of this facility that all dietary equipment and the environment are cleaned and sanitized in a manner that meets local (if applicable), state, and federal regulations. Fundamental Information Routine cleaning will be practiced on a regular basis to keep all dietary equipment and the environment safe, sanitary, and in compliance with state and federal regulations. Cleaning is the practice of removing soil and dirt with an approved cleaning agent . (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Cleaning Frequency Daily, weekly, monthly . The Food and Drug Administration Food Code 2022 specified [in part]: Chapter 4 4-602.13 Nonfood-Contact Surfaces. The presence of food debris or dirt on nonfood contact surfaces may provide a suitable environment for the growth of microorganisms which employees may inadvertently transfer to food. If these areas are not kept clean, they may also provide harborage for insects, rodents, and other pests.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 14408 Based on interview and record review , the facility failed to maintain medical records that were complete and accurately documented in accordance with accepted professional standards and practices for 2 of 3 residents (Residents #14 and #66) whose record were reviewed for accurate and complete documentation. The facility failed to prevent the following: 1. The facility failed to ensure Resident #14's Out of Hospital - Do Not Resuscitate Order form was signed as by the resident and two witnesses in the box at the bottom of the form. 2. The facility failed to ensure Resident #66's Out of Hospital - Do Not Resuscitate Order form included a date for the physician's stamped signature, the physician's printed name, or the physician's license number. This failure could place residents at risk for discrepancies in the provision of necessary medical care and services and desired end-of-life decisions not being honored. The findings included: 1. Resident #14 Review of Resident #14's Admission Record, dated 1/24/2024 revealed a [AGE] year-old male admitted to the facility on [DATE]. His diagnoses included: chronic obstructive pulmonary disease (chronic lung disorder); chronic respiratory failure; hypertension (high blood pressure); heart failure; type 2 diabetes mellitus; bipolar disorder; schizoaffective disorder; anxiety disorder; major depressive disorder; and traumatic brain injury. The Admission Record documented the resident was DNR status. Review of Resident #14's Physician Order Summary dated 1/24/2024 revealed an order for DNR dated 8/29/2023. Review of Resident #14's OOH-DNR form revealed it had been signed by the resident on 5/22/22, signed by 2 witnesses on 5/26/22, and signed by the physician on 6/06/22. The resident and the 2 witnesses did not sign in the bottom box of the form to acknowledge the form being properly completed. In an interview and record review on 1/24/24 at 2:53 PM, the Social Worker stated she had a binder notebook with copies of the residents' OOH-DNR order forms. Review of the notebook revealed it contained the same copy of the OOH-DNR order that was in Resident 14's electronic health record. There was no evidence of an updated form. 2. Resident #66 (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #66's Admission Record, dated 1/24/2024 revealed a [AGE] year-old male admitted to the facility on [DATE]. His diagnoses included: hypertension (high blood pressure); anxiety; cerebral infarction (stroke); dysphagia (swallowing problem); hypothyroidism (thyroid disorder); alcohol abuse; and hypokalemia (high potassium level). The record documented the resident was DNR status. Review of Resident #66's comprehensive care plan revealed a care plan dated 4/24/23 which addressed the order for DNR status. Review of Resident #66's Physician Order Summary dated 1/24/2024 revealed an order for DNR dated 4/24/2023. Review of Resident #66's OOH-DNR form revealed it had been signed by the resident's representative and 2 witnesses on 4/21/2023. There was a stamped physician signature but it was not dated and the physician's license number and printed name were not documented on the form. In an interview on 1/24/24 at 2:53 PM, the Social Worker stated she had a binder notebook with copies of the residents' OOH-DNR order forms. She stated there was a code status binder at the nurses station desk and there were Hospice binders in the chart room which may have updated OOH-DNRs. Review of the Social Worker's binder revealed it contained the same copy of what was in Resident 66's electronic health record. Observation and interview on 1/24/24 at 03:05 PM revealed the Social Worker went to nurses station desk and asked for the code status binder. The LVN at the desk did not find it at nurses station desk. The LVN stated the medical records clerk may have taken it to update it. Observation and record on 1/24/24 at 3:08 PM revealed the chart room had residents' hospice charts on a chart rack. Review of Resident #66's hospice chart revealed no evidence of an OOH-DNR form. The name of the physician listed as the hospice doctor was the same as the physician name stamped on Resident #66's OOH-DNR Order form. Review of the facility's policy and procedure for Advance Directives and Advance Care Planning, dated as revised 4/2015 revealed it did not include instructions for the accuracy of completing the Out of Hospital - Do Not Resuscitate form.