STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675377	A. Building B. Wing	07/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bangs Nursing and Rehabilitation	1105 Fitzgerald Bangs, TX 76823

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44722 Based on observation, interview, and record review, the facility failed to ensure that a resident received care, consistent with professional standards of practice, to prevent pressure ulcers that were avoidable for 1 of 14 residents (Resident #28) reviewed for quality of care. The facility failed to ensure Resident #28's physician ordered pressure relief boots were placed on Resident #28's feet while he was laying in his bed. This failure could place residents at risk of having skin breakdown . Findings included: Record review of Resident #28's face sheet dated 07/02/2024 revealed a [AGE] year-old male admitted on [DATE] with an original admitted [DATE], with diagnosis of Spastic Quadriplegic Cerebral Palsy(, disorder of bone density and structure, protein-malnutrition and muscle weakness. Record review of Resident #28's Quarterly MDS assessment dated [DATE], revealed: Section C-Cognitive Patterns, Resident #28 had a BIMS score of 0 meaning Resident #28 was given the assessment because he was rarely/never understood; Section GG-Functional Abilities and Goals, Resident #28 was dependent on staff for all ADL's; Section M- Skin Conditions, Resident #28's skin intact , no pressure ulcers. Record review of Resident #28's physician orders revealed Start date of 12/30/2022 Keep bed in low position, pressure relief scoop mattress, pressure relief cushion to w/c [wheel chair], pressure relief boots to feet for prevention. Every day and night shift During an observation on 06/30/2024 at 9:10 AM , Resident #28 laying in his bed. Resident #28's bed was in lowest position. Pressure relief boots were laying on top of the covers and were not on Resident #28's feet. During interview on 07/02/2024 at 12:24 PM the ADMN stated he would refer any clinical questions to his DON and the staff should have followed the policies of the facility. (continued on next page)

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

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and interview on 07/02/2024 at 12:55 PM, the DON stated Resident #28 should have been wearing pressure relief boots on both his feet to prevent pressure ulcers. The DON stated if the order stated every day and night shift, then the boots should be on when Resident #28 was laying in bed. The DON stated Resident #28 did not have any skin issues, the order for pressure relief boots was to prevent pressure ulcers. The DON lifted the sheet up to reveal that Resident #28 was not wearing pressure relief boots. The skin on Resident #28's feet was intact with no redness or open areas. The DON stated she did not know why the boots were not on. She stated they may have been in laundry. The DON located the boots in the top of Resident #28's closet. The DON stated her expectation was that orders should have been followed, and per orders, the boots should have been on Resident #28 feet. The DON stated the effect on resident could have been a pressure ulcer could have developed. The DON stated she did not have a response to why the boots were not on Resident #28's feet. The DON stated they did not have a policy for following physician orders.

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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 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** 44558 Based on observations, interviews, and record reviews, the facility failed to ensure that a resident who needs respiratory care, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences for 2 of 5 (Resident # 85 and Resident #19) reviewed for quality of care. 1. The facility failed to ensure Resident #85's oxygen nasal cannula and oxygen tubing were not lying in the floor. 2. The facility failed to ensure Resident #19's nebulizer mask/tubing was placed in a clear plastic bag when not in use. These failures placed residents of the facility at risk for respiratory illnesses. Findings included: Resident #85 Record Review of Resident #85's electronic Face sheet dated 07/01/2024, revealed a [AGE] year-old male admitted on [DATE], with the following diagnoses Malignant Neoplasm (uncontrolled abnormal growth of cells or tissue in the body) unspecified part of unspecified Bronchus or Lung, Anxiety, Hypertension (high blood pressure) and COPD (Chronic Obstructive Pulmonary Disease) Record review of Resident #85's Admission MDS assessment dated [DATE] revealed: Section C- Cognitive Behavior Resident # 85 had a BIMS score of 10, meaning moderately impaired cognitive function. Record review of Resident 85's Care Plan dated 06/27/2024 revealed: requires supplemental oxygen for respiratory status of COPD and SOB (shortness of breath) The goal: Resident will tolerate use of supplemental oxygen and oxygen saturation will remain within normal ranges daily. Interventions: Monitor for complications related to oxygen use (ears, nose, dry mucosa membranes), Oxygen per nasal cannula as ordered, Oxygen tubing changed per facility protocol Record review of Resident #85's Physician Orders dated 06/01/2024 revealed change (oxygen) mask/tubing every night shift every Sunday. During an observation and attempted interview on 06/30/2024 at 2:25 PM, Resident #85 was lying in bed, nasal canula for oxygen was lying on floor beside resident's bed. Resident #85 was not able to provide response. Resident #19 Record review of Resident #19's electronic face sheet dated 03/07/2024 revealed a [AGE] year-old female admitted on [DATE] with the following diagnoses: non-ST elevation Myocardial Infarction (Heart attack) and Shortness of Breath (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review Resident #19's Quarterly MDS dated [DATE] revealed: Section C- Cognitive Behavior Resident #19 had a BIMS Score 13 meaning no cognitive impairment; Section O -Special Treatment Resident #19 required oxygen therapy. Record review Resident #19's Care Plan dated 05/16/2024 Resident #19 Required PRN supplemental oxygen for shortness of breath to maintain O2 (oxygen) sats (saturation) above 90%. The goal: Resident will tolerate use of supplemental oxygen and oxygen saturation will remain within normal ranges daily. Interventions: Monitor for complications related to oxygen use (ears, nose, dry mucosa membranes), Oxygen per nasal cannula as ordered, Oxygen tubing changed per facility protocol Record review Resident #19's Physician orders dated 06/01/2024 Oxygen 2-4 liter per minute PRN (as needed). Change (oxygen) tubing/mask every night shifts every Sunday. During an observation on 06/30/24 at 2:30 PM Resident #19 was sitting up in her wheelchair. Her nebulizer equipment was not stored in a plastic bag or dated when tubing was last changed. Nebulizer mask was lying on a table at the resident's bedside. During an interview on 07/02/24 at 10:33 AM, Resident # 19 stated the staff did not always put her nebulizer mask in a bag. She stated she wished they would have kept the mask in bag to keep it clean. She stated that she only needed breathing treatments occasionally. During an interview on 07/02/24 at 10:45 AM, the DON stated oxygen tubing should have been in a clear plastic bag when not in use. She stated nebulizer masks or tubing and nasal canula should have been in a clear plastic bag when not in use. She stated tubing and breathing treatment supplies should have been kept in plastic bag when not in use, for infection control. She stated the Charge Nurse on the Sunday night shift was responsible for changing oxygen tubing and mask, and nebulizer device each week, and they should have been dating the plastic bag. She stated there was no harm to residents unless the supplies got dirty. She stated the best practice was to place tubing in plastic bag. She stated she did not know why this failure occurred. During an interview on 07/02/2024 at 10:50 AM, RN A stated the nebulizer tubing, mask, handheld device should have been in plastic bag when not in use. She stated if she found oxygen tubing on the resident's floor, she would have replaced it with a new oxygen tubing and nasal canula. She stated the Sunday night shift nurse should have changed the tubing and put it in a plastic bag, with the date on the bag. She stated the resident could possibly have gotten an infection if dirty tubing was used. She stated she did not know how this failure occurred. During interview on 07/02/2024 at 12:24 PM the ADMN stated he would refer any clinical questions to his DON and the staff should have followed the policies of the facility. Review of facility policy titled, Departmental (Respiratory Therapy)-Prevention of Infection dated November 2011 revealed: The purpose of this procedure is to guide prevention of infection associated with respiratory therapy tasks and equipment, including ventilators, among resident and staff . Steps in the Procedure: 8. Keep the oxygen cannula and tubing used PRN in a plastic bag when not in use .