| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 675434 | A. Building<br>B. Wing | 03/28/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Silver Pines Nursing and Rehabilitation Center | 503 Old Austin Highway<br>Bastrop, TX 78602 |

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| F 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28689<br><br>Citation Text for Tag 0557, Regulation FF12<br><br>May, [NAME] L.<br><br>Based on observation, interview, and record review the facility failed to promote care for residents in a manner and in an environment that maintained or enhanced each resident's dignity for 2 of 2 residents (Residents #147, and #148) reviewed for dignity.<br><br>1. Residents #147's urinary catheter bag was uncovered with dark yellow urine visible from the entrance to her room.<br><br>2. Residents #148's urinary catheter bag was uncovered with yellow urine visible upon entering her room.<br><br>This failure could affect residents by putting them at risk for loss of self-worth and a decline in their psychosocial well-being.<br><br>Findings included:<br><br>1.<br><br>Review of Resident #147's undated Face Sheet reflected she was an 83 -year-old female admitted to the facility on [DATE] 00/00/00 with diagnoses of Pressure Ulcer of right hip Stage 4 (ulcer extending into the muscle, tendon, ligament, cartilage and possibly exposing bone), Neuromuscular Dysfunction of Bladder (lack of bladder control due to brain, spinal cord or nerve problems), Anemia (condition in which blood doesn't have enough healthy red blood cells), Hypothyroidism (condition in which thyroid gland doesn't produce enough thyroid hormones), Type 2 Diabetes Mellitus (chronic condition that affects the way the body processes blood sugar) with Diabetic Neuropathy (nerve damage as a result of high blood sugar), Severe protein-calorie Malnutrition (low nutritional status resulting in muscle wasting, loss of fat under the skin, weight loss, bedridden or significantly reduced functional capacity), Hyperlipidemia (high concentration of fats in the blood), and personal history of Transient Ischemic Attack (brief stoke-like attack) and Cerebral Infarction (brain stroke) without residual (lasting) effects.<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 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of Resident #147's Care Plan dated 03/23/2023 and revised on 03/27/2023 reflected she had an indwelling Suprapubic catheter (surgically created connection between the urinary bladder and the skin used to drain urine from the bladder) due to Neurogenic bladder (lack of bladder control due to brain, spinal cord or nerve problems). Interventions: Position catheter bag and tubing below the level of the bladder and away from the entrance room door.<br><br>Review of Resident #147's Comprehensive MDS dated [DATE] reflected she had a BIMS score of 7 indicating severe cognitive impairment.<br><br>Observation on 03/26/2023 at 2:05 PM of Resident #147's bed revealed her urinary catheter bag was uncovered and facing the entrance door to her room where it was visible from the hallway.<br><br>2.<br><br>Review of Resident #148's undated Face Sheet reflected she was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses of Amyotrophic Lateral Sclerosis (progressive nervous system disease that weakens muscles and impacts physical function), Lyme Disease (tick borne illness that causes fatigue and flu-like symptoms), Neoplasm Unspecified (abnormal growth in some part of the body), Anxiety Disorder (mental health disorder characterized by feelings of worry, anxiety, or fear that are strong enough to interfere with one's daily activities), and abnormal weight loss.<br><br>Review of Resident #148's Care Plan dated 03/24/2023 reflected she had an unspecified catheter with intervention to monitor and document intake and output as per facility policy. No other interventions were noted.<br><br>Review of Resident #148's Nursing Home and Swing Bed Tracking MDS dated [DATE] reflected she was admitted to the nursing facility from at home hospice care.<br><br>Observation on 03/26/2023 at 2:00 PM, of Resident #148 revealed her urinary catheter bag was uncovered and facing the doorway.<br><br>Interview on 03/28/2023 at 9:36 AM, LVN D stated it was a dignity issue to have uncovered urinary catheter bags.<br><br>Interview on 03/28/2023 at 1:00 PM, the DON stated urinary catheters should have a cover on them and it was a dignity issue if they were uncovered. She further stated that residents don't need to look at their urine and people going down the hall don't need to see it.<br><br>Interview on 03/28/2023 at 2:10 PM, the ADON stated it was the nurse's responsibility to put covers on the catheter bags and they were available in the facility.<br><br>Interview on 03/28/2023 at 2:45 PM, the Administrator stated her expectations were for urinary catheter bags to be covered to allow privacy and dignity for the resident.<br><br>A Policy and Procedure regarding urinary catheters was requested from the DON but none was available. |

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| F 0558<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Reasonably accommodate the needs and preferences of each resident.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44174<br><br>Based on observation, interview, and record review the facility failed to ensure residents received services in the facility with reasonable accommodation of each resident's needs for 4 of 10 Rresidents (#76, #148, #147 and #49) reviewed for call lights in that:<br><br>Residents #76, #148, #147 and #49 were observed in their rooms with their call lights not in reach.<br><br>This failure could affect all residents who needed assistance with activities of daily living and could result in needs not being met.<br><br>Findings included:<br><br>1. Review of Resident #76's undated Face Sheet reflected he was a [AGE] year-old male admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses of Alzheimer's Disease (progressive disease that destroys memory and other important mental functions), Muscle wasting and Atrophy (decrease in size and strength of muscles), repeated falls, unspecified lack of coordination, Type 2 Diabetes (chronic condition that affects the way the body processes blood sugar) with Diabetic Neuropathy (nerve damage as a result of high blood sugar), and Schizoaffective Disorder, Bipolar Type (psychotic symptoms such as delusions or hallucinations as well as emotional highs).<br><br>Review of Resident #76's Care Plan dated 04/11/2023 and revised on 03/20/2023 reflected he had an actual fall due to loss of balance. Interventions: Remind resident to ask for assistance when self-ambulating to the bathroom.<br><br>Review of Resident #76's Quarterly MDS dated [DATE] reflected he had a BIMS score of 6 indicating severe cognitive status. Functional status reflected he required supervision of one-person to walk to the bathroom.<br><br>Observation and interview on 03/26/2023 at 10:20 AM, with Resident #76 revealed his call light was on the floor and not in reach. He stated, I try to get up by myself.<br><br>2. Review of Resident #148's undated Face Sheet reflected she was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses of Amyotrophic Lateral Sclerosis (progressive nervous system disease that weakens muscles and impacts physical function), Lyme Disease (tick borne illness that causes fatigue and flu-like symptoms), Neoplasm Unspecified (abnormal growth in some part of the body), Anxiety Disorder (mental health disorder characterized by feelings of worry, anxiety, or fear that are strong enough to interfere with one's daily activities), and abnormal weight loss.<br><br>Review of Resident #148's Care Plan dated 03/24/2023 reflected she had an unspecified catheter with intervention to monitor and document intake and output as per facility policy. No other interventions were noted.<br><br>Review of Resident #148's Nursing Home and Swing Bed Tracking MDS dated [DATE] reflected she was admitted to the nursing facility from hospice care at her home.<br><br>(continued on next page) |

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| F 0558<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Observation on 03/26/2023 at 2:00 PM, in Resident # 148's room revealed her call light was on the floor and entangled with Resident #147's call light.<br><br>3. Review of Resident #147's undated Face Sheet reflected she was an [AGE] year-old female admitted to the facility on [DATE] with diagnoses of Pressure Ulcer of right hip Stage 4 (ulcer extending into the muscle, tendon, ligament, cartilage and possibly exposing bone), Neuromuscular Dysfunction of Bladder (lack of bladder control due to brain, spinal cord or nerve problems), Anemia (condition in which blood doesn't have enough healthy red blood cells), Hypothyroidism (condition in which thyroid gland doesn't produce enough thyroid hormones), Type 2 Diabetes Mellitus (chronic condition that affects the way the body processes blood sugar) with Diabetic Neuropathy (nerve damage as a result of high blood sugar), Severe protein-calorie Malnutrition (low nutritional status resulting in muscle wasting, loss of fat under the skin, weight loss, bedridden or significantly reduced functional capacity), Hyperlipidemia (high concentration of fats in the blood), and personal history of Transient Ischemic Attack (brief stoke-like attack) and Cerebral Infarction (brain stroke) without residual (lasting) effects.<br><br>Review of Resident #147's Care Plan dated 03/23/2023 and revised on 03/27/2023 reflected she had an indwelling Suprapubic catheter (surgically created connection between the urinary bladder and the skin used to drain urine from the bladder) due to Neurogenic bladder (lack of bladder control due to brain, spinal cord or nerve problems). Interventions: Position catheter bag and tubing below the level of the bladder and away from the entrance room door.<br><br>Review of Resident #147's Comprehensive MDS dated [DATE] reflected she had a BIMS score of 7 indicating severe cognitive impairment.<br><br>Observation on 03/26/2023 at 2:05 PM revealed Resident #147's call light was on the floor and entangled with Resident #148's call light.<br><br>Interview on 03/26/2023 at 2:20 PM with RN B who observed Resident # 147's and Resident #148's call light entangled on the floor and if stated if their call lights are on the floor, they can't let us know if they need help.<br><br>4. Review of Resident #49's undated Face Sheet reflected she was a [AGE] year-old female admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses of Unspecified Sequelae of Cerebrovascular Disease (lasting effects of a condition that affects blood flow to the brain), Hemiplegia and Hemiparesis (paralysis and partial weakness) following Cerebral Infarction (brain stroke) affecting left non-dominant side, Dysphagia (difficulty swallowing) following Cerebral Infarction, Unspecified Dementia (progressive or persistent loss of intellectual functioning), Contractures (condition of shortening and hardening of muscles, tendons and other tissue often leading to deformity and rigidity of joints) left ankle and left foot, Alzheimer's Disease (progressive disease that destroys memory and other important mental functions), and Type 2 Diabetes (chronic condition that affects the way the body processes blood sugar).<br><br>Review of Resident #49's Care Plan dated 04/09/2019 and revised on 03/31/2021 reflected she had an ADL self-care performance deficit related to immobility. Intervention: Encourage the resident to use bell to call for assistance.<br><br>(continued on next page) |

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| F 0558<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Review of Resident #49's Quarterly MDS dated [DATE] reflected she had a BIMS score of 4 indicating severe cognitive status. Her functional status reflected she was totally dependent on one-person physical assist for all ADLs.<br><br>Observation on 03/28/2023 at 9:30 AM, of Resident #49 in her bed with her call light on a tray table out of her reach.<br><br>Interview on 03/28/2023 at 9:34 AM, with LVN D who observed Resident #49's call light on her tray table and stated she could not call for help as it was not in her reach.<br><br>Interview on 03/28/2023 at 9:38 AMam, MA I stated anyone who worked at the facility could put call lights in reach of the resident. She stated if the resident cannot reach the call light they could fall.<br><br>Interview on 03/28/2023 at 10:11 AM, CNA F stated CNAs are responsible for making sure call lights are in reach and if the resident cannot reach them, they will not be able to call for assistance.<br><br>Interview on 03/28/2023 at 2:45 PM, the Administrator stated her expectations were for call lights to be in reach so the resident could push the button if they needed help. She further stated if residents do not have access to the call light, they might not get timely assistance and it could lead to a delay in care or an injury.<br><br>Review of a facility policy dated 10/13/2022 reflected Call Lights: Accessibility and Timely Response. The purpose of this policy is to assure the facility is adequately equipped with a call light at each residents' bedside, toilet, and bathing facility to allow residents to call for assistance. All staff will be educated on the proper use of the resident call system, including how the system works and ensuring resident access to the call light. Staff will ensure the call light is within reach of the resident and secured, as needed. |

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| F 0565<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Honor the resident's right to organize and participate in resident/family groups in the facility.<br><br>40884<br><br>Based on interview and observation, the facility failed to provide a private space for residents' monthly council meetings and the confidential resident group meeting during survey for seven of sevenresidents reviewed for resident council.<br><br>The facility did not provide a private space for resident council meetings.<br><br>This failure could place residents, who attended resident council meetings, at risk of not being able to exercise their rights of being able to voice their grievances in a private without uninvited staff being present.<br><br>Findings Included:<br><br>In an interview on 03/26/2023 at 1:30 PM, the Activity Director stated the Resident Council meetings were held in the dining room. She stated there was not another area for the residents to meet in private. She stated she would place signs on the doors and have someone to stand at each door to prevent any staff from entering the dining room. She also stated she would notify dietary staff before the meeting not to come out of the kitchen until after the resident group meeting.<br><br>Record review on 03/27/2023 at 8:30 AM of the Resident Council Meeting Minutes for the months of December 2022, January 2023 and February 2023 reflected only new business was documented. There was not a list of residents who attended the meetings or where the residents met. The resident council president or any council member signed the minutes.<br><br>(continued on next page) |

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| F 0565<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Observation and interview on 03/27/2023 at 9:30AM, during a confidential resident group meeting held in the dining room with seven residents revealed six different staff at various times during the resident group meeting entered the dining room and when the residents were answering questions and voicing their opinions. There were signs on both doors entering the dining room stating do not enter resident group in progress. The residents in the meeting requested the administrator immediately be informed about the interruptions and they needed privacy to voice their opinions without staff overhearing them. The administrator came to the dining room and asked two staff to leave the dining room due to having a confidential resident group meeting. The administrator went to the kitchen and informed kitchen staff not to interrupt the meeting. After the administrator left the dining room, another staff entered the dining room, and a dietary staff came out of the kitchen into the dining room. The resident group was stopped for the fourth time and the residents requested the Administrator to do something about the interruptions and they did not feel comfortable voice their opinions with staff in the dining room. The Administrator was notified, and she assigned one staff member to stand at each door to ensure no one entered the dining room. The meeting continued and approximately five minutes later dietary staff entered the dining room from the kitchen. Two of the residents yelled at the staff there was a private resident meeting, and she was not invited. The dietary staff exited the dining room and entered the kitchen. The residents in attendance of the resident group meeting stated interruptions occurs every- time they had a Resident Council meeting. One resident stated the staff will usually come in and sit during their Resident Council meetings and the staff would not have an invitation to attend their council meeting. The other residents in attendance agreed. There were two residents stated there was a room at the end of B hall where staff had private meetings. One resident stated she had asked the Activity Director why the residents could not meet in that private room and the resident stated she did not receive any response from the Activity Director. Another resident stated they asked Activity Director about having resident council in the private room at the end of B hall and never got a response. Both stated they asked the Activity Director sometime in January of this year (2023) after a resident council meeting.<br><br>In an interview on 03/27/2023 at 10:15 AM, the Administrator stated the resident council meetings and the resident group meeting during survey to meet without any interruptions. She stated the dining room was not private for residents to meet during resident council. She stated there were signs on the door for staff not to enter. She also stated she would speak with the Activity Director to ensure the resident council meetings were private without any type of interruptions. She stated she had informed the dietary staff not to enter the dining room until after the meeting. She also stated there were too many interruptions in today's (03/27/2023) survey group meeting with the residents.<br><br>In an interview on 03/27/2023 at 10:35 AM one of the residents attended the confidential resident group meeting stated no one never signed or was shown the resident council minutes.<br><br>(continued on next page) |

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| F 0565<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | In an interview on 03/27/2023 at 11:30 AM the Activity Director stated she had placed a do not enter resident group in progress sign on both doors prior to today's (03/27/2023) meeting. She stated she informed dietary staff not to enter the dining room during resident group meeting. She stated the resident council always met in the dining room. She stated the staff did come in the dining room during resident council meetings. She stated she did place signs on the doors for all resident council meetings. She wrote on the signs, do not enter - residents council meeting in progress. She stated she did not inform the Administrator of the issue of resident council meetings being interrupted by staff. She stated the residents needed a private room to meet. She stated there was a possibility the residents would not voice their concerns or opinions when uninvited staff was in the dining room during resident council meetings. She stated two residents did voice a concern of needed a private place for the residents to meet for their council meetings. She stated the two residents asked about using the room at the end of B hall where the staff had their meetings. She stated she forgot to speak with the Administrator about the residents asked if they could use the private room at the end of B hall for resident council meetings. She stated the residents voiced the concern about meeting in the room on the end of B Hall after a resident council meeting approximately two months. She stated it was her responsibility to ensure the resident council meeting was private.<br><br>In an interview on 03/28/2023 at 11:30 AM, the Administrator stated the facility did not have a policy or protocol on resident council meetings.<br><br>In an interview on 03/28/2023 at ,2:40 PM, the Administrator stated the residents had the right to meet in a private area. She stated the residents may not feel free to voice grievances if there were un-invited staff in the same room during resident council meeting. She stated during the resident group meeting this week (03/27/2023) there were too many interruptions and the residents needed to feel comfortable in speaking with surveyor during the group meeting. She stated the facility did not have a policy or protocol related to resident council meetings. |

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| F 0575<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Post a list of names, addresses, and telephone numbers of all pertinent State agencies and advocacy groups and a statement that the resident may file a complaint with the State Survey Agency.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28689<br><br>Citation Text for Tag 0574, Regulation FF12<br><br>[NAME], [NAME]<br><br>Based on interview and record review the facility failed to ensure the location of the state agency phone number was reviewed with the residents and ensure information was discussed on how to file a complaint with the state agency with seven residents reviewed for resident council.<br><br>The facility failed to ensure the residents was aware the location in the facility of the phone number for the complaint hotline with the state agency.<br><br>This failure could prevent residents from calling state agency to voice concerns about their care.<br><br>Findings included:<br><br>Observation on 03/25/2023 at 11:45 AM there were medication carts in front of the postings for staff and residents in the display case. The medication carts blocked the postings in the display case except for one posting located at the very top in large print.<br><br>In an interview on 03/27/2023 at 9:30AM during a confidential resident group meeting held in the dining room with seven residents revealed the residents were all in agreement they did not know the location of the state agency toll free phone number and did not know they could voice concern with the state agency. Three of the residents stated when they were admitted to the facility it was very hard for them to accept, they were in a nursing home. All the residents stated they were nervous when they were admitted to the facility. All the residents in attendance agreed it was difficult to remember everything the staff explained to them when they were first admitted to the facility and a few weeks after they were admitted . All agreed no one had discussed in resident council on the location of the toll-free phone number and they had a choice to contact state agency if they had a concern.<br><br>Observation on 03/27/2023 at 1:55 PM medication carts parked in front of the display case. The medication carts were blocking the postings in the display case except for two at the top. One of the two postings was difficult to read due to being small print and could not get near the display case to read it. The other postings in middle and at the bottom of the display case was blocked by the medication carts.<br><br>In an interview on 03/28/2023 at 11:35 AM the ADON stated the medication carts are always parked in front of the display cases when the nurses were not using them to administer medications.<br><br>(continued on next page) |

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| F 0575<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | In an interview and observation on 03/28/2023 at 1:05 PM the Administrator was standing in front of the display cases, and she stated the information to call state agency to voice concern was listed as the following: DADS can provide information about the nursing facility administrator at and gave the phone number. She stated later in the conversation this was not the phone number for the residents to use to call the state agency to voice concern. She stated she can get a poster or type the information of the agency and phone number to call to voice a concern with the state and would place it in the display case.<br><br>In an interview/observation on 03/28/2023 at 2:50 PM the Administrator stated the state agency number was in the display case and she looked at the pictures taken of the display case and showed the Agency and number. The number and the agency name were on a letter size paper. In small print on one letter size paper was the following information: Medicare information, Medicaid information, Office of the Inspector General information and on bottom of the letter size paper stated Texas Department of Aging and Disability Services. Where to submit a complaint about the quality of life or quality of care inside a nursing home. Toll free: (800) [PHONE NUMBER], Local (512) [PHONE NUMBER]. www.dads.state.tx.us. The print was small approximately eight or ten point typing and was difficult to view this information. She also stated it would be difficult for the residents in wheelchairs or ambulatory residents to view the postings in the display case if the medication carts were in front of the display case. She stated the print on the paper was small and may be difficult for the residents to see the information. She stated the residents may not understand the wording on the posting such as: submit a complaint about quality of life or quality of care inside a nursing home. She stated it was possible it could be misleading to the residents. The information for the residents to call and voice concerns to the state agency was so small the administrator did not see the information during the observation and interview on 3/28/2023 at 1:05 PM. |

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| | 675434 | A. Building<br>B. Wing | 03/28/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Silver Pines Nursing and Rehabilitation Center | 503 Old Austin Highway<br>Bastrop, TX 78602 |

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| F 0577<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Allow residents to easily view the nursing home's survey results and communicate with advocate agencies.<br><br>40884<br><br>Based on interviews, the facility failed to post a notice and inform residents of availability to the results of the most recent survey.<br><br>The facility failed to inform residents by verbally informing residents or by posting a sign letting the residents know the location of the most recent survey.<br><br>This failure placed residents at risk of not being able to fully exercise their rights to be informed of the facility's survey citation history.<br><br>Findings include:<br><br>In a confidential group interview on 03/27/2023 at 9:30 AM through 10:00 AM, seven residents stated they did not know where or how to access survey results in the facility. Several of the residents stated they would like to have access to this information, because the staff did not tell them anything about visits from the state. Two of the residents stated they did not know the state sent a report to the facility of any type of visits. The other four residents agreed. They all stated it would be great if they knew the results of the surveys. All the residents stated if they were informed at the time of admission they did not recall. All the residents stated when they were admitted to the facility it was difficult on them and they could not remember what was discussed at the that time. Residents they were too nervous when admitted to the facility and it was difficult to remember anything discussed with them first few weeks of their admission.<br><br>Observation on 03/26/2023 at 1:30 PM and 03/27/2023 at 10:05 AM could not find the results of the state inspection.<br><br>In an interview on 03/28/2023 at 12:30 PM the Activity Director stated she did not know where the location of the state inspection survey results was in the facility. She stated she had not discussed with the residents in resident council meeting or on an individual basis the residents had a right to review the results of any type of survey.<br><br>Observation on 03/28/2023 at 2:10 PM revealed a black binder lying flat on a shelf underneath the top shelf of a bookcase located near the receptionist desk in the lobby. There was no sign or indication on the black binder that it was the stated inspection book. The Administrator showed where the state results binder was in the facility.<br><br>In an interview on 03/28/2023 at 2:15 PM the Administrator stated the state results binder was a little high for residents to be able to reach it from a wheelchair. She stated there was not a sign indicated where the state survey results binder was located, and there was no documentation indicated which binder on the shelf had the state survey results. |

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| 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** 28689<br><br>40884<br><br>Based on observation, interview and record review, the facility failed to develop and implement a baseline care plan for each resident that included the instructions needed to provide effective and person-centered care of the resident that met professional standards of quality of care and failed to ensure a care plan was developed within 48 hours of a resident's admission for two of eight residents (Resident # 197 and Resident # 148) reviewed for baseline care plans.<br><br>The facility failed to complete a baseline care plan for Resident # 197 and Resident #148 within the required 48-hour timeframe.<br><br>This failure could place residents at risk for not receiving necessary care and services or having important care needs identified and met.<br><br>Findings include:<br><br>1. Record review of Resident # 197's face sheet, dated 03/28/2023, reflected a [AGE] year-old male who was admitted to the facility on [DATE] with diagnoses which included pain in right upper arm ( often due to muscle , tendon- cord-like tissue that connects muscle to bone, or ligament damage - elastic connective tissue that surround a joint to give support and limit joint's movement), mood disorder due to known physiological condition with mixed features (general emotional state or mood is distorted or inconsistent with your circumstances and interferes with your ability to function), unspecified cirrhosis of liver (damage where healthy cells are replaced by scar tissue), chronic viral hepatitis c (liver infection), depression (persistent sadness and a lack of interest or pleasure in previously enjoyable activities), and essential hypertension ( high blood pressure).<br><br>Record review of Resident # 197's Baseline Care Plan, dated 03/24/2023, reflected the following:<br><br>- Resident had an ADL self-care performance deficit related to (it does not specify what the problem was related to). Goal- Resident would improve current level of function in specify ADLs (it did not specify which adls). Interventions: did not specify if resident required assistance with bathing/showering, how many staff required for bed mobility and the frequency for repositioning, the location of contracture and the frequency of skin care, what type of assistance needed for personal hygiene and how many staff required to assist resident, was resident able to toilet himself or did he require assistance by staff. Transfers- was resident able to transfer himself or did he require assistance. Did resident require assistance to move between surfaces.<br><br>- Resident was on sedative/ hypnotic therapy (specify medication) related to: (staff did not specify the medication or what the problem was related to). Goal: there was not a goal documented. Interventions: there were not any interventions.<br><br>(continued on next page) |

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| F 0655<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | - Resident used antidepressant medication (specify medication) related to: (staff did not specify the medication or what the problem was related to). Goal: there was not a goal documented. Interventions: there were not any interventions.<br><br>- Resident used anti-anxiety medications related to: (staff did not specify the medication or what the problem was related to). Goal: there was not a goal documented. Interventions: there were not any interventions.<br><br>- Resident had pressure ulcer or potential for pressure ulcer development related to: (staff did not specify location of the pressure ulcer or if the resident had a pressure ulcer. Did not specify what the problem was related to). Intervention: what location needed to be avoided when positioning the resident.<br><br>- Resident was risk for falls related to (did not specify if resident was high, moderate, or low risk for falls or what the problem was related to) Interventions: resident needed what type of safe environment and what type of footwear.<br><br>Record review of the Care Plans in the electronic medical record reflected there was not a comprehensive care plan.<br><br>2. Review of Resident #148's undated Face Sheet reflected she was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses of Amyotrophic Lateral Sclerosis (progressive nervous system disease that weakens muscles and impacts physical function), Lyme Disease (tick borne illness that causes fatigue and flu-like symptoms), Neoplasm Unspecified (abnormal growth in some part of the body), Anxiety Disorder (mental health disorder characterized by feelings of worry, anxiety, or fear that are strong enough to interfere with one's daily activities), and abnormal weight loss.<br><br>Review of Resident #148's Baseline Care Plan dated 03/24/2023 did not reflect her use of oxygen.<br><br>Review of Resident #148's Nursing Home and Swing Bed Tracking MDS dated [DATE] reflected she was admitted to the nursing facility from hospice care at her home.<br><br>Observation on 03/26/2023 at 2:00 PM Resident #148 was receiving oxygen at 2.5 LPM (liters per minute).<br><br>In an interview on 03/27/2023 at 11:47 AM MDS Coordinator stated all baseline care plans were expected to be completed within 48 hours of resident's admitted . She stated baseline care plans included problems, goals, and interventions. She also stated on the baseline care plan where it was documented to specify, the staff completing the baseline care plan was expected to specify what the problem was related to, all interventions especially the ADLs. She stated if there were no specifications of how many staff was required to care for a resident the CNAs would not know what type of care to give the residents. She also stated any type of treatment including oxygen was required to be on the baseline care plan. She stated the base line care plan was developed by the charge nurse on duty when the resident was admitted . She stated the ADON reviewed the baseline care plan and a signature from the DON was required. She stated if a resident's baseline care plan was not fully completed there was a potential a resident would not receive the proper care required to assist the resident in all areas of the residents physical and mental condition. She stated there was a potential a resident may exhibit a decline in health if their baseline care plan was not documented correctly.<br><br>(continued on next page) |

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| F 0655<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | In an interview on 03/28/2023 at 9:30 AM LVN D Nurse supervisor stated it was the nurse on duty responsibility when the resident was admitted ensure the baseline care plan was completed. She stated it was crucial for all information to be documented within 48 hours of residents' admission. She stated if ADLs was not completed and other care plans was incomplete, there was a potential the resident would not receive the care ordered by the physician. She stated it was a possibility a resident may fall if the staff did not know how to transfer a resident or give any type of care to the resident. She stated the nurse supervisor on duty was to complete the baseline care plan, the ADON was to review it and the DON was to sign it.<br><br>In an interview on 03/28/2023 at 10:30 AM DON stated the nurse supervisor on duty when the resident was admitted to the facility was responsible for completing the baseline care plan. She stated she would sign the baseline care plan after it was reviewed and approved by the ADON. She stated if the baseline care plan was not completed in its entirety there was a potential a resident would not receive appropriate care. She stated a resident had a potential of being injured if staff did not know the amount of assistance a resident needed for personal care/ADLS. She also stated if a resident was on oxygen it was required to be documented on the baseline care plan. She stated there was a potential the resident may not receive proper care with all their physical needs and emotional needs. She stated a resident had potential for decline in quality of life and quality of care.<br><br>In an interview on 03/28/2023 at 12:15 PM the ADON stated it was the nurse supervisor on duty to develop the baseline care plan within 48 hours of the resident's admitted . He stated it was the DON's responsibility to review and sign the baseline care plan when it was completed. He stated it was the DON's and the MDS coordinator responsibility to ensure the baseline care plan was completed and correct. He stated if the baseline care plan was not completed the resident would not receive the appropriate care for their physical and mental needs. He stated all baseline care plans was required to include any type of equipment including oxygen tank. He stated to refer to the DON for any further questions concerning the baseline care plan.<br><br>In an interview on 03/28/2023 at 2:40 PM the Administrator stated the baseline care plan was expected to be completed within 48 hours of the resident's admission to the facility. She stated it was required for the baseline care plan to be completed. She also stated if the baseline care plan was not completed it could affect the care the resident received if the specifications of what type of assistance a resident needed was not documented. She stated it was the nurse supervisor responsibility to complete the baseline care plan and the ADON and/ or the DON was to review the baseline care plan with the DON's signature.<br><br>(continued on next page) |

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| F 0655<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of the facility Baseline Care Plan Policy and Procedure dated, 10/22/2022 reflected The facility will develop and implement a Baseline Care Plan for each resident that includes the instructions need to provide effective and person-centered care of the resident that meet professional standards of care. The Baseline Care Plan will be developed within 48 hours of a resident's admission. Include the minimum healthcare information necessary to properly care for a resident including but not limited to: Initial goals based on admission orders. Physician orders. Dietary Orders. Therapy Services. Social services and PASSAR recommendation, if applicable. The admitting nurse, or supervising nurse on duty, shall gather information from the admission physical assessment, physician's orders, and discussion with the resident and resident representative, if applicable. Initial goals shall be established that reflect the residents stated goals and objectives. Interventions shall be initiated that assess the residents' current needs including: any health and safety concerns, any special needs such as for IV (intravenous) therapy, dialysis, or wound care. A supervising nurse shall verify within 48 hours that a Baseline Care Plan has been developed. |

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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide care and assistance to perform activities of daily living for any resident who is unable.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28689<br><br>40884<br><br>Based on observation, interview, and record review the facility failed to ensure residents unable to carry out activities of daily living (ADLs) received the necessary services to maintain good grooming and personal hygiene for 4 of 20 residents (Residents #198, #88, #36 and #197) reviewed for quality of care.<br><br>1. The facility failed to ensure Resident # 198's facial hair was shaved, his nails were trimmed and cleaned, and his adult brief was changed every two hours.<br><br>2. The facility failed to ensure Resident #88's mustache was trimmed.<br><br>3. The facility failed to ensure Resident #36 received showers on his preferred shower days, failed to trim and clean his fingernails and failed to shave his face.<br><br>4. The facility failed to ensure Resident #197 received showers or baths, failed to trim and clean his fingernails, and failed to wash his hair and shave his facial hair.<br><br>These failures put residents at risk for poor hygiene, dignity issues and decreased quality of life.<br><br>1.<br><br>Review of Resident #198's undated Face Sheet reflected he was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses of Traumatic Subdural hemorrhage (a pool of blood between the brain and its outermost covering) with loss of consciousness, Type 2 Diabetes (chronic condition that affects the way body processes blood sugar) with Diabetic Neuropathy (nerve damage), Major Depressive Disorder (mental health disorder characterized by persistently depressed mood or loss of interest in activities causing significant impairment in daily life), Primary Hypertension (high blood pressure), Gastro-Esophageal Reflux Disease without Esophagitis (chronic condition in which stomach acid flows back into the food pipe without inflammation), unspecified displaced fracture of T5-T6 vertebra (unstable injury involving bone in middle portion of spine in which a vertebra moves off a vertebra next to it) subsequent encounter for routine healing, unspecified fracture of unspecified lumbar vertebra (fracture of lower back portion of spine), and unspecified fracture of shaft of Humerus, left arm (broken bone of the upper arm).<br><br>Review of Resident #198's Care Plan dated 03/13/2023 and revised on 03/26/2023 reflected he had an ADL self-care deficit related to decreased mobility related to lumbar fractures and a left humerus fracture. Interventions: Check nail length and trim and clean on bath day and as necessary. The resident requires limited to extensive assistance of one staff with personal hygiene.<br><br>Review of Resident #198's Comprehensive MDS dated [DATE] reflected he had a BIMS score of 4 indicating severe cognitive impairment. His functional status reflected he required extensive assistance of one-person physical assist to complete his personal hygiene.<br><br>(continued on next page) |

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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Observation on 03/27/2023 at 12:43 PM, Resident #198 had facial hair approximately 1/2 inch long and fingernails that were approximately 3/4 inch long with dark brown debris underneath.<br><br>Interview on 03/27/2023 at 12:45 PM, Resident #198 stated he wanted to be shaved and his adult brief had not been changed that day.<br><br>Observation and interview on 03/27/2023 at 12:50 PM, in Resident #198's room with LVN Treatment Nurse revealed his brief was soaking wet and the sheet was wet with a large ring of urine under him. LVN Treatment Nurse stated the wet brief could cause skin breakdown, bacterial infection and feces and urine could cause irritation leading to MASD (Moisture Associated Skin Damage). Resident #198 complained of a burning sensation to his testicles as he was being cleaned and LVN Treatment Nurse stated that sensation could be from the urine. LVN Treatment Nurse stated if Resident #198's nails were not trimmed, he could scratch himself and cause an infection.<br><br>Interview on 03/27/2023 at 1:00 PM, NA G stated she had worked at the facility 1 1/2 weeks stated NA H had changed Resident #198 that morning around 9:00 AM before she left the facility for an emergency.<br><br>Interview on 03/27/2023 at 1:05 PM, CNA F stated Resident #198 was changed before 9:00 AM. She stated if a resident did not have their brief changed on a regular schedule, they could get redness to the skin and skin breakdown. She stated the aide who changed him that morning left for some personal issue. She did not state who was responsible for changing him between 9:00 AM and 1:00 PM.<br><br>2.<br><br>Review of Resident #88's undated Face Sheet reflected he was an [AGE] year-old male admitted to the facility on [DATE] with diagnoses of Cerebral Infarction (brain stroke), Hemiplegia and Hemiparesis (complete paralysis and partial weakness) following Cerebral Infarction affecting left non-dominant side, Dysphagia (difficulty swallowing) following Cerebral Infarction, Dysarthria (speech disorder caused by muscle weakness) following Cerebral infarction, Pneumonia (infection that inflames air sacs in one or both lungs which may fill with fluid), and Type 2 Diabetes (chronic condition that affects the way body processes blood sugar).<br><br>Review of Resident #88's Care Plan dated 11/04/2022 and revised on 01/11/2023 reflected he had an ADL self-care deficit related to stroke with left side hemiplegia. Interventions: personal hygiene: the resident requires extensive assistance of one staff with personal hygiene and oral care.<br><br>Review of Resident #88's Quarterly MDS dated [DATE] reflected he had a BIMS score of 4 indicating severe cognitive impairment. His functional status reflected he was totally dependent on one-person physical assistance for personal hygiene.<br><br>Observation on 03/27/2023 at 12:45 PM, of Resident #88 revealed his mustache was curled under and in his mouth.<br><br>Interview on 03/27/2023 at 12:47 PM, with Resident #88 who stated, I want my mustache trimmed so it's not in my mouth.<br><br>3.<br><br>(continued on next page) |

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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Record review of Resident # 36's, undated, face sheet reflected a [AGE] year-old male who was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included need for assistance with personal care (actually performing a personal task for a person in the performance of activities of daily living), muscle wasting not elsewhere classified, multiple sites and atrophy ( the decrease in size and wasting of muscle tissue), unspecified lack of coordination ( prevents people from being able to control the position of their arms, legs and/or their posture), combined forms of age-related cataract , right eye (develops cloudy patches), myopia right eye (tiny bulges in the tiny blood vessels in retinas), hyphemia in right eye (blood collects inside the front of the eye), glaucoma (causes gradual loss of sight), type 2 diabetes mellitus with diabetic nephropathy (damage blood vessel clusters in your kidneys that filter waste from your blood. This can lead to kidney damage and cause high blood pressure).<br><br>Record review of Resident #36's Annual MDS Assessment, dated 01/18/2023, reflected resident had a BIMS score of 15 which indicated resident cognition was intact. Resident #36's vision was assessed to be highly impaired and wears corrective glasses. Resident did not show any behavior problems such as: rejection of care. The resident needed one person assistance with dressing and bathing. Resident #36 needed supervision with personal hygiene.<br><br>Record review of Resident #36's Care Plan revised on 02/08/2023, reflected he preferred to shower twice a week. The days he preferred to shower was Tuesday and Saturday. Goal: Facility will comply with Resident #36's wishes. Intervention: Encourage him to bathe twice per week. Staff will ask him every Tuesday and Thursday if he wanted a shower. Resident #36 had an ADL self-care performance deficit related to impaired balance. Bathing/Showering: Resident #36 needed supervision with setup and one staff assistance with bathing/showering. Personal hygiene: Resident #36 needed supervision with set-up with one person assistance with personal hygiene and oral care. Resident had potential for complications related to Diabetes Mellitus (damage blood vessel clusters in your kidneys that filter waste from your blood. This can lead to kidney damage and cause high blood pressure). Resident was assessed to have potential for pressure ulcer development related to limitation in mobility. Resident needed dialysis related to renal failure. Resident dialysis days were Tuesday, Thursday, and Saturday.<br><br>Record Review of Resident #36's Shower Record dated 02/27/2023 -03/25/2023 reflected Resident #36's bathing schedule was Monday, Wednesday, and Friday from 7:00 AM - 7:00 PM. The shower record reflected the staff did not ask if Resident #36 wanted a shower on Tuesday, Thursday as indicated of his shower preference care plan. Resident received a shower two times on 03/08/2023 and 03/13/2023 from 02/27/2023- 03/27/2023. Resident refused showers five times, and these were on either Wednesdays or Fridays. The staff did not offer Resident #36 any showers on his preferred shower days.<br><br>Observation on 03/26/2023 at 9:33 AM, Resident #36 nails on both hands were long and the fore finger and middle finger on his right-hand nails were jagged. There were black/brownish substance underneath all nails on his right hand and underneath his ring finger and middle finger on his left hand. Resident beard was long and had approximately six inches of hair underneath his chin and on his neck.<br><br>(continued on next page) |

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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | In an interview on 03/26/2023 at 9:36 AM, Resident #36 stated he was a diabetic and only a nurse was allowed to cut and clean his nails. He stated he did request a nurse assistant to report to the nurse he wanted his nails cut and cleaned. He stated he made this request over 2 weeks ago. He also stated it was someone new working at the facility and he did not recall her name. He stated she was not wearing a name badge. Resident #36 also stated when the medication nurse comes in the room, he did ask her if she would trim his nails and clean them, and she stated only a Registered Nurse was allowed to trim or clean his nails. He stated he did not recall her name. He stated he requested this from the medication nurse approximately two-three weeks ago. He also stated he did want to be shaved under his chin and around his neck. He stated the hair in this area was too long.<br><br>Observation on 03/27/2023 at 7:29 AM, Resident #36 nails on both hands were long and the nails on his forefinger and middle finger on his right-hand were jagged. There were blackish/brownish substance underneath all nails on his right hand and underneath his ring finger, fore finger, and middle finger on his left hand. Resident beard was long and had long hair approximately six inches underneath his chin and around his neck.<br><br>In an interview on 03/27/2023 at 7:34 AM, Resident #36 stated he had preferred his showers twice per week on Tuesdays and Thursdays. Resident stated he had reported this to a nurse asking him questions about his preferences. Resident stated that was over a year ago and no one had asked if he wanted to change his shower schedule. Resident stated he was never offered showers on his preferred shower days. Resident also stated only reason he refused showers they were not offered to him on Tuesdays and Thursdays. He stated he wanted a shower prior to going to dialysis. He stated he did not leave for dialysis until around 10:30 AM and there was time for the staff to give him a shower prior to leaving for dialysis. He stated he had explained to numerous nursing staff he preferred his showers on Tuesday and Thursdays. He stated he became tired of explaining this to the nursing staff and he would refuse when he was offered showers Monday, Wednesdays, and Fridays.<br><br>In an interview on 03/28/2023 at 9:00 AM, CNA E stated the staff referred to the electronic medical record under tasks to follow shower/ bathing schedule. She stated if Resident #36 had another schedule for showers she was not aware of it and she was informed by nursing staff (all nursing supervisors) to follow the shower schedule documented on the shower record in the electronic medical record. She stated she had offered shower for Resident #36, and he had refused. She stated she did not return at a different time or ask him when he preferred to be showered. She stated she had been in serviced on ADL care. She also stated she did not remember the last time she had ADL in-service.<br><br>4.<br><br>Record review of Resident # 197's face sheet, dated 03/28/2023, reflected a [AGE] year-old male who was admitted to the facility on [DATE] with diagnoses which included pain in right upper arm (often due to muscle , tendon- cord-like tissue that connects muscle to bone, or ligament damage - elastic connective tissue that surround a joint to give support and limit joint's movement), mood disorder due to known physiological condition with mixed features ( general emotional state or mood is distorted or inconsistent with your circumstances and interferes with your ability to function), unspecified cirrhosis of liver (damage where healthy cells are replaced by scar tissue), chronic viral hepatitis c (liver infection), depression (persistent sadness and a lack of interest or pleasure in previously enjoyable activities), and essential hypertension (high blood pressure).<br><br>(continued on next page) |

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|---|---|---|---|
| | 675434 | A. Building<br>B. Wing | 03/28/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Silver Pines Nursing and Rehabilitation Center | 503 Old Austin Highway<br>Bastrop, TX 78602 |

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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Record review of Resident #197's Baseline Care Plan, dated 03/24/2023, reflected Resident had an ADL self-care performance deficit related to (it does not specify what the problem was related to). Goal- Resident would improve current level of function in specify ADLs (it did not specify which adls). Interventions: did not specify if resident required assistance with bathing/showering, how many staff required for bed mobility and the frequency for repositioning, the location of contracture and the frequency of skin care, what type of assistance needed for personal hygiene and how many staff required to assist resident, was resident able to toilet himself or did he require assistance by staff.<br><br>Record review of Care Plans in the electronic medical record reflected there was not a comprehensive care plan.<br><br>Record review of resident #197's shower record dated 03/25/2023 reflected there were no showers/baths given to resident since his admission on 03/24/2023 and there was not a shower schedule listed on the shower record.<br><br>Observation on 03/26/2023 at 10:09 AM, reflected Resident #197's nails on his right and left hands were long and jagged. There were also blackish /brownish substance underneath the fore finger, middle finger, and ring finger on his right hand. Resident #197's hair was oily, and he had approximately 4 inches beard.<br><br>In an interview on 03/26/2023 at 10:12 AM, Resident #197 stated he had asked someone about getting a shower and the nursing staff informed him the staff does not give showers or cut nails on the weekends. He stated he did not know any of the staff's names. He stated he needed to be shaved and his hair needed to be washed. He stated he was not able to shave prior to entering the facility. He stated he did not prefer any hair on his face. He also stated he wanted his nails cut and cleaned.<br><br>Observation on 03/27/2023 at 7:50 AM, reflected Resident #197's nails on his right and left hands were long and jagged. There was also blackish/ brownish substance underneath the fore finger, middle finger, and ring finger on his right hand and underneath the middle finger and ring finger on his left hand.<br><br>In an interview on 03/27/2023 at 7:53 AM, Resident #197 stated he asked someone worked here if he could get a shower and a shave. He stated the staff explained to him they did not know about his shower needs at this time.<br><br>Observation on 03/28/2023 at 8:03 AM, Resident #197 nails on his right and left hands were long and jagged. There was also blackish/ brownish substance underneath the fore finger, middle finger, and ring finger on his right hand and underneath the middle finger and ring finger on his left hand.<br><br>In an interview on 03/28/2023 at 8:05 AM, Resident # 197 stated he asked two or three people worked in this facility if he could get a shower, his nails cut and a shave. He stated all three staff explained to him they would need to ask about his shower schedule.<br><br>In an interview on 03/28/2023 at 9:00 AM, CNA E stated she was not aware if Resident #197's shower schedule had been set up by the nurses. She stated she did not view any shower schedule in the electronic medical record. She also stated the staff did not give showers on Sundays; however, they did give nail care on Sundays. She stated she preferred not to respond to any other questions.<br><br>(continued on next page) |

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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | In an interview on 03/28/2023 at 12:15 PM, ADON stated Resident #197 shower schedule was Tuesday's, Thursday's, and Saturday's. He stated the staff did give showers and nail care on the weekends. He also stated Resident #197 was expected to be given a shower, shaved and nails cleaned /trimmed since his admission on 3/24/2023. He stated this had potential to cause all types of issues concerning his physical condition. The ADON was asked if there was a potential of any negative adverse effect when Resident #197 did not receive a shower, nails was not clean or cut and he was not shaved. ADON did not respond to this question or any further questions of whose responsibility to monitor shower schedules.<br><br>In an interview on 03/28/2023 at 9:30 AM, LVN D- Nurse Supervisor, stated the nurse supervisor was responsible to ensure all residents received showers. She stated if a resident had a shower preference, the resident's preference was to be honored and the nursing department was responsible for entering the shower schedule. She stated if there was a mistake in the shower schedule someone was expected to make the changes immediately. She also stated if a resident continues to refuse showers the CNA was expected to report it to the charge nurse. She stated she was not aware Resident #36 only had a shower two times in the past 30 days. She stated she was not aware Resident #36 had a shower preference. She stated anytime a resident was observed to have dirty fingernails or their nails needed to be trimmed or cut the CNA was expected to perform this ADL care except if the resident was a diabetic. She stated the RN was expected to cut/ trim and clean any residents with a diagnosis of diabetes nails. She stated if a resident refused a shower the resident beard could be trimmed and/ or shaved in the resident's room without going to the shower. She also stated she did not have any further answers to this situation. She stated she did not know why Resident #197 shower schedule was not documented on the shower record in the electronic medical records. She stated this documentation was required to be on the shower schedule on the day resident was admitted . She stated the CNA's needed this information to know when Resident #197 needed a shower. She also stated if a resident's hair was oily, needed a shave and had dirty -long fingernails, ADL care was required to be given as soon as possible. She stated the resident had potential of ingesting bacteria if the resident ate with their hands. She stated there was a potential of stomach problems with ingesting bacteria.<br><br>(continued on next page) |

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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | In an interview on 03/28/2023 at 10:30 AM, the DON stated all residents shower/bathing schedule expected to be arranged by the resident's preference. She stated if it was on the care plan the resident had a shower preference of two days per week on Tuesday and Thursdays, the resident's preference was required to be honored. She stated the shower record was expected to reflect the residents shower preference. She also stated the CNA'S was expected to follow the shower schedule in the electronic medical records. She also stated this was probably reason resident only had two showers in the past thirty days. She stated if a resident refused a shower the staff was expected to ask resident when they would prefer their shower and return on a different day and time if needed. She stated she was new in the facility and was hired two weeks ago for the interim DON. She also stated if residents were not receiving their showers as scheduled the resident had a potential of developing skin and hygiene issues. She stated skin assessments and skin observations was required during resident's showers. She stated the resident most definitely had a potential of developing hygiene concerns, skin concerns and had a potential of decrease quality of life. She stated any resident with a diagnosis of Diabetes the nurse was required to trim, cut, and clean the residents' nails. She stated it was nurse supervisor responsibility to ensure diabetic residents nails were trimmed and clean. She also stated if a resident's nails were dirty, and the resident ate any food with their hands there was a potential a resident would ingest bacteria. She also stated there was a possibility a resident would develop stomach virus or any type of stomach infection. She stated if a resident became dehydrated or seriously ill with any type of stomach virus there was a possibility a resident would be admitted to the hospital.<br><br>In an interview on 03/28/2023 at 2:40 PM, the Administrator stated all residents were expected to be offered and receive showers. She stated if a resident refused the staff was expected to return on a different time and/or date to offer the resident another shower. She also stated if a Resident had preferred shower days this preference was expected to be honored. She also stated the nursing staff does follow the schedule on the shower record in the electronic medical records. She also stated if there was a different schedule on the care stated the resident's preference, the schedule on the shower record was expected to reflect the care plan. She stated it was the nursing supervisor's responsibility to update the shower record.<br><br>Interview on 03/28/2023 at 02:45 PM, the Administrator stated her expectations were that nail care should be as needed and as requested. She stated dirty nails could increase the potential risk of infection and residents could scratch themselves.<br><br>Review of a facility policy dated 10/24/2022 and titled Activities of Daily Living reflected Policy: Care and services will be provided for the following activities of daily living: Bathing, dressing grooming and oral care, toileting. A resident who is unable to carry out activities of daily living will receive the necessary services to maintain good grooming, and personal and oral hygiene. |

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| F 0692<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide enough food/fluids to maintain a resident's health.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44174<br><br>Based on observation, interview and record review, the facility failed to ensure residents maintained acceptable parameters of nutritional status for three (Resident #62, #88, #65) of 16 residents reviewed for nutrition on pureed diets.<br><br>The facility failed to ensure Resident #62, #88, and #65 whose diet order was for pureed diet maintained acceptable parameters of nutritional status and prevented weight loss with effective interventions.<br><br>This failure put residents at risk for malnutrition, weight loss and decreased quality of life.<br><br>Findings included:<br><br>1. Review of Resident #62's face sheet revealed Resident #62 was a [AGE] year-old male admitted to the facility on [DATE] with a diagnoses of Alzheimer's disease (progressive disease beginning with mild memory loss and possibly leading to loss of the ability to carry on a conversation and respond to the environment), high blood pressure, epilepsy and arthritis.<br><br>Review of Resident #62's significant change MDS assessment dated [DATE] revealed Resident #62 had a BIMS score of zero to indicate severe cognitive impairment. Resident #62 was totally dependent by one staff member for ADL's including eating. Resident #62 experienced a significant change and was under the care of hospice. Resident #62 required a mechanically altered diet.<br><br>Review of Resident #62's care plan dated 09/08/2021 revealed Resident #62 required extensive assistance by one staff member for eating. Resident #62 was at risk for weight loss and had interventions including fortified meal plan with breakfast and dinner, monitor and record food at each meal and offer substitutes at each meal.<br><br>Review of Resident #62's Physician Orders dated 12/24/2022 revealed Resident #62 was ordered a regular diet, pureed texture, regular liquids consistency, fortified food for all meals, supplemental dessert with a lunch and dinner.<br><br>Review of Resident #62's Weight records dated 03/28/2023 revealed:<br><br>03/05/2023 131.0 lbs,<br><br>02/05/2023 132.0 lbs,<br><br>12/01/2022 132.0 lbs,<br><br>11/11/2022 147.2 lbs,<br><br>09/15/2022 143.4 lbs,<br><br>30 day wt loss - 0.75 %,<br><br>(continued on next page) |

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| F 0692<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | 3 month wt loss - 0.75%,<br><br>4 month wt loss - 11.0 %, and<br><br>6 month wt loss - 8.6 %.<br><br>In an interview on 03/28/2023 at 10:30 AM, the RP for Resident #62 stated Resident #62 was completely dependent on staff for eating and she came to the facility daily to make sure he was fed. She stated Resident #62 lost weight in December 2022 because he had COVID. She said he had COVID and for eight days she was unable to visit him and assist with feeding him. She stated when she was able to visit him again he was weaker and had developed a bed sore on his buttocks. She stated the bed sore has since healed but Resident #62 continued to lose weight and was unable to chew and swallow mechanical soft food. She stated she would try to feed him after he had COVID and he would just hold the food in his mouth. She stated they switched him to pureed foods and when she fed him, he would eat all of his food. She stated staff will report he did not eat well for them. She stated she brought him health shakes and he would drink them well for her. She said the facility did not provide him with health shakes after he lost weight. She stated in January 2023 they decided his health would not improve and he was placed under the care of hospice. She said she was not aware of significant weight change he experienced in November 2022 in which his weigh dropped 15 pounds. She said she would have thought the weight change would have happened in December 2022 when he had COVID.<br><br>Review of Resident #62 Nursing Progress noted dated 12/05/2022 revealed Resident #62 tested positive for COVID and was placed in isolation.<br><br>2. Review of Resident #88 face sheet dated 03/28/2023 revealed Resident #88 was an [AGE] year old male admitted to the facility on [DATE] with a diagnoses of a stroke, partial paralysis of the left side, dysphagia (difficulty swallowing), type 2 diabetes mellitus, dementia, gastrostomy (feeding tube), high blood pressure and GERD (heart burn).<br><br>Review of Resident #88 quarterly MDS assessment dated [DATE] revealed Resident #88 had a BIMS score of four to indicate severe cognitive impairment. Resident #88 required total assistance by two staff member for eating. Resident #88 was noted to require a feeding tube which supplied greater than 51% of calories per day. Resident #88 was not noted with weight loss.<br><br>Review of Resident #88's care plan dated 01/11/2023 revealed Resident #88 was totally dependent on one staff member for eating assistance. Resident #88 required tube feeding related to dysphagia following a stroke. On 01/11/2023 a revision to Resident #88's care plan included Resident #88 had the potential for weight variance related to tube feedings and interventions included to administer medications as ordered, monitor/record/report to MD as needed for weight loss and RD to evaluate and make diet change recommendations as needed.<br><br>Review of Resident #88's physician orders dated 02/13/2023 revealed Resident #88 was ordered regular diet, pureed texture, regular liquids consistency, for all meals with assistance with staff in dysphagia drinking cup with 3 cc amount of liquid. Fortified Meal Plan for all meals, supplemental dessert with lunch and dinner. Resident #88 was ordered on 03/08/2023 Glucerna 1.5 give 360 mL if PO intake is <50% of his meal, FWF (free water flushes) of 30 mL before and after each bolus. Provides 540 kcal, 30 gm protein and 333 mL of FW (free water).<br><br>(continued on next page) |

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| F 0692<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Review of Resident #88's weight record dated 03/28/2023 revealed:<br><br>03/23/2023 190.0 lbs.,<br><br>02/27/2023 193.0 lbs.,<br><br>12/01/2022 231.1 lbs.,<br><br>11/04/2022 221.2 lbs.,<br><br>30 day - 1.5%,<br><br>3 month - 17.8%, and<br><br>4 month - 14.1%.<br><br>In an interview on 03/28/2023 at 12:30 PM, the RP for Resident #88 stated Resident #88 was admitted to the facility being fed by a tube and a couple of months ago stated eating pureed foods. She stated he was not eating well at first and they hired a private caregiver to assist with his care in the facility. She stated since that time he had improved significantly. She stated he ate all his food and the caregiver would frequently ask for seconds because the normal portion would not fill him up. She stated Resident #88 was a tall man over six feet tall and the facility gave him the same size portions as a little old lady. She said no one at the facility had said anything about giving him double portions to help him regain weight. She said he lost weight because he was on a tube feeding and could not eat food. She stated when Resident #88 could eat food again they stopped the tube feedings. She stated she was not aware of any interventions the facility put in place to stop Resident #88 from losing further weight or to regain some of the weight he lost.<br><br>In an observation and interview on 03/28/2023 at 12:50 PM, Resident #88's trays was observed and intake of pureed foods was 100% and 100% supplemental dessert cup. He stated he liked the food and the pureed texture was not a problem, he just did not get enough of it most days. He stated his caregiver CG R would go to the kitchen ask for seconds and then he would fill full. He stated today they provided him with double portions so today he felt full. He stated he knew he lost weight since he was admitted due to the tube feeding. He said he did not know whether he was regaining the weight he lost. He felt like he was starving he was so hungry some days.<br><br>In an interview on 03/28/2023 at 12:55 PM, CG R stated she was the private caregiver for Resident #88 and assisted with his care in the facility. She went to the kitchen at least once daily to ask for seconds or additional portions of the pureed food. She stated no one had offered to change his meal ticket to double portions. She stated Resident #88 did not get full on the regular portions. She stated she told the kitchen staff of his need for increased portions but not anyone else.<br><br>3. Review of Resident #65 face sheet dated 03/28/2023 revealed Resident #65 was a [AGE] year-old male admitted to the facility on [DATE] with a diagnoses of stroke, partial paralysis of left side following stroke, dysphagia (difficulty swallowing), aphasia (inability to form speech), type 2 diabetes mellitus, high blood pressure and epilepsy (seizure disorder).<br><br>(continued on next page) |

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| F 0692<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Review of Resident #65 quarterly MDS assessment dated [DATE] revealed Resident #65 had a BIMS score of five to indicate severe cognitive impairment. Resident #65 required supervision and set-up assistance by one staff member for eating. Resident #65 required a therapeutic and mechanically altered diet and was not noted to have weight loss.<br><br>Review of Resident #65 care plan dated 03/18/2021 revealed Resident #65 was able to feed self with tray set up and cueing. Resident #65 had the potential for weight variance related to dysphagia. Interventions included administer medications as ordered, food in bowls, monitor/document/report dysphagia, monitor/document/record as needed for malnutrition, provide, serve diet as ordered: Reduced Concentrated sweets diet, pureed texture, regular liquids consistency and RD to evaluate and make diet change recommendations as needed.<br><br>Review of Resident #65 physician ordered dated 03/01/2022 revealed Resident #65 was ordered Reduced Concentrated sweets diet, pureed texture, regular liquids consistency, food in bowls.<br><br>Review of Resident #65 physician orders dated 03/26/2023 revealed Resident #65 was ordered a house shake after meals and at bedtime for stabilize weight.<br><br>Review of Resident #65 weight records dated 03/28/2023 revealed:<br><br>03/23/2023 136.2 lbs.,<br><br>02/05/2023 142.0 lbs.,<br><br>01/13/2023 150.2 lbs.,<br><br>12/05/2022 142.0 lbs.,<br><br>09/07/2022 150.0 lbs.,<br><br>30 day - 4.08%,<br><br>2 month - 9.32%,<br><br>3 month - 4.08%, and<br><br>6 month - 9.2%.<br><br>In an observation on 03/26/2023 at 12:45 PM, Resident #65 ate 100% of his pureed food that was served in bowls.<br><br>In a follow-up observation and interview on 03/28/2023 at 1:00 PM, Resident #65 ate 100% of his pureed food in bowls and was eating a second serving of pureed foods on a divided plate. He stated he like the food and would always like more. He stated when he asked for more he did not always receive more. He did not know why he did not receive seconds when he asked.<br><br>(continued on next page) |

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| F 0692<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | In an interview on 03/28/2023 at 1:05 PM, NA G stated if Resident #65 ate all of his food and asked for seconds, staff would ask the kitchen for more. She stated there were times the kitchen ran out of pureed food and they would offer to make Resident #65 something else but he would not want to wait for it. She stated she did not know why double portions were not served to Resident #65 routinely.<br><br>In an interview on 03/28/2023 at 11:10 AM, LVN D stated Resident #65 ate very well and did not know why he experienced weight loss. She stated he was changed to pureed due to pocketing and coughing while swallowing. She stated Resident #65 liked the pureed foods and had no complaint. She stated if Resident #65 asked for seconds they would request more from the kitchen. She stated she was not familiar with Resident #62 and Resident #88 and could not say why they experience weight loss.<br><br>In an interview on 03/28/2023 at 11:20 AM, ADON stated Resident #65 always ate all of his food and did not complain about the pureed texture. He stated he was not sure what would have caused him to lose weight. He stated Resident #65 ate in the dining room and they monitored his intake closely. He said Resident #65 would often request seconds with meals and they would ask for seconds from the kitchen. He stated he was unaware of anyone making a change so that Resident #65 received double portions. He stated Resident #62 experienced weight loss because he had COVID in December 2022 and experienced a decline. He could not say what caused the weight loss in Resident #62 in November 2022, before Resident #62 had COVID. He said Resident #88 was previously fed by tube feeding only until he advance a couple of months ago to a pureed diet. He stated Resident #88 ate well and had no problems tolerating the pureed food. He stated he was unaware of Resident #88 routinely asking for seconds and wanting more food.<br><br>In an interview on 03/28/2023 at 1:22 PM, the RD stated when a resident was downgraded to pureed food they did not have any procedure or protocol to monitor weights to ensure the change did not cause weight loss. The RD stated Resident #62 lost weight and suffered decline related to COVID in December 2022. She could not explain the weight loss for Resident #62 in November 2022 when experienced the most weight loss. She stated in December 2022 they downgraded his diet to pureed due to not chewing and swallowing his food. The RD stated Resident #65's weight loss may be due to fluid shifts though Resident #65 was not known for fluid shifts. She stated she was unaware of Resident #65 wanting double portions or seconds with meals. She stated the weight loss could be due to method and measurement errors when weighing Resident #65. She stated Resident #88 was on a TF and then upgraded to pureed diet in February 2024. She could not explain the big weight change in from December 2022 to February 2023 as there were no indications Resident #88 was not tolerating his TF. She stated the amount he received via TF was enough to meet estimated daily needs. She stated she was unaware that Resident #88 was eating 100% of pureed food and wanted seconds for most meals. She stated double portions could be ordered for both Resident #65 and Resident #62.<br><br>In an interview on 03/28/2023 at 1:50 PM, with the DON stated she was new to the facility and had only been there about to weeks. She stated she was not familiar with Resident #62, Resident #65 and Resident #88. She stated it would have been her expectation that when residents experienced a significant or severe change in their weight that a progress note with a root cause analysis would be completed with RD and MD notification. She stated in looking at the EMR she could not say what cause the weight loss in all three residents. She stated there were issues with weight measurements and consistent methods and they implemented weekly weights to establish accurate baselines for residents.<br><br>(continued on next page) |

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|---|---|---|---|
| | 675434 | A. Building<br>B. Wing | 03/28/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Silver Pines Nursing and Rehabilitation Center | 503 Old Austin Highway<br>Bastrop, TX 78602 |

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| F 0692<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | In an interview on 03/28/2023 at 2:55 PM, the ADMIN stated there were issues with weighing methods and measurements and the weight loss for Resident #62, Resident #65 and Resident #88 were not accurate. She stated she was unaware of other reasons for why they lost weight.<br><br>Review of Weight Management System (undated) revealed residents with a significant weight loss or gain (5%, 7.5% or 10% or more) will be placed on weekly weights x 4 weeks or until weight is stable . If weight concerns are noted/weights are not stable , implement interim nutrition interventions, notify RDN/NTR via referral form and continue weekly weight until stable .All weight changes are considered unplanned unless the MD has documented a plan for desired weight change and the facility has care planned PRIOR to the weight change occurring. |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide safe and appropriate respiratory care for a resident when needed.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28689<br><br>40884<br><br>Based on observation, interview, and record review, the facility failed to provide respiratory care consistent with professional standards of practice for 2 of 2 residents (Residents #148 and #147) reviewed for oxygen therapy.<br><br>The facility failed to ensure Resident #148's oxygen tubing and humidifier were dated.<br><br>The facility failed to ensure Resident #147's oxygen tubing was dated.<br><br>This failure placed residents at risk of respiratory infections.<br><br>Findings included:<br><br>Review of Resident #148's undated Face Sheet reflected she was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses of Amyotrophic Lateral Sclerosis (progressive nervous system disease that weakens muscles and impacts physical function), Lyme Disease (tick borne illness that causes fatigue and flu-like symptoms), Neoplasm Unspecified (abnormal growth in some part of the body), Anxiety Disorder (mental health disorder characterized by feelings of worry, anxiety, or fear that are strong enough to interfere with one's daily activities), and abnormal weight loss.<br><br>Review of Resident #148's Care Plan dated 03/24/2023 reflected no problems, goals or interventions were documented for oxygen administration.<br><br>Review of Resident #148's Nursing Home and Swing Bed Tracking MDS dated [DATE] reflected she was admitted to the nursing facility from hospice care at her home.<br><br>Observation on 03/26/2023 at 2:00 PM revealed Resident #148's oxygen tubing was not dated.<br><br>Review of Resident #147's undated Face Sheet reflected she was an 83 -year-old female admitted to the facility on [DATE] with diagnoses of Pressure Ulcer of right hip Stage 4 (ulcer extending into the muscle, tendon, ligament, cartilage and possibly exposing bone), Neuromuscular Dysfunction of Bladder (lack of bladder control due to brain, spinal cord or nerve problems), Anemia (condition in which blood doesn't have enough healthy red blood cells), Hypothyroidism (condition in which thyroid gland doesn't produce enough thyroid hormones), Type 2 Diabetes Mellitus (chronic condition that affects the way the body processes blood sugar) with Diabetic Neuropathy (nerve damage as a result of high blood sugar), Severe protein-calorie Malnutrition (low nutritional status resulting in muscle wasting, loss of fat under the skin, weight loss, bedridden or significantly reduced functional capacity), Hyperlipidemia (high concentration of fats in the blood), and personal history of Transient Ischemic Attack (brief stoke-like attack) and Cerebral Infarction (brain stroke) without residual (lasting) effects.<br><br>(continued on next page) |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of Resident #147's Care Plan dated 03/23/2023 and revised on 03/27/2023 reflected she had an indwelling Suprapubic catheter (surgically created connection between the urinary bladder and the skin used to drain urine from the bladder) due to Neurogenic bladder (lack of bladder control due to brain, spinal cord or nerve problems). Interventions: Position catheter bag and tubing below the level of the bladder and away from the entrance room door.<br><br>Review of Resident #147's Comprehensive MDS dated [DATE] reflected she had a BIMS score of 7 indicating severe cognitive impairment.<br><br>Observation on 03/26/2023 at 2:05 PM, revealed Resident #147's oxygen tubing was not dated.<br><br>Interview on 03/27/2023 at 2:20 PM, RN B stated the Resident #147's oxygen tubing should be dated for infection control.<br><br>Interview on 03/28/2023 at 2:45 PM, the Administrator stated her expectation was for oxygen tubing to be dated and respiratory equipment to be bagged. She stated it was a potential infection control issue if tubing was not dated and equipment was not bagged.<br><br>A Policy and Procedure for care of respiratory equipment/oxygen therapy was requested from the DON but none was presented at time of exit from the facility. |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | 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.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28689<br><br>Based on observation, interview, and record review the facility failed to ensure that drugs and biologicals used in the facility were stored properly for 1 of 2 nurse medication carts (Hall 100) and 1 of 1 Medication storage rooms reviewed for drug storage.<br><br>The nurse medication cart for Hall 100 had a sticky substance in the cart with loose pills and hair stuck in it.<br><br>Two bottles of a diabetic nutritional oral supplement with expiration dates of ,d+[DATE] were found in the cart.<br><br>Three bottles of a diabetic nutritional oral supplement with an expiration date of ,d+[DATE] were found stored in the medication storage room<br><br>This failure placed residents at risk of receiving contaminated medications and expired oral supplements.<br><br>Findings included:<br><br>Observation and Iinterview on [DATE] at 11:55 AM, of the nurse medication cart for Hall 100 revealed the second drawer of the cart had a sticky yellow/brown/black substance with hairs and loose pills stuck to it. Medication bottles were observed sitting in the sticky substance. Two bottles of a diabetic nutritional oral supplement with expiration dates of [DATE] were found in the cart. LVN C stated it could be an infection control issue to have the cart unclean and the other medications could become contaminated. She stated all the nursing staff should be keeping the carts clean. She stated the oral supplements were donated by a resident and they should not give expired supplements to a resident.<br><br>Observation on [DATE] at 12:00 PM, in the medication storage room revealed three bottles of a diabetic nutritional oral supplement with expiration dates of [DATE].<br><br>Interview on [DATE] at 1:00 PM, the DON stated her expectations regarding the medication carts are they should be wiped and cleaned every day. She stated there was a big risk of medication contamination if the carts were unclean. She stated the expired diabetic nutritional oral supplement could cause illness in a resident. She stated nothing expired should be given to the residents.<br><br>Interview on [DATE] at 1:46 PM, with the RD stated the expired diabetic nutritional oral supplements could be spoiled and should be discarded. She stated the potential risk of a resident receiving expired oral supplements could be gastrointestinal (relating to the stomach and intestines) distress.<br><br>Interview on [DATE] at 2:45 PM, the Administrator stated her expectations were for the medication carts to be kept orderly and clean. She further stated other medications could potentially be contaminated if the cart was not clean.<br><br>(continued on next page) |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Review of a facility policy and procedure dated [DATE] titled Medication Administration: General Guidelines reflected The licensed nurse or medication aide should maintain a clean top surface on the medication cart while passing medications and clean and replenish the medication cart after each use. Equipment and supplies relating to medication administration are clean and orderly.<br><br>Review of a facility policy and procedure dated [DATE] titled Medication Storage and Disposal reflected When medications are discontinued by physician order, a resident is transferred or discharged and does not take the medications with him/her, or in the event of a resident death, the medications are marked appropriately and destroyed. |

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| F 0810<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide special eating equipment and utensils for residents who need them and appropriate assistance.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44174<br><br>Based on observation, interview, and record review the facility failed to provide special eating equipment and utensils for residents who need them and appropriate assistance to ensure that the resident can use the assistive devices when consuming meals and snacks for one resident (Resident #7) of five residents reviewed.<br><br>The facility failed to provide Resident #7's physician ordered independent mug with lunch.<br><br>This failure put residents at risk for decreased fluid intake, dehydration and decreased quality of life.<br><br>Findings included:<br><br>Review of Resident #7's face sheet dated 03/28/2023 revealed Resident #7 was an [AGE] year old female admitted to the facility on [DATE] with a diagnoses of a history of stroke with left upper limb partial paralysis (lack of oxygen to the brain causing immobility to the left upper limb), chronic obstructive pulmonary disease (lung disease which causes difficulty breathing), congestive heart disease (chronic condition in which the heart doesn't pump blood as well as it should), depression, high blood pressure and dysphagia (difficulty swallowing).<br><br>Review of Resident #7's quarterly MDS assessment dated [DATE] revealed Resident #7 had a BIMS score of one to indicate severe cognitive impairment. Resident #7 was noted to require limited assistance by one staff member for eating. Resident #7 was not noted to have a swallowing disorder or required a mechanically altered diet.<br><br>Review of Resident #7 care plan dated 04/15/2021 revealed Resident #7 required supervision with set up assistance by one staff member to eat. Resident #7 required a regular diet, pureed texture, regular liquids with a two handletwo-handle cup, divided plate and fortified foods with breakfast and dinner.<br><br>Review of Resident #7's physician order dated 01/18/2023 revealed Resident #7 was ordered a regular diet, pureed texture, regular liquids with a divided plate and independent mug with fortified foods with breakfast and dinner for pureed diet.<br><br>In an observation on 03/26/2028 on 12:25 PM, Resident #7 did not have the independent mug on her tray. She had cups of liquids in regular cups with no handles.<br><br>In an interview on 03/26/2028 at 12:40 PM, CNA J stated he was not sure why Resident #7 did not have the independent mug or two handled mug. He stated he would check with dietary staff to find out where her independent mug was located. He stated Resident #7 was able to drink fluid independently if she had the independent mug.<br><br>(continued on next page) |

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| F 0810<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | In an observation on 03/27/2028 at 12:40 PM, Resident #7 was observed to have iced tea in an independent mug on her tray with milk in a Styrofoam cup. Resident #7 attempted to drink the milk in the Styrofoam cup and as she lifted the cup it tipped into the top of her independent mug.<br><br>In an interview on 03/27/2023 at 12:42 PM, CNA F stated she was not sure why Resident #7 did not have an independent mug for all of her preferred drinks with lunch. She stated Resident #7 was not able to use a regular cup to drink as it was difficult for her to control.<br><br>In an interview on 03/28/2028 at 11:10 AM, LVN D stated they check trays prior to tray service to ensure residents have the correct diet order and the necessary assistive devices for meals. She stated she was not sure why Resident #7 did not have her independent mug on her tray. She said Resident #7 not having her independent mug could result in less fluid intake by Resident #7 and dehydration. She stated dietary staff were responsible for ensuring the independent mug was on the tray and the charge nurse should check for it prior to tray service.<br><br>In an interview on 03/28/2023 at 1:22 PM, the RD stated residents should be provided with all physician ordered assistive devices with all meals. She stated Resident #7 had the independent mug ordered by therapy to promote independence and increased fluid intake. She said dietary staff were responsible for the placement of the independent mug on the tray and the charge nurse was responsible for checking the trays for correct diet order and assistive devices. She stated Resident #7 was at risk for decreased independence, decreased fluid intake and dehydration without the independent mug. She stated she was not sure why Resident #7 was provided other drinks in regular cups and only one drink in the independent mug on 03/27/2023.<br><br>In an interview on 03/28/2023 at 2:53 PM, the DM stated Resident #7 should have had the independent mug on her tray on 03/26/2028. She stated the resident was at risk for decreased fluid intake and dehydration if not provided the correct assistive devices. She stated the kitchen did not always have the independent mugs because the independent mugs were sent to the hallways on trays and did not return to the kitchen. She stated the lids to the independent mugs would go missing too. She stated she and the ADMIN would need to order more to ensure a sufficient supply for residents.<br><br>In an interview on 03/28/2023 at 3:05 PM, the ADMIN stated it was her expectation that residents receive their physician ordered assistive devices with all meals. She stated Resident #7 should have had her independent mug at all meals to allow for sufficient fluid intake and independence. This put Resident #7 at risk for decreased fluid intake and dehydration.<br><br>Review of Diets Offered by the Facility dated June 2018 revealed the facility is committed to providing the best nutritional care possible to its residents. All residents will receive diets as ordered by the attending physicians. |