STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675802	A. Building B. Wing	03/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Kemp Care Center	1351 South Elm Street Kemp, TX 75143

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44637 Based on observation, interview and record review, the facility failed to provide residents with personal privacy and confidentiality of his or her personal and medical records.for 2 of 5 (Resident #2 and Resident #3) residents reviewed for resident rights. 1. The facility did not ensure the door was closed during wound care on Resident #2 resulting in another resident trying to enter the room to speak with the nurse during Resident #2's wound care . 2. The facility failed to prevent RN A from discussing Resident #3 with Resident #2. This failure could place residents at risk for diminished quality of life, loss of dignity and self-worth. Findings included: 1. Record review of the face sheet dated 3/6/24 indicated Resident #2 was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses including cellulitis (a common and potentially serious bacterial skin infection) of the right and left lower limb, lymphedema (swelling, most often in the arm or leg, caused by a lymphatic system (a network of delicate tubes throughout the body) blockage), diabetes, and chronic kidney disease. Record review of the MDS dated [DATE] indicated Resident #2 understood others and was understood by others. The MDS indicated Resident #2 had a BIMS of 14 and was cognitively intact. The MDS indicated Resident #2 had one venous or arterial artery present. Record review of the care plan revised 1/21/24 indicated Resident #2 had a venous stasis ulcer (a wound on the leg or ankle caused by abnormal or damaged veins) of the left calf related to poor circulation with interventions including wound care as ordered. During an observation and interview on 3/5/24 at 1:38 p.m. Observed RN performed wound care on Resident #2. RN a left the door open to Resident #2's room while setting up, removing dirty dressing, leaving the room to obtain scissors, and only shut the door when Resident #3 tried to enter the room in the middle of the wound care to talk to RN A. RN A said Resident #3 entered the room during wound care because RN A did not shut the door prior to starting wound care. RN A said the importance of shutting the door prior to providing care to a resident was for privacy and to prevent interruptions. (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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/6/24 at 1:35 p.m. RN B said when performing wound care, privacy should be provided. RN B said it was important to provide privacy during wound care for the resident's dignity. During an interview on 3/6/24 at 1:38 p.m. the DON said she expected staff to provide privacy when providing any type of care. The DON said the importance of providing privacy was dignity and resident rights. 2. Record review of the face sheet dated 3/6/24 indicated Resident #3 was an [AGE] year-old female readmitted to the facility on [DATE] with diagnoses including dementia, cognitive communication deficit, and bipolar disorder. Record review of the MDS dated [DATE] indicated Resident #3 usually understood others and was usually understood by others. The MDS indicated Resident #3 had a BIMS of 4 and was severely cognitively impaired. Record review of the care plan revised 10/19/23 indicated Resident #3 had an impaired cognitive function/dementia or impaired thought processes. During an observation and interview on 3/5/24 at 1:38 p.m. RN A left the door open to Resident #2's room while setting up, removing dirty dressing, leaving the room to obtain scissors, and only shut the door when Resident #3 tried to enter the room in the middle of the wound care. RN A redirected Resident #3 out of Resident #2's room. RN A said to Resident #2 she believed that the full moon really did effect people. RN A said to Resident #2 she thinks the full moon effects people because Resident #3 had been very emotional today. RN A said Resident #2 and Resident #3 talked regularly. RN A said she was sure Resident #2 already knew Resident #3 was emotional today. During an interview on 3/6/24 at 12:53 p.m. Resident #2 said she did not know the resident who entered her room while wound care was being performed. Resident #2 said she had seen Resident #3 but did not know her. Resident #2 said she had only been at the facility since December 2023 and was just starting to really get to know some of the other residents. During an interview on 3/6/24 at 1:35 p.m. RN B said it was never ok to talk about another resident to a resident. RN B said it was a HIPAA violation and unprofessional to talk about one resident to another. During an interview on 3/6/24 at 1:38 pm the DON said staff should never talk about one resident to another resident. The DON said it was a HIPAA violation and a breach in confidentiality for staff to talk about one resident to another resident. Record review of the facility's Resident Rights policy revised 11/28/16 indicated, The resident had the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States .The resident has the right to be treated with respect and dignity .The resident has a right to personal privacy and confidentiality of his or her personal and medical records .

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44637 Based on observation, interview and record review, the facility failed to ensure residents receive treatment and care in accordance with professional standards of practice and the comprehensive person-centered care plan for 1 of 5 (Resident #2) residents reviewed for quality of care. 1.The facility failed to ensure Resident #2's venous stasis ulcer (a wound on the leg or ankle caused by abnormal or damaged veins) treatment was performed daily as ordered. 2.The facility failed to ensure the nurses initialed and dated wound dressings when wound care was performed on Resident #2 . These failures could result in residents with venous stasis ulcer of not having their treatments performed as ordered, wounds becoming infected wounds, and decreased wound healing. Findings included: 1. Record review of the face sheet dated 3/6/24 indicated Resident #2 was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses including cellulitis (a common and potentially serious bacterial skin infection) of the right and left lower limb, lymphedema (swelling, most often in the arm or leg, caused by a lymphatic system (a network of delicate tubes throughout the body) blockage), diabetes, and chronic kidney disease. Record review of the physician orders dated 3/6/24 indicated Resident #2 had an order to cleanse left venous stasis ulcer to calf with normal saline, pat dry, apply leptospermum honey (used to treat wound infections), wrap with kerlix (bandage roll) and secure with paper tape daily starting 1/4/24. The physician orders indicated Resident #2 had an order to cleanse right lower leg with normal saline, pat dry, wrap with kerlix, and wrap with ace wrap every Monday, Wednesday, and Friday. Record review of the MDS dated [DATE] indicated Resident #2 understood others and was understood by others. The MDS indicated Resident #2 had a BIMS of 14 and was cognitively intact. The MDS indicated Resident #2 had one venous or arterial artery present. Record review of the care plan revised 1/21/24 indicated Resident #2 had a venous stasis ulcer of the left calf related to poor circulation with interventions including wound care as ordered. Record review of the TAR dated 2/1/24 through 2/29/24 indicated Resident #2's treatment to cleanse left venous stasis ulcer to calf with normal saline, pat dry, apply leptospermum honey, wrap with kerlix and secure with paper tape daily was only performed on 2/4/24, 2/6/24, 2/8/24, 2/9/24. 2/11/24, 2/13/24, 2/14/24, 2/16/24, 2/17/24, 2/19/24, 2/20/24, 2/21/24, 2/2/24, 2/23/24, 2/24/24, 2/25/24, and 2/27/24. The TAR indicated Resident #2's treatment to cleanse right lower leg with normal saline, pat dry, wrap with kerlix, and wrap with ace wrap every Monday, Wednesday, and Friday was only performed on 2/9/24, 2/14/24, 2/16/24, 2/19/24, 2/21/24, and 2/23/24. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 2/29/24 at 12:30 p.m. the ADON said she had been performing wound care for approximately a month. The ADON said a nurse could check the TAR to indicated if a treatment had been done. The ADON said she did not date her treatments because she was the only one doing them. The ADON said the charge nurses were responsible for checking off on the TAR treatments were done when they finished them. The ADON said she did the treatments when she was working. The ADON said her normal schedule was Monday through Friday 8:00 am to 5:00 pm, but she had worked several different shifts and positions recently. The ADON said if the treatment was not signed off on the TAR it had been completed there was no way to prove it had been done. During an observation and interview on 3/5/24 at 1:38 p.m. RN A performed wound care on Resident #2. The wound dressing on Resident #2's left calf was dated 3/3/24. RN A completed wound care to the left calf and left the room to obtain betadine for Resident #2's heel. RN A confirmed she was completely finished with the wound care to the left calf. RN A said the dirty dressing had been dated 3/3/24 and indicated wound care had not been completed on 3/4/24. RN A said the importance of performing wound care daily as ordered was because Resident #2's wound had been infected and would easily become infected again especially with her diagnoses of diabetes. RN A said she needed to get a piece of tape to date the dressing to Resident #2's left calf. RN A said a wound dressing did not need to be initialed and dated if the same nurse was going to be performing the wound care the next day. RN A said if different nurses were working the hall, or the nurse was not going to be there the next day the dressing should be initialed and dated. During an interview on 3/6/24 at 1:35 p.m. RN B said when performing wound care privacy should be provided, the dressing should be dated and initialed, and the treatment should be signed off on the TAR. RN B said it was important to date and initial the wound dressings for proof wound care was completed. RN B said if wound care was not signed off on the TAR it could not be proved the wound care was performed as ordered. RN B said it was important to perform wound care as ordered to ensure proper healing. During an interview on 3/6/24 at 1:38 p.m. the DON said she expected staff to date and initial wound dressings. The DON said dating and initialing wound dressing verified the wound care was performed. The DON said she expected staff to sign off on the TAR when wound care was completed. The DON said if the TAR was not signed off there was no way to prove wound care had been performed as ordered. Record review of the facility's undated Dressing Change Checklist indicated, Verifies orders for wound treatment from the TARs and chart .document procedure per facility protocol. Record review of the facility's Skin Integrity Management policy dated 2003 indicated, .Wound care should be performed as ordered by the physician .

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44637 Based on interview and record review, the facility failed to ensure the necessary treatment and services, in accordance with comprehensive assessment and professional standards of practice, to prevent development of pressure injuries was provided for 1 of 5 (Resident #1) residents reviewed for pressure injuries. The facility failed to ensure Resident #1's wound care was performed daily as ordered . These failures could place residents at risk for worsening of existing pressure injuries, infection, pain, and decreased quality of life. Findings included: 1. Record review of the face sheet dated 3/5/24 indicated Resident #1 was a [AGE] year-old female, readmitted to the facility on [DATE] with diagnoses including dementia, diabetes, COPD, hydronephrosis, and chronic pain. Record review of the physician orders dated 3/5/24 indicated Resident #1 had an order to cleanse coccyx (small triangular bone at the base of the spinal column) with normal saline, pat dry, apply collagen (used to treat partial-thickness wounds and some pressure ulcers) to wound and a dry dressing one time a day for wound healing starting 1/4/24. The physician orders indicated Resident #1 had an order to cleanse MASD (moisture associated skin damage) area to coccyx with normal saline, pat dry, apply silver alginate (a wound dressing with antibacterial silver for moderate to highly exudating (fluids moving to the site of an injury)), and cover with a dry dressing daily until resolved starting 2/7/24. Record review of the comprehensive MDS dated [DATE] indicated Resident #1 usually understood others and was usually understood by others. The MDS indicated Resident #1 had a BIMS score of 9 and was moderately cognitively impaired. The MDS indicated Resident #1 had a pressure ulcer/injury, a scar over bony prominence, or a non-removable dressing/device that was present on admission or re-entry. Record review of the care plan revised on 12/18/23 indicated Resident #1 had a pressure ulcer or potential for pressure ulcer development: Stage 2 (partial thickness loss of dermis presenting as a shallow open ulcer with red or pink wound bed without slough (yellow/white material in the wound bed) or bruising) to coccyx. Record review of the TAR dated 2/1/24 through 2/29/24 indicated Resident #1's treatment to cleanse coccyx with normal saline, pat dry, apply collagen to wound and a dry dressing one time a day for wound healing on dates 2/1/24 through 2/13/24 was only performed on 2/6/24. The TAR indicated Resident #1's treatment to cleanse MASD area to coccyx with normal saline, pat dry, apply silver alginate, and cover with a dry dressing daily on dated 2/7/24 through 2/23/24 was only performed on 2/13/24, 2/16/24, 2/17/24, 2/18/24, 2/19/24, 2/20/24. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the weekly ulcer assessment dated [DATE] indicated Resident #1 had a Stage 3 (an ulcer that has burrowed past the dermis (the skin's second layer) and reached the subcutaneous tissue (fat layers) beneath) to the sacrum measuring 1.2 cm x 0.6 cm x 0.72 cm that was not present on admission. During an interview on 2/29/24 at 12:30 p.m. the ADON said she had been performing wound care for approximately a month. The ADON said a nurse could check the TAR to indicated if a treatment had been done. The ADON said the charge nurses were responsible for signing off on the TAR treatments were done when they finished them. The ADON said if the treatment was not signed off on the TAR it had been completed there was no way to prove it had been done. During an interview on 3/6/24 at 1:35 p.m. RN B said when performing wound care privacy should be provided, the dressing should be dated and initialed, and the treatment should be signed off on the TAR. RN B said if wound care was not signed off on the TAR it could not be proved the wound care was performed as ordered. RN B said it was important to perform wound care as ordered to ensure proper healing. During an interview on 3/6/24 at 1:38 p.m. the DON she expected staff to sign off on the TAR when wound care was completed. The DON said if the TAR was not signed off there was no way to prove wound care had been performed as ordered. Record review of the facility's undated Dressing Change Checklist indicated, Verifies orders for wound treatment from the TARs and chart .document procedure per facility protocol. Record review of the facility's Skin Integrity Management policy dated 2003 indicated, .Wound care should be performed as ordered by the physician .

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44637 Based on interview and record review the facility failed to ensure a resident who was incontinent of bladder and bowel received appropriate treatment and services to prevent urinary tract infections for 1 of 1 (Resident #1) residents reviewed for incontinence care. The facility failed to ensure Resident #1's discharge order for a urinary straight catheter (also called an intermittent catheter, is a soft, thin tube used to pass urine from the body) four times a day was initiated upon re-admission to the facility . This failure could place residents at risk for urinary retention (difficulty urinating and completely emptying the bladder), pain, and urinary tract infections. Findings included: 1. Record review of the face sheet dated 3/5/24 indicated Resident #1 was a [AGE] year-old female, readmitted to the facility on [DATE] with diagnoses including dementia, diabetes, COPD, hydronephrosis, and chronic pain. Record review of the physician orders dated 3/5/24 indicated Resident #1 did not have an order for a urinary straight catheter four times a day. Record review of the comprehensive MDS dated [DATE] indicated Resident #1 usually understood others and was usually understood by others. The MDS indicated Resident #1 had a BIMS score of 9 and was moderately cognitively impaired. The MDS indicated Resident #1 had occasional urinary incontinence. Record review of the care plan revised on 12/18/23 indicated Resident #1 had a resident had an ADL self-care performance deficit with interventions including toileting assistance of one staff required. Record review of the hospital progress notes from 1/6/24 through 1/9/24 indicated Resident #1's assessment and plan included foley catheter (a semi-flexible tube inserted into the bladder and has a bag on the other end used when a person cannot urinate normally), then urinary straight catheter four times a day upon discharge. Record review of the hospital discharge orders dated 1/10/24 indicated Resident #1 discharged to the facility with an order for a urinary straight catheter four times a day. Record review of the urology progress note dated 2/15/24 indicated Resident #1 had a history of urinary retention and frequent urinary tract infections. The progress note indicated Resident #1 was without a foley catheter. The progress note indicated Resident #1 had complete urinary incontinence and emptied well. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 3/5/24 at 9:47 a.m. the DON said she was unsure what happened with Resident #1's order for a urinary straight catheter four times a day. The DON said she would have to find out what happened with the order for a urinary straight catheter not being entered in the computer. During an interview 3/6/24 at 11:23 a.m. the Nurse at Urologist office said importance of performing the in and out catheterization (urinary straight catheterization) as ordered was to prevent urinary retention which could lead to urine backing up into the kidneys and causing damage to the kidneys, bladder damage, and to prevent pain. The Urology Nurse said they would have expected the facility to have performed the in and out catheterizations as ordered until Resident #1 had her follow-up appointment with the Urologist. During an interview on 3/6/24 at 1:35 p.m. RN B said if a resident discharged from the hospital with orders for an in and out catheter the order should be implemented. RN B said it was important to implement orders for an in and out catheter to prevent urinary retention and UTI. During an interview on 3/6/24 at 1:38 p.m. the DON said she expected staff to implement all discharge orders from the hospital. The DON said the importance in ensuring discharge orders were implemented was for patient care and overall outcome. The DON said orders entered after an admission/re-admission were reviewed in the morning meeting or she would review them later. The DON said she did not see the order for Resident #1 to have an in and out catheter four times a day until the surveyor pointed it out. Record review of the facility's Catheter Care policy dated 2003 indicated, Determine if the resident's urine level has increased. If the level stays the same, or increases rapidly, report it to your supervisor. Should the resident indicate his or her bladder is full or that he or she needs to void (urinate), report immediately to your supervisor .Observe for and report to charge nurse .e. Urinary complaints such as dysuria (painful urination), burning, urgency, frequency, or flank pain. f. Other significant observations.

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F 0770 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Provide timely, quality laboratory services/tests to meet the needs of residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44637 Based on interview and record review the facility failed to ensure laboratory services were obtained to meet the needs for 1 of 5 (Resident #1) residents reviewed for laboratory services. The facility did not ensure Resident #1 had weekly CBC (complete blood count-used to look at overall health and find a wide range of conditions including anemia (condition in which the blood does not have enough healthy red blood cells) and infection and BMP (basic metabolic panel-test that checks the body's fluid balance and levels of electrolytes) lab tests as ordered. Resident #1 was lethargic and requested to be sent to the hospital on 2/20/24 where she was admitted for hyponatremia (decreased sodium with symptoms including fatigue, lethargy, and mental confusion), dehydration and AKI (acute kidney injury-a condition in which the kidneys suddenly cannot filter waste from the blood. Resident #1 did not receive her weekly lab draws as ordered on the weeks of 1/15/24-1/19/24, 1/22/24-1/26/24, 1/29/24-2/2/24, 2/5/24-2/9/24, and 2/12/24-2/16/24. An Immediate Jeopardy (IJ) was identified on 3/5/24 at 12:00 p.m. While the IJ was removed on 3/6/24, the facility remained out of compliance at a with a scope identified as pattern and severity of potential for more than minimal harm due to the facility's need to complete in-service training and evaluate the effectiveness of the corrective systems. This failure could place the residents at risk of not receiving lab services as ordered and suffering from an undetected infection, decreased electrolyte balances, dehydration, and decreased kidney function. Findings included: Record review of the face sheet dated 3/5/24 indicated Resident #1 was a [AGE] year-old female, readmitted to the facility on [DATE] with diagnoses including dementia, diabetes, COPD, hydronephrosis, and chronic pain. Record review of the physician orders 3/5/24 indicated Resident #1 had an order for a CBC and BMP weekly starting 12/15/23. Record review of the comprehensive MDS dated [DATE] indicated Resident #1 usually understood others and was usually understood by others. The MDS indicated Resident #1 had a BIMS score of 9 and was moderately cognitively impaired. Record review of the care plan revised on 12/18/23 indicated Resident #1 had a potential fluid deficit with interventions including obtain and monitor lab/diagnostic work as ordered and monitor/document/report to the physician signs and symptoms of fluid deficits including but not limited to: decreased or no urine output, cracked lips, new onset of confusion, and fatigue/weakness. (continued on next page)

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F 0770 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of the NP progress note dated 2/20/24 indicated, . [The family] stated that [Resident #1] complained to feeling very weak and usually when she complained of this, she needed s blood transfusion. [The family] also noted that [Resident #1] was complaining of hip pain .Offered to order stat labs and x-ray but [the family] declined. Stated that [Resident #1] wanted to go to the hospital. Gave order to nurse send patient to the hospital. Record review of the hospital records dated 2/20/24 indicated Resident #1 presented to the ED with a chief complaint of generalized weakness. The hospital records indicated Resident #1 had a blood pressure of 76/61 (normal blood pressure-120/80) at 5:26 p.m., 95/51 at 5:45 p.m., and 107/62 at 5:56 p.m. The hospital records indicated Resident #1 had a sodium level of 121 (normal sodium level range 135-145) and a creatinine (a blood test to measure creatinine levels in the blood. This test was done to see how well the kidneys were working) level of 3.08 (normal creatinine level 0.7-1.2. The hospital records indicated Resident #1 had lab work significant for hypovolemia (condition in which the liquid portion of the blood is too low), hyponatremia, and acute kidney injury. The hospital records indicated Resident #1 received a total of 2.2. liters of IV fluid bolus (a single dose of fluid or medication administered of a short time), and her blood pressure was currently in the 130s. During an interview on 3/5/24 at 9:47 am the DON said nursing was responsible for ensuring labs were drawn as ordered. The DON said lab orders were entered in the computer and when lab came in the mornings the nurses knew who needed lab draws. The DON said Resident #1 had gone out to the hospital on 1/3/24 and the lab cancelled her routine lab draws. The DON said the facility should have contacted the lab and had the routine lab draws for Resident #1 restarted when she readmitted to the facility on [DATE]. The DON said the importance routine BMPs was to check kidney function, sodium levels, and for dehydration. The DON said the average turnaround time for stat lab results from the mobile lab was 8-12 hours. During an interview on 3/5/24 at 10:28 a.m. the Medical Director stated he would probably expect the facility to resume lab orders if they were weekly when a resident returned from the hospital. The Medical Director said a CBC checked for anemia BMP checked for kidney function and potassium level. The Medical Director said for a sodium level of 121 it would depend on resident's history if he was concerned or felt treatment was needed. The Medical Director said if the sodium level was 119 or 120, he would further investigate what was going on with a resident. The Medical Director said he was not familiar with resident with Resident #1. The Medical Director said sodium can decrease rapidly. The Medical Director said he was unsure if weekly labs would have detected a sodium level declining. The Medical Director said it would depend on the resident. The Medical Director said the best-case scenario for stat labs at the facility was 12 hours. The Medical Director said it would depend on how rapidly sodium levels were dropping to know if delay in stat labs would have affected the resident. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675802	A. Building B. Wing	03/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Kemp Care Center	1351 South Elm Street Kemp, TX 75143

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F 0770 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 3/5/24 at 1:21 p.m. CNA C said she had worked at the facility since October 2021. CNA C said she usually worked the 200 hall. CNA C said she was familiar with Resident #1. CNA C said Resident #1 kept to herself and would not use the call light. CNA C said Resident #1 always received juice at meals and always asked for extra juice. CNA C said Resident #1 would tell her she needed the juice. CNA C said Resident #1 always had juice or milk at her bedside. CNA C said the last couple weeks Resident #1 was at the facility she had stopped asking for extra juice and stopped drinking her juice. CNA C said approximately a week prior to Resident #1 going to the hospital on 2/20/24 Resident #1 had told CNA C she thought she needed to go to the hospital because she did not feel good and felt weak. CNA C said she reported Resident #1's request and concerns to the charge nurse. CNA C said she did not remember who the charge nurse was that day. CNA C said Resident #1 did not get sent out to the hospital the day she requested to regarding not feeling well and feeling weak. During an interview on 3/5/24 at 1:35 p.m. RN B said she had worked at the facility for about a month. RN B said when a resident readmitted to the facility the admitting nurse would contact the physician, if physician wanted to resume all previous ordered including routine labs the admitting nurse would ensure the orders were in the computer, and then complete a new lab requisition to resume scheduled labs. RN B said routine CBCs were to check to make sure a resident was not bleeding out or had an infection and routine BMP was to check kidney function. Record review of the facility's Admission/Readmission policy dated 2003 indicated, .Readmission to a facility occurs after a hospitalization or therapeutic leave. Readmission involves a review of the initial admission data with reinforcement where needed and an update of information regarding health status .Notify attending physician of the admission. Compile a new clinical record and document pertinent admission information . Record review of the facility's Physician's Orders policy dated 2015 indicated, Purpose: To monitor and ensure the accuracy and completeness of the medication orders, treatment orders, and ADL order for each resident .Nurse will review the order and if needed contact the prescriber for any clarifications. The nurse will enter the order into [the electronic medical records] for the resident .The receiving nurse will contact any other department or external facilities as required, i.e., dietary department, pharmacy, lab provider, x-ray provider, etc. The Administrator was notified on 3/5/24 at 12:13 p.m. that an Immediate Jeopardy situation was identified due to the above failure. The Administrator was provided the Immediate Jeopardy template on 3/5/24 at 12:17 p.m. The facility's Plan of Removal was accepted on 3/5/24 at 6:21 p.m. and included: Interventions: o Resident #1 has been transferred to another facility as of 3/5/24. o A complete audit of all lab orders was performed by the Regional Compliance Nurse, DON, and ADON on 3/5/24 to ensure all labs orders are scheduled to be drawn by the lab company. The Administrator, DON, and ADON were in-serviced 1:1 by the Regional Compliance Nurse on 3/5/24. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0770 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	o Reconciling admission and readmission orders to include labs. The charge nurse will be responsible for reconciling the lab orders with the physician, calling the lab company, and restarting the labs. The DON will be responsible for calling the lab company, reviewing/overseeing all orders, including labs daily to ensure they are restarted. This will be completed 7 days per week by the DON or designee for weekends. o Following physician orders to include labs. o The medical director was notified of the immediate jeopardy situation on 3/5/24. o An ADHOC QAPI (When needed Quality Assurance and Performance Improvement) meeting was completed by the QA committee to include the medical director on 3/5/24 to discuss the immediate jeopardy and subsequent plan. In-services: o The following in-services were initiated by the Administrator, DON, and Regional Compliance Nurse on 3/5/24 for Charge Nurses. All Charge Nurses not present on 3/5/24 will be in-serviced prior to the start of next shift. All new hires will be in-serviced during orientation. All agency staff will be in-serviced prior to the start of their shift. In-services will be completed on 3/5/24. No staff will be allowed to work their scheduled until in-serviced. o Reconciling admission and readmission orders to include labs. The charge nurse will be responsible for reconciling the lab orders with the physician, calling the lab company, and restarting the labs. The DON will be responsible for calling the lab company, reviewing/overseeing all orders, including labs daily to ensure they are restarted. This will be completed 7 days per week by the DON or designee for weekends. o Following physician orders to include labs. Monitoring: The DON, ADON, or Designee will monitor the order report to include labs daily 7 days per week & as needed indefinitely. This process was part of our daily morning clinical meeting. On 3/6/24 the surveyor confirmed the facility implemented their plan of removal sufficiently to remove the Immediate Jeopardy (IJ) by: Record review of an undated Off Cycle QA Meeting Sign-in Sheet indicated the facility had an ADHIC QA Meeting with the Medical Director, AIT, DON, MDS Nurse, Admission Coordinator, and the ADON present . Interviews between 9:03 am and 10:55 am with staff (LVN D, RN E, RN B, LVN F, LVN G, RN H, LVN J, ADON) they said when a resident admitted or readmitted to the facility their orders should be reconciled and confirmed with the physician or PA (Physician Assistant). Staff said all orders should be put in the electronic medical records and relayed on the 24-hour report (continued on next page)

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F 0770 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of a random sample of 15 resident's orders and lab requisitions indicated a new lab requisition had been made and placed in the lab book for each lab order in a resident's electronic medical record. During an interview on 3/6/24 at 10:53 a.m. the DON said she was in-serviced regarding the importance of ensuring labs were completed as ordered, orders were reconciled when a resident admitted or readmitted to the facility, lab requisitions were completed to restart any routine labs or perform any one-time lab draws, and to monitor labs to ensure they are completed as ordered. The DON said she would have a binder for residents with routine labs indicating what month or week they were due and would check it daily to ensure routine labs were performed as ordered. The DON said for stat or one-time order labs there would be a log placed in the lab requisition book that she and the charge nurses would check daily to ensure labs were performed as ordered. On 3/6/24 at 11:11 a.m., the Administrator was informed the IJ was removed; however, the facility remained out of compliance with a scope identified as pattern and severity of potential for more than minimal harm due to the facility's need to complete in-service training and evaluate the effectiveness of the corrective systems.

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F 0837 Level of Harm - Potential for minimal harm Residents Affected - Many	Establish a governing body that is legally responsible for establishing and implementing policies for managing and operating the facility and appoints a properly licensed administrator responsible for managing the facility. 44637 Based on interview the governing body failed to appoint an administrator who was Licensed by the State, where licensing was required; responsible for management of the facility; and reports to and was accountable to the governing body for 1 of 1 facilities reviewed for having an Administrator. The facility failed to appoint a Licensed Administrator while having an Administrator in Training in the facility . This failure could result in the facility not being managed in a responsible manner, which could affect the health and safety of all residents. Findings included: During an interview on 3/6/24 at 11:34 a.m. The Regional Nurse Consultant said the AIT had completed all his hours and was just awaiting to take if Nursing Facility Administrator test. The Regional Nurse Consultant said there was not an Administrator License over the building at this time. The Regional Nurse Consultant said she reached out to their corporate and it was confirmed there was not an Administrator License over the facility at this time. During an interview on 12:22 p.m. the DON said the facility did not have a policy regarding Administrator staffing