STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676006	A. Building B. Wing	08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Richmond Health Care Center	705 Jackson St Richmond, TX 77469

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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 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 16989 Based on observation, interview, and record review, the facility failed to ensure a copy of the 30-day discharge notice was sent to a representative of the State Long-Term Care Ombudsman for one (Resident #35) of four residents reviewed for discharge planning. -The Long-Term Care Ombudsman did not receive a copy for Resident #35's discharge notice. -The Ombudsman contact information on the letter was incorrect. The failure could place residents at risk for not being able to have representation to contest the discharge. Findings include: Record review of the Admission Record (copied 08/29/24) revealed Resident #35 was a [AGE] year old female, and was admitted to the facility on [DATE]. Diagnoses included, but were not limited to, Alzheimer's disease, bipolar disorder, and dementia. Record review of the MDS dated [DATE] for Resident #35 revealed she scored 0 of 15 on the BIMS, indicative of severely impaired cognition. Record review of the Care Plan (revised 02/28/23) for Resident #35 revealed she required living on a secured unit due to wandering risk. Record review of the 30-Day Discharge Notice for Resident #35, dated 08/01/24 revealed the letter was sent to the resident's family member on that date. The Notice reflected a move-out date of 08/31/24. The Ombudsman contact information (address and telephone number) was not for the county (County A) of where Resident #35 resided. The contact information reflected on the Notice was for County B. In a telephone interview on 08/27/24 at 8:48 a.m. the Ombudsman for County A said Resident #35's family member was given a 30-Day Discharge Notice by the facility. He said the Notice did not have the correct contact information, and a copy had not been received by County A Ombudsman. He said the family did contact him and provided him with a copy of the Notice. At that time, he was able to schedule an appeal meeting. He said he contacted the County B Ombudsman, and was told they had not received a copy of the Notice either. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observations of the secure unit on 08/27/24 revealed the following: *At 09:12 a.m. and 01:05 p.m. revealed Resident #35 was asleep in her room. *At 1:05 p.m. Resident #35 was asleep in her room. In an interview on 08/29/24 at 01:05 p.m. the Administrator said Resident #35 was the only resident issued a 30-day Discharge Notice since she has been the Administrator of this facility. She said a copy was sent to the Responsible Party via Certified Mail. She said the Ombudsman's copy was not sent Certified Mail. In an interview on 08/29/24 at 2:05 p.m. the Administrator said the Ombudsman in County A was sent a copy of the Notice for Resident #35 after the facility realized the contact information on the Notice was incorrect. She did not provide a date. She provided a copy of an email dated 08/09/24 in which the Ombudsman in County A discussed the Notice. In an interview via telephone on 08/29/24 at 2:14 p.m., the Ombudsman in County A said he had an email from the Ombudsman in County B confirming they did not receive a copy of the Notice for Resident #35. Review of the email from the Ombudsman in County B, dated 08/15/24 revealed they had not received a copy of the Notice for Resident #35 as of that date. In an interview via telephone on 08/29/24 at 5:15 p.m., the Ombudsman in County B said they had not received a copy of the Notice for Resident #35. When the Surveyor read him the address on the Notice, the Ombudsman said that was the address to the school of nursing. Record review of the facility policy Transfer and Discharge (2003) read, in part, .4. The facility's transfer/discharge notice will be provided to the resident and the resident's representative in a language and manner in which they can understand. The notice will contain all of the following at the time it is provided .h. The name, address (mailing and email), and phone number of the representative of the Office of the State Long-Term Care Ombudsman. In addition, the document read, in part, .7. The facility will maintain evidence that the notice was sent to the Ombudsman.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48863 Based on observation, interview, and record review the facility failed to ensure the resident who was unable to carry out activities of daily living received the necessary services to maintain good nutrition, grooming, and personal and oral hygiene for 1 of 18 residents (Resident #53) reviewed for ADLs. The facility failed to ensure CNA B provided incontinent care every two hours as required for Resident #53 on 08/28/24, which resulted in a saturated brief, linens, and mattress. This failure could result in pressure injuries, infections, psychosocial harm, and a decreased quality of life. Findings included: Record review of a face sheet dated 08/29/24 indicated Resident #53 was an [AGE] year-old male admitted to the facility on [DATE] with diagnoses which included unspecified dementia without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety (deterioration of memory, language, and other thinking abilities with behaviors), cerebral infarction (damage to tissues in the brain due to a loss of oxygen to the area), and Benign Prostatic Hyperplasia (noncancerous enlargement of the prostate gland). Record review of Resident #53's MDS quarterly assessment dated [DATE] revealed resident had a BIMS Summary Score of a 09 (moderate impairment). Record review of Resident #53's care plan date initiated 03/22/24 indicated he had bowel and bladder incontinence. Resident #53's care plan indicated he should be checked every 2 hours and as required for incontinence. His perineum should be washed, rinsed, and dried, with change of clothes as needed. The goal was for the resident to remain free from skin breakdown due to incontinence and use of briefs. Observation and interview on 08/28/24 at 3:25 PM, Resident #53 said he had not been changed and felt dirty. He was unable to provide a timeframe but pushed the call light for assistance . CNA A entered the room and said she would assist the resident; however, this was not her assigned room. CNA A removed the covers and observed resident brief, gown, and linen saturated with urine. CNA A provided peri care times 2 wipes with wet towelette. She turned Resident #53 to right side, and soft brown stool was noted on his buttocks. CNA A agreed the linen, gown and brief was saturated. The resident's blue mattress was darker where his buttocks was laying and lighter above and below the buttocks area. Interview on 08/28/24 at 3:45 PM with CNA A, said she was not aware of the CNA who was assigned the room but it was usually located in the assignment book. CNA A said the CNAs was supposed to round on the residents and check them every 2 hours. CNA A said it was important to provide incontinent care to the residents frequently so they did not have skin breakdown, and because they could get an infection. (continued on next page)

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	676006	A. Building B. Wing	08/29/2024

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 08/28/24 at 5:30 PM Resident #53 stated he does not remember being changed after 6:00 AM. He said he enjoyed being change every two hours and having clean and fresh gowns on. He said he deflated when his brief was soiled and he does not get changed regularly. Interview on 08/28/24 at 5:47 PM CNA B, said she did not check her assignment today and was not aware she was assigned to Resident #53's room. CNA B said she had not checked on Resident #53 today. CNA B said she was supposed to check on incontinent residents every two hours. CNA B said it was important to provide incontinent care to prevent skin breakdown. Interview on 08/28/24 at 6:04 PM LVN F, said she was informed by CNA C that CNA B had not been in Resident #53's room today and it appeared Resident #53 had not been changed all day. LVN F said the CNAs should be checking on the residents at least every 2 hours. LVN F said not providing incontinent care could cause pressure ulcers and infections. Interview on 08/28/24 at 6:08 PM with the DON, stated Resident #53 had not received care since change of shift at 6:00 AM. The DON said the CNAs should be checking on the residents at least every 2 hours. The DON said she was unaware of why the assigned CNA (CNA B) did not check her assignment this morning. She said not assessing a resident in 8 hours can contribute to a multitude of issues including pressure injuries and infection. During an interview on 08/28/24 at 7:37 PM, the Administrator said Resident #53 was wet and had not been changed until after 3:30 PM. The Administrator said the CNAs should be checking on the residents every 2 hours and as needed. The Administrator said not changing the residents in adverse effects such as skin breakdown.

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	676006	A. Building B. Wing	08/29/2024

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48863 Based on observation, interview and record review, the facility failed to ensure that pain management was provided to residents who require such services, consistent with professional standards of practice for 1 of 5 residents (Resident #4) reviewed for pain management. The facility failed to ensure Resident #4's pain control was maintained at a level acceptable to the resident. This failure could place the resident at risk of a decrease in quality of life due to pain. Findings included: Record review of a face sheet dated 08/29/24 indicated Resident #53 was an [AGE] year-old male admitted to the facility on [DATE] with diagnoses which included unspecified dementia without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety (deterioration of memory, language, and other thinking abilities with behaviors), End Stage Renal Disease (Condition in which the kidneys lose the ability to remove waste and balance fluids), Benign Prostatic Hyperplasia (noncancerous enlargement of the prostate gland), and Type 2 Diabetes Mellitus (Chronic condition when your body cannot use insulin properly). Record review of Resident #4's Quarterly MDS Assessment on 07/24/24 revealed resident had a BIMS Summary Score of a 05 (severe impairment). Record review of Resident #4's care plan date initiated 02/21/24 indicated he had a risk for pain related to ESRD , Vascular wound, PVD, and right Below Knee amputation. The Physicians was to be notified if current complaint was a significant change from residents past experience of pain. Record review of Resident #4's physician orders started on 07/17/24 indicated Tylenol with Codeine #3 300-30 MG 1 tab every 8 hours for pain and Tylenol 325 mg 2 tabs every 4 hours as needed for pain. Record review of Resident #4's MAR dated 8/28/2024 revealed resident was administered his 8:00 AM Tylenol with Codeine #3 300- 30 MG 1 tab. Observation and interview with Resident #4 and RN A on 08/28/24 at 8:21 AM. revealed the resident awake and alert and complained of pain to penis. RN A was aware and stated the resident had received his scheduled medication. Record review of progress notes indicated that RN A reassessed resident complaint of pain and noted it was a 4 on the pain scale. He was administered Tylenol 325 mg 2 tabs every 4 hours as needed for pain. At 11:08 AM, the pain was listed as a 0 on the pain scale. (continued on next page)

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	676006	A. Building B. Wing	08/29/2024

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the ADON on 08/29/24 at 10:53 AM, who said she was not aware Resident #4 had complaint of pain. She said if the pain medication was not sufficient and the resident was not getting relief from the pain medication, or have a new pain concern the staff should notify the physician. She said if the resident was having penial pain, he should be referred to the Urologist and the pain management doctor. Interview on 08/29/24 at 4:15 p.m. the Administrator, said it was her expectation to see pain levels decrease once pain medication was administered. She said staff should follow the nursing protocol and notify the physician if the resident was not provided relief after administration. She said the risk of constant pain could cause adverse effects and decrease quality of life. Observation and interview Resident #4 and RN B on 08/29/24 at 4:25 PM who said his dick hurt. Nurse pulled brief back and there was a skin tear noted near the urethral opening of the penis. RN B moved penis to assess tear. Facial grimaces were noted from resident during the assessment. Resident verbalized he was in pain. Nurse B stated she was aware of the skin tear that had been there for weeks. RN B said she did not inform the doctor of the resident's penis pain because he was confused and his pain comes and goes. Review of the facility's policy Pain Management, not dated, read in part .The facility must ensure that pain management is provided to residents who require such services . Pain Management and Treatment: 7. i. Facility staff will notify the practitioner, if the resident's pain is not controlled by the current treatment regimen .

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	676006	A. Building B. Wing	08/29/2024

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. 40249 Based on observation, interview and record review, the facility failed to ensure that the daily staffing was posted and readily accessible for review for 1 of 1 facility reviewed for required postings. -The facility failed to post the daily nursing staffing information on 08/27/2024. This failure could affect residents, facility visitors, vendors and emergency personnel by placing them at risk of not having access to information regarding daily nursing staffing in a timely manner. Findings Included: Observation on 08/27/24 at 11:05a.m., during rounds revealed nursing staffing information was posted by the receptionist desk dated 08/20/2024. Observation on 08/28/24 at 9:05a.m., during rounds revealed nursing staffing information was posted by the receptionist desk dated 08/20/2024. Record review and interview on 08/28/24 at 1:12p.m., with the Activities director, she stated the receptionist was responsible for posting the daily nursing staff information. The Activities director stated Receptionist was on leave and the staff were taking turns answering phone. The Activities director stated, need to update. That one is from 8/20. In an interview on 08/28/24 at 3:43 p.m., with the Administrator, she stated the receptionist was responsible for the daily nursing staffing posting and the staffing coordinator helped. Both happen to leave last week. It falls on nursing. It was overlooked. She stated the ADON will update posting daily until further notice. She stated it was important to post the staffing information to know how many residents were in the facility. Staffing information for the potential visitors coming to the facility. In interview on 08/29/24 at 3:33 p.m., the DON stated the receptionist along with the staffing coordinator were responsible for the daily nursing posting. She stated after it was brought to their attention and it was decided nursing DON/ADON will be responsible to post daily nursing staffing. The DON stated the daily nursing staffing was supposed to be posted in the front of the facility each day. Record review of the facility's Nurse Staffing Posting Information policy (February 2023 Revision) read in part: .Policy: It is the policy of this facility to make nurse staffing information readily available in a readable format to residents and visitors at any given time. Policy Explanation and Compliance Guidelines: The Nurse Staffing Sheet will be posted on a daily basis and will contain the following information: (continued on next page)

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	676006	A. Building B. Wing	08/29/2024

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Facility name The current date Facility's current resident census The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: Registered Nurses Licensed Practical Nurses/Licensed Vocational Nurses Certified Nurse Aides The facility will post the Nurse Staffing Sheet at the beginning of each shift. The information posted will be: Presented in a clear and readable format. In a prominent place readily accessible to residents and visitors .

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	676006	A. Building B. Wing	08/29/2024

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40249 Based on interview and record review the facility failed to ensure there was a communication process, which included how the communication would be documented between the LTC facility and the hospice provider, to ensure that the needs of the resident were addressed and met 24 hours per day for 1 of 2 residents (Resident #36) reviewed for hospice services. -The facility failed to maintain required hospice forms and documentation to ensure Resident #36 received adequate end-of-life care. This failure could place the residents who receive hospice services at-risk of receiving inadequate end-of-life care. Findings included: Record review of the admission sheet (undated) for Resident #36 revealed a [AGE] year-old female who was admitted to the facility on [DATE] and readmitted on [DATE]. She had diagnoses which included dysphagia (swallowing difficulties) , cognitive communication deficit (reduced awareness and ability to initiate and effectively communicate needs) and encounter for palliative care (specialized medical care that focuses on providing relief from pain and other symptoms of a serious illness). Record review of Resident #36's Quarterly MDS, dated [DATE], revealed the BIMS score was 12 out of 15 indicated intact cognitively. She required supervision from staff for personal hygiene, toilet and transfer. Record review of Resident #36's physician order, dated 07/17/2024 read in part, .Patient is admitted to [hospice company name] under services of hospice Dr. [name] and facility services of Dr [name] . Record review of Resident #36's Care plan, initiated 08/06/2021 and revised on 07/25/2024, revealed the following: Focus: [Resident #36] is under hospice care and requires special attention for comfort and hospice care. Goal: The resident's comfort will be maintained through the review date. Interventions: Consult with physician and Social Services to have Hospice care for resident in the facility. Work cooperatively with hospice team to ensure the resident's spiritual, emotional, intellectual, physical and social needs are met. Record Review of Resident #36's medical file revealed there was no documentation of coordination of care or any communication with hospice company after 7/16/24. (continued on next page)

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	676006	A. Building B. Wing	08/29/2024

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview and record review with on 8/29/23 at 12: 37 p.m., with RN C she said she was the nurse for Resident #36. She said Resident #36 was receiving hospice services. RN C said hospice staff communicated with the facility by always logging in their binder when they were there. She said they told them verbally what they did, and they also documented in their binders. When asked when did the last time hospice came and what they did when they were there, she said, RN C stated I need to check the binder to see when hospice last came to see the resident. RN C reviewed the hospice binder for Resident #36 with the Surveyor. RN C said she could not find the documentation which stated what Hospice did while they were there. She checked the binder and said, there is RN initial assessment dated [DATE] but no weekly assessment. RN C said she did not know who was responsible for ensuring hospice was documenting in the binder. RN C said it was important for nursing to know the hospice's plan of care for the patient. In an interview and record review on 8/29/23 at 1:23 p.m., the DON reviewed Resident #36's hospice binder and said the hospice nurse came once a week and the hospice aides were supposed to come 3 times a week. The DON said, she would get with hospice company to see what the plan was and to request current notes for the binder. She said it was important to have the current hospice plan of care for the resident if there were any changes to keep the facility informed and for communication purpose. In an interview on 8/29/24 at 2:34p.m., the DON presented Surveyor Resident#36's skilled nursing visit documentations. DON stated medical records had access to hospice documentation. Medical records was responsible for printing hospice documentation and file in resident's hospice binder for nursing staff. In an interview on 8/29/24 at 3:55p.m., the Medical Records/HR, she said hospice company randomly sent documentation either by email or paper and her responsibility was to print the documents and upload them in PCC (electronic medical records) for nursing to review. Medical records/HR said she was not a nurse and did not review the hospice documents when received. Record review of facility's Hospice Services Facility Agreement (February 2023 Revision) read in part: . Policy: It is the policy of this facility to provide and/or arrange for hospice services in order to protect a resident's right to a dignified existence, self-determination, and communication with, and access to, persons and services inside and outside the facility. Policy Explanation and Compliance Guidelines: 6d. Obtaining the following information from the hospice: i. The most recent hospice plan of care specific to each resident ii. Hospice election form iii. Physician certification and recertification of the terminal illness specific to each resident iv. Names and contact information for hospice personnel involved in hospice care of each resident v. Instructions on how to access the hospice's 24-hour on-call system vi. Hospice medication information specific to each resident vii. Hospice physician and attending physician (if any) orders specific to each resident (continued on next page)

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	676006	A. Building B. Wing	08/29/2024

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Richmond Health Care Center	705 Jackson St Richmond, TX 77469

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	7. The facility will, under a written agreement, ensure that each resident's written plan of care includes both the most recent hospice plan of care and a description of the services furnished by the facility to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being .

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48863 Based on observations, interviews, and record review, the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infection for 1 of 6 residents (Resident #53) reviewed for infection control. The facility failed to ensure CNA A followed proper infection control and hand washing procedure during incontinent care for Resident #53. This failure could lead to cross-contamination and the development of infection. Findings included: Record review of a face sheet dated 08/29/24 indicated Resident #53 was an [AGE] year-old male admitted to the facility on [DATE] with diagnoses which included unspecified dementia without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety (deterioration of memory, language, and other thinking abilities with behaviors), cerebral infarction (damage to tissues in the brain due to a loss of oxygen to the area), and Benign Prostatic Hyperplasia (noncancerous enlargement of the prostate gland). Record review of Resident #53's Quarterly MDS Assessment on 06/13/24 revealed resident had a BIMS Summary Score of a 09 (moderate impairment). Record review of Resident #53's care plan date initiated 03/22/24 indicated he had an ADL self-care performance deficit and required 1 to 2 persons extensive to total assistance with toileting, bed mobility and transfers. Observation on 08/28/24 at 3:36 PM, revealed CNA A provided Resident #53 with incontinence care. CNA A did not perform hand hygiene prior to entering the resident's room, nor prior to donning clean gloves. CNA A provided peri care 3 times with wet wipes from [NAME]-wipe packet. She turned the resident over to his right side and cleaned moist, brown stool of resident's buttocks, retrieving wipes from the same multi-use packet without changing gloves. CNA A wiped buttocks 6 times until resident wet wipe was clean and free from discoloration. Soiled linen was removed and placed in bag. CNA did not doff gloves and attempted to apply clean lined with same soiled gloves. Surveyor intervened when staff attempted to retrieve new linen, gown, and brief. CNA A doffed soiled gloves without washing or sanitizing her hands and donned clean gloves. CNA A completed incontinent care and with the new gloves she touched the resident's clean gown, brief, and sheets. She completed her incontinent care and did not wash her hands after doffing gloves before leaving the room. Interview on 08/28/24 at 3:35 PM with CNA A who said she started working full time at the facility 4 years ago. She said she did not recall doing CNA competency checks for incontinent care but had an in-service last month regarding hand hygiene. CNA A said not performing hand hygiene while changing gloves could cause infection and cross-contamination. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676006	A. Building B. Wing	08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Richmond Health Care Center	705 Jackson St Richmond, TX 77469

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 08/29/24 at 12:40 PM, with the DON, she said she expected staff to make sure they provided complete and proper incontinent care each time they perform incontinent care. She said staff should wash/sanitize their hands upon entering a resident's room, in between glove changes, and before leaving the resident's room. She said these failures could result in cross-contamination. Interview on 08/28/24 at 3:32 PM the Administrator said she expected staff to wash/sanitize their hands before, during and after providing incontinent care to residents. She said the risk of not washing/sanitizing their hands was spreading infection and contaminating surface areas. Record review of facility's In-Service Program Attendance Record dated 8/22/2024 revealed Topic: Hand Hygiene was signed by CNA A. Record review of facility's Hand Hygiene Policy undated, read in part: .Policy: All staff will perform proper hand hygiene procedures to prevent the spread of infection to other personnel, residents, and visitors. 6. Additional considerations: a. The use of gloves does not replace hand hygiene. If your task requires gloves, perform hand hygiene prior to donning gloves, and immediately after removing gloves . Record review of facility's Standard Precautions Infection Control Policy not dated, read in part: .Policy: All staff are to assume that all residents are potentially infected or colonized with an organism that could be transmitted during the course of providing resident care services. Therefore, all staff shall adhere to Standard Precautions to prevent the spread of infection to residents, staff, and visitors. Explanation and Compliance Guidance: 1. Hand Hygiene: a. During delivery of resident care services, avoid unnecessary touching of surfaces in close proximity to the resident to prevent both contamination of clean hands from environmental surfaces and transmission of pathogens from contaminated hands to surfaces. b. Perform hand hygiene in accordance with the facility's Hand Hygiene Policy