STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675933	A. BUILDING _____ B. WING _____	**09/01/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
TREASURE HILLS HEALTHCARE AND REHABILITATION CENTE	**2204 PEASE ST HARLINGEN, TX 78550**

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 0656 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to develop and implement a comprehensive person-centered care plan for each resident that included measurable objectives and time frames to meet a resident's medical, nursing, and mental and psychosocial needs, for one Resident (R#1) of three residents reviewed for care plans, in that: The facility did not develop a care plan to address R#1's unplanned seven-pound weight loss in one month. This failure could place residents with unplanned weight loss at risk of not having their needs met. The findings included: Record review of R#1's electronic record revealed R#1 was [AGE] years-old and was admitted to facility on 05/01/16. R#1's [DIAGNOSES REDACTED]. R#1 had a physician's orders [REDACTED]. Record review of R#1's Comprehensive Care plan, last reviewed on 11/01/19, revealed R#1 had potential for nutritional problem due to Consistent Carbohydrate (CCD) diet, mechanical soft texture, and thin liquids consistency. Record review of R#1's of medical record revealed: Weekly weight x 4 and then monthly if stable; initiated 02/14/20. There were no electronic nursing notes addressing R#1 weight loss. Record review of R#1's Monthly Weight Report revealed: -05/01/20: 102 pounds -06/01/20: 102 pounds -07/01/20: 100 pounds -08/01/20: 93 pounds Record review of R#1's Nutrition/Hydration Risk Assessment, dated 08/07/20, revealed: -category: high risk -level of consciousness; lethargic, -self feeding ability; fed by staff or tube feed -weight status: stable within 3 months -food intake: good-eats 50% to 75% of most meals, -fluid intake: 2.500-100 cc daily -snacks/supplements; takes most of the time -food preferences; few food dislikes. Record review of R#1's Annual Minimum Data Set (MDS) assessment, dated 08/20/20, revealed R#1 required extensive assistance from staff for eating and had no weight loss. Record review of R#1's comprehensive care plan revealed there was no focus, goal or interventions for his weight loss. Record review of R#1's progress notes, dated 08/21/20 revealed R#1 was transferred to the hospital on [DATE], as per family request. Record review of R#1's progress notes, dated 08/21/20, revealed: Patient not eating and difficulty to arouse. Call placed to RP to inform of patient status. RP revoked DNR and requesting patient to be transferred to ER for evaluation. She stated do everything you can for my (R#1). In an interview on 08/27/20 at 8:47 a.m., R#1's FM A said R#1 was transferred to the hospital on [DATE] and was still in the hospital. R#1's FM A said she was told at the hospital that R#1 was dehydrated. FM A said R#1's family was not told that R#1 had lost weight. In an interview on 08/27/20 at 3:26 p.m., the DON said the nurse who was in charge of keeping track of residents' weights no longer worked at the facility. The DON said she (DON) had been working the floor and had not been checking residents' weights. The DON said the Dietary Manager was helping with keeping track of weights. The DON said the Dietary Manager reviewed weights and if a resident triggered for weight loss, they were to be placed on weekly weights and their care plan needed to be modified to address weight loss. In an interview on 08/27/20 at 3:44 p.m., the Dietary Manager said she monitored weights and residents who triggered for weight loss were supposed to be placed on weekly weights. The Dietary Manager said it was considered a significant weight loss when a resident lost 5% or more in a month. She said after a weight loss was noticed, she was to inform the DON and the Dietician. In an interview on 08/28/20 at 1:28 p.m., the Dietary Manager said she had talked to the Dietitian about R#1's weight loss so the Dietitian could provide recommendations, however that was when R#1 went to the hospital. The Dietary Manager said she also informed the DON about R#1's weight loss, but did not have electronic documentation about it, only paper notes. In an interview on 08/28/20 at 2:24 p.m., the DON said the Dietary Manager had reported R#1's weight and the Dietitian was informed. The DON said the Speech Therapist initiated therapy due to poor appetite. In an interview on 08/28/20 at 3:10 p.m., the DON said they were going to inform the Dietitian but R#1 was diagnosed with [REDACTED]. The DON said she could not say why R#1 was losing weight because, according to documentation, he was eating between 75% to 100% of his meals. The DON said R#1's Physician was informed and only ordered speech therapy. The DON said R#1 was eating well, so she could not tell if his weight loss was avoidable or unavoidable. In an interview on 08/28/20 at 4:49 p.m., LVN/MDS B said the Dietary Manager was the staff member who updated weight loss in the care plans. LVN/MDS B said R#1's care plan should have been updated to address his 5% weight loss between July and August of 2020. In an interview on 08/31/20 at 1:40 p.m., CNA C said R#1 required total assistance for eating. CNA C said that, on previous days, before R#1 was transferred to hospital, he did not want to eat. She said she offered a shake, but he was also refusing that. She said R#1 required total assistance for eating and used to eat well. In an interview 08/31/20 at 2:15 p.m., the DON said, to her understanding, the Dietitian had not reviewed R#1's weights and had not made recommendations. The DON said R#1's physician only recommended speech therapy. The DON said R#1 was eating his meals. In an interview on 08/31/20 at 4:44 p.m., the Dietitian said, if she remembered correctly, she had made recommendations for R#1, including health shakes, snacks, and to do a new food preference assessment. In an interview on 08/31/20 at 4:50 p.m., the Dietary Manager said the Dietitian had recommended house shakes for R#1 but, since shakes were for all residents, instructions were not included on R#1's meal ticket to place shakes on R#1's meal tray. The Dietary Manager said she told the DON about the Dietitian's recommendations but a nurse had to call the physician to approve the recommendations, and she (Dietary Manager) never got a response back. The Dietary Manager said the Dietitian had sent an email with handwritten recommendations. Record review of a Dietitian consult follow up, dated 08/03/20, revealed there were recommendations, but the handwritten note did not contain a resident's name or any other type of identification indicating which resident was the recommendations were for. In an interview on 09/01/20 at 9:20 a.m., the Dietary Manager said she had not added R#1's weight loss on R#1's care plan. She said the care plan nurses were also able to add weight loss in the care plans. In an interview on 09/01/20 at 9:50 a.m., the Dietary Manager said the email that the Dietitian sent to her with a follow up consult did not indicate a resident's name, only a date. The Dietary Manager said the CNAs would ask for a meal shake if R#1 had not eaten his meals. The Dietary Manager said the Dietitian's recommendations were only recommendations, not orders from a doctor. The Dietary Manager said R#1's meal tray did not include a shake. Record review of the facility's policy on, Care Planning, revised 05/2007 revealed: Policy: It is the policy of this facility that the interdisciplinary team (IDT) shall develop a comprehensive care plan for each resident.
F 0689 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that each resident received adequate supervision and assistance devices to prevent accidents, for one Resident (R#2) of four residents reviewed for supervision. The facility did not provide adequate supervision and assistance devices to prevent R#2 from falling nine times in four months. This failure could place residents at risk for falls and injury. The findings were: Record review of R#2's

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

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.

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TREASURE HILLS HEALTHCARE AND REHABILITATION CENTE	2204 PEASE ST HARLINGEN, TX 78550

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F 0689 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 1) electronic record revealed R#2 was a [AGE] year-old female who was admitted to the facility on [DATE]. R#2's [DIAGNOSES REDACTED]. Record review of R#2's Quarterly MDS assessment, dated 06/15/20, revealed R#2: -had severely impaired cognition, -required limited assistance from staff for bed mobility, transfers, walking in room, and toilet use, -used a walker or wheelchair for mobility, and -had one fall, with no injury. Record review of R#2's care plans revealed: -Date initiated 04/13/20 - Resident is at risk for falls due to ambulating without a walker. -Date initiated 06/15/20 - Resident has had an actual fall on 06/14/20 with no injury due to spilling water on floor and slipped. -Date initiated 06/20/20 - Resident has had an actual fall with no injury due to attempting to go the the restroom without assistance. -Date initiated 06/21/20 - Resident has had an actual fall with possible major injury due to weakness, forgetful, attempting to get out of bed without assistance, no use of call light. C/O pain to left wrist and hand. Noted to be red and slightly swollen. Resident was offered pain medication and refused. -Date initiated 06/22/20 - X-ray results show left wrist fracture, 06/23/20 increased weakness. -Date initiated 06/24/20 - Resident has had an actual fall due to ambulating without assistance, increased weakness. -Date initiated 08/18/20 - Resident became upset and was opening dresser when pulled drawer and resident went back, this nurse assisted resident to sitting on floor resident sat on bottom, not hit head. -Resident had an actual fall with no injury due to poor communication/comprehension. -Date initiated 08/21/20 - Resident has had an actual fall due to slipping off bed. at risk for falls due to gait/balance problems dementia. She was noted to be on the floor laying to her right side of her body. Resident denies hitting her head. Resident with no changes to LOC. Denied any pain. Resident assisted back to bed. Record review of facility's incident/accidents for R#2 revealed: 06/14/20 fall, unwitnessed, resident room, no treatment 06/20/10; fall, unwitnessed, resident room, fracture to the left ulnar styloid process. 07/19/20: fall, unwitnessed, hallway, no treatment 07/21/20: fall unwitnessed, skin tear 07/28/20: fall, witnessed, no treatment. 08/18.20; fall, assisted, resident room, no treatment, witnessed 08/19/20: fall, unwitnessed, hallway, no treatment 08/21/20: fall, unwitnessed, resident room, no treatment. 08/27/20: fall self-transfer, residents room, no treatment, unwitnessed. 08/28/20: fall, self-transfer, resident room, no treatment, unwitnessed. 08/30/20; fall, self-transfer, resident room, no treatment, unwitnessed. In an interview/observation via Face Time (video chat service) on 08/31/20 at 10:20 a.m., R#2 said she had a fall but could not remember how she fell . R#2 was sitting in a wheelchair. R#2's bed had floor mats on both sides. In an interview 08/31/20 at 10:30 a.m., LVN D said R#2 was oriented to self, required limited assistance for activities of daily living and did not use the call light to ask for assistance. He said R#2 was under close supervision, had floor mats, and had a low bed. LVN D said R#1 liked to clean trash cans and would walk to the med carts and attempt to empty trash bags. LVN D said R#1 sometimes would go 12 hours with hardly any rest. LVN D said R#2 was not aware of safety precautions. In an interview on 08/31/20 at 10:45 a.m., CNA E said R#2 required limited assistance, rarely used the call light, and would not remember to ask for assistance for self-transfer or other activities. CNA E said R#2 was ambulatory and used a walker. CNA E said R#2 had falls when she attempted to self-transfer or when she walked. CNA E said R#2 had interventions to prevent falls, like a low bed, floor mats, and frequent supervision. In an interview on 08/31/20 at 2:44 p.m., the DON said R#2 was very anxious and combative, and had an unsteady gait, especially when she got upset. The DON said R#2 was asked to join activities and they tried to keep R#2 close to the nurses' station. The DON said R#2 had been moved to a room closer to the nurses' station. The DON said they had adjusted R#2's medications but R#2 was forgetful and not aware of her safety. The DON said R#2 got especially upset when she did not have contact with her family. Record review of the facility's undated policy on fall prevention revealed: It is the policy of this facility to investigate the circumstances surrounding each resident fall and implement actions to reduce the incidence of additional falls and minimize potential for injury.
F 0692 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide enough food/fluids to maintain a resident's health.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure a resident maintained acceptable parameters of nutritional status, for one Resident (R#1) of three residents reviewed for weight loss. R#1 had an unplanned seven-pound weight loss in one month. The facility did not develop and implement effective interventions to address R#1's significant weight loss. This failure could place residents with unplanned weight loss at risk of not having their nutritional needs addressed. The findings included: Record review of R#1's electronic record revealed R#1 was [AGE] years-old and was admitted to facility on 05/01/16. R#1's [DIAGNOSES REDACTED]. R#1 had a physician's orders [REDACTED]. Record review of R#1's Comprehensive Care plan, last reviewed on 11/01/19, revealed R#1 had potential for nutritional problem due to Consistent Carbohydrate (CCD) diet, mechanical soft texture, and thin liquids consistency. Record review of R#1's of medical record revealed: Weekly weight x 4 and then monthly if stable; initiated 02/14/20. There were no electronic nursing notes addressing R#1 weight loss. Record review of R#1's Monthly Weight Report revealed: -05/01/20: 102 pounds -06/01/20: 102 pounds -07/01/20: 100 pounds -08/01/20: 93 pounds Record review of R#1's Nutrition/Hydration Risk Assessment, dated 08/07/20, revealed: -category: high risk -level of consciousness; lethargic, -self feeding ability; fed by staff or tube feed -weight status: stable within 3 months -food intake: good-eats 50% to 75% of most meals, -fluid intake: 2.500-100 cc daily -snacks/supplements; takes most of the time -food preferences; few food dislikes. Record review of R#1's Annual Minimum Data Set (MDS) assessment, dated 08/20/20, revealed R#1 required extensive assistance from staff for eating and had no weight loss. Record review of R#1's comprehensive care plan revealed there was no focus, goal or interventions for his weight loss. Record review of R#1's progress notes, dated 08/21/20 revealed R#1 was transferred to the hospital on [DATE], as per family request. Record review of R#1's progress notes, dated 08/21/20, revealed: Patient not eating and difficulty to arouse. Call placed to RP to inform of patient status. RP revoked DNR and requesting patient to be transferred to ER for evaluation. She stated do everything you can for my (R#1). In an interview on 08/27/20 at 8:47 a.m., R#1's FM A said R#1 was transferred to the hospital on [DATE] and was still in the hospital. R#1's FM A said she was told at the hospital that R#1 was dehydrated. FM A said R#1's family was not told that R#1 had lost weight. In an interview on 08/27/20 at 3:26 p.m., the DON said the nurse who was in charge of keeping track of residents' weights no longer worked at the facility. The DON said she (DON) had been working the floor and had not been checking residents' weights. The DON said the Dietary Manager was helping with keeping track of weights. The DON said the Dietary Manager reviewed weights and if a resident triggered for weight loss, they were to be placed on weekly weights and their care plan needed to be modified to address weight loss. In an interview on 08/27/20 at 3:44 p.m., the Dietary Manager said she monitored weights and residents who triggered for weight loss were supposed to be placed on weekly weights. The Dietary Manager said it was considered a significant weight loss when a resident lost 5% or more in a month. She said after a weight loss was noticed, she was to inform the DON and the Dietician. In an interview on 08/28/20 at 1:28 p.m., the Dietary Manager said she had talked to the Dietitian about R#1's weight loss so the Dietitian could provide recommendations, however that was when R#1 went to the hospital. The Dietary Manager said she also informed the DON about R#1's weight loss, but did not have electronic documentation about it, only paper notes. In an interview on 08/28/20 at 2:24 p.m., the DON said the Dietary Manager had reported R#1's weight and the Dietitian was informed. The DON said the Speech Therapist initiated therapy due to poor appetite. In an interview on 08/28/20 at 3:10 p.m., the DON said they were going to inform the Dietitian but R#1 was diagnosed with [REDACTED]. The DON said she could not say why R#1 was losing weight because, according to documentation, he was eating between 75% to 100% of his meals. The DON said R#1's Physician was informed and only ordered speech therapy. The DON said R#1 was eating well, so she could not tell if his weight loss was avoidable or unavoidable. In an interview on 08/28/20 at 4:49 p.m., LVN/MDS B said the Dietary Manager was the staff member who updated weight loss in the care plans. LVN/MDS B said R#1's care plan should have been updated to address his 5% weight loss between July and August of 2020. In an interview on 08/31/20 at 1:40 p.m., CNA C said R#1 required total assistance for eating. CNA C said that, on previous days, before R#1 was transferred to hospital, he did not want to eat. She said she offered a shake, but he was also refusing that. She said R#1 required total assistance for eating and used to eat well. In an interview 08/31/20 at 2:15 p.m., the DON said, to her understanding, the Dietitian had not reviewed R#1's weights and had not made recommendations. The DON said R#1's physician only recommended speech therapy. The DON said R#1 was eating his meals. In an interview on 08/31/20 at 4:44 p.m., the Dietitian said, if she remembered correctly, she had made recommendations for R#1, including health shakes, snacks, and to do a new food preference assessment. In an interview on 08/31/20 at 4:50 p.m., the Dietary Manager said the Dietitian had recommended house shakes for R#1 but, since shakes were for all residents, instructions were not included on R#1's meal ticket to place shakes on R#1's meal tray. The Dietary Manager said she told the DON about the Dietitian's recommendations but a nurse had to call the physician to approve the recommendations, and she (Dietary Manager) never got a response back. The Dietary Manager said the Dietitian had sent an email with handwritten recommendations. Record review of a Dietitian consult follow up, dated 08/03/20, revealed there were recommendations, but the handwritten

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F 0692 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 2) note did not contain a resident's name or any other type of identification indicating which resident was the recommendations were for. In an interview on 09/01/20 at 9:20 a.m., the Dietary Manager said she had not added R#1's weight loss on R#1's care plan. She said the care plan nurses were also able to add weight loss in the care plans. In an interview on 09/01/20 at 9:50 a.m., the Dietary Manager said the email that the Dietitian sent to her with a follow up consult did not indicate a resident's name, only a date. The Dietary Manager said the CNAs would ask for a meal shake if R#1 had not eaten his meals. The Dietary Manager said the Dietitian's recommendations were only recommendations, not orders from a doctor. The Dietary Manager said R#1's meal tray did not include a shake. Record review of the facility's undated, Policy for Nutrition, revealed: Is the policy of this facility to ensure that all resident maintain acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical conation demonstrates that this is not possible. Purpose: to provide care and services including: -assessing the resident's nutritional status and the factors that put the resident at risk of not maintaining acceptable parameters of nutritional status. -Defining and implementing interventions for maintaining or improving nutritional status that are consistent with resident needs, goals, and recognized standards of practice, or explaining adequately in the medical record why the facility could not or should not do so; and Monitoring and evaluating the resident's response or lack of response to the interventions; and revising or discontinuing the approaches as appropriate, or justify the continuation of current approaches. -weight loss: significant weight loss (5% in (1) month. Facility approaches to address weight loss may include an ongoing search for the cause(s) or weight loss, unless the facility determined that the cause is known or the search for the cause has been exhausted of should be limited. Documentation reflects the reason why the search for the cause (s) was limited of discontinued. Once the cause(s) is/are identified relevant care plan decision are made and documented. Ongoing interventions are evaluated and modified as needed.