STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675210	A. BUILDING _____ B. WING _____	03/11/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
HERITAGE HOUSE NURSING AND REHABILITATION	407 N COLLEGE ST ROSEBUD, TX 76570

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

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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** Based on interview and record review, the facility failed to notify the resident and the resident's representative of a transfer/discharge and the reason for the transfer, in writing, for two of two residents (Resident #44 and Resident #46) reviewed for discharge. 1. Resident #44 and their responsible party were not provided a transfer notice when there was a facility-initiated transfer to the hospital. 2. Resident #46 and their responsible party were not provided a discharge notice. This failure could place residents at risk of not having access to available advocacy services, discharge/transfer options, and the appeal process. Findings include: 1. Review of Resident #44's face sheet reflected a [AGE] year old male resident was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of Resident #44's care plan, dated 12/15/2019, reflected Resident #44 was at risk for falls, potential fluid deficit, and uncontrollable pain. Review of Resident #44's nursing progress notes did not reflect an order was received to send Resident #44 to the hospital. Review of Resident #44's medical record did not reflect the resident, or the family member were notified in writing of the transfer to the hospital. Review of Resident #44's discharge summary reflected he was discharged on [DATE] to the emergency room related to unrelieved chest pain. 2. Review of Resident #46's face sheet reflected a [AGE] year-old female admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of Resident #46's MDS, dated [DATE] reflected resident received a 15 on the BIMS assessment. A score of 15 reflects resident was cognitively intact. Review of Resident #46's care plan, revision date of 09/06/2019 reflected, Resident #46 has impaired thought processes due to long history of [MEDICAL CONDITION] disorder, OCD, impaired decision-making [MEDICAL CONDITION] drug use. Discharge from the facility is not feasible as evidenced by her inability to manage her health and mental condition. Resident will be provided an opportunity to receive information on returning to community unless the resident has chosen not to be asked this. Review of Resident #46's progress notes from 08/29/2019 through 12/18/2019 did not reflect any documentation of discharge goals or plans. Review of Resident #46's medical record did not reflect the resident, or the family member were notified in writing of the resident-initiated discharge. Review of Resident #46's discharge summary dated 12/20/2019 reflected Resident #46 had history of delusional behavior related to dx of [MEDICAL CONDITION] and obsessive-compulsive disorder; ambulatory w ith no aide of walker or wheelchair; continent of bladder and bowel and to continue medications and treatments as ordered. The discharge summary did not reflect where the resident was discharged to. In an interview on 03/11/2020 at 12:20 P.M. SW stated nursing contacts family when a resident is transferred to the hospital. She stated when a resident is discharged home she thinks nursing contacts the family and she has never sent out anything in writing. In an interview on 03/11/2020 at 1:17 P.M. LVN E stated during a facility emergency transfer, EMS is called along with the physician and the family and we provide them with information of where they are being sent. She stated they do not notify in writing, this is something she never has done. In an interview on 03/11/2020 at 3:32 P.M. DON stated family is notified of a hospital discharge and I did not realize discharge letters needed to be sent out for a transfer and a discharge to residents, responsible party, and the ombudsman. Record Review of facility undated Admission Packet Statement of Resident Rights on page 5 reflected the following: --Receive a thirty-day written notice sent to you, your legally authorized representative, or a family member. --Appeal the discharge within 10 days of receiving notice in a Medicaid facility. Record Review of undated facility policy titled Discharge or Transfer to another facility reflected the following information: --When a resident is temporarily transferred on an emergency basis to an acute care facility, this type of transfer is considered to be a facility-initiated transfer and a notice of transfer will be provided to the resident and resident representative as soon as practicable. Copies of notices for emergency transfers will also still be sent to the ombudsman, but they may be sent went practicable, such as a list on a monthly basis. In situations where the facility has decided to discharge the resident while the resident is still hospitalized , the facility will send out a notice of discharge to the resident and resident representative, and will also send a copy of the discharge notice to a representative of the Office of the State LTC Ombudsman. Notification of Discharges: For a facility-initiated transfer or discharge of a resident, the facility will notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. Additionally, the facility will send a copy of the notice of transfer or discharge to the representative of the Office of the State Long-Term (LTC) Ombudsman.
F 0660 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Plan the resident's discharge to meet the resident's goals and needs.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to develop and implement an effective discharge care plan for 1 of 2 (Resident #46) of 1 resident reviewed for discharge. Resident #46 was discharged homme without an effective discharge care plan. This failure could place residents at risk of not having their discharge goals and needs identified, planned for, and met. Findings included: Review of Resident #46's face sheet reflected a [AGE] year-old female admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of Resident #46's MDS, dated [DATE] reflected resident received a 15 on the BIMS assessment. A score of 15 reflects resident was cognitively intact. Review of Resident #46's care plan, revision date of 09/06/2019 reflected, Resident #46 has impaired thought processes due to long history of [MEDICAL CONDITION] disorder, OCD, impaired decision-making [MEDICAL CONDITION] drug use. Discharge from the facility is not feasible as evidenced by her inability to manage her health and mental condition. Resident will be provided an opportunity to receive information on returning to community unless the resident has chosen not to be asked this. Review of Resident #46's nursing progress notes from 08/29/2019 through 12/18/2019 did not reflect any documentation of discharge goals or plans. Review of Resident #46's discharge summary dated 12/20/2019 reflected Resident #46 had history of delusional behavior related to dx of [MEDICAL CONDITION] and obsessive-compulsive disorder; ambulatory with no aide of walker or wheelchair; continent of bladder and bowel and to continue medications and treatments as ordered. The discharge summary did not reflect where the resident was discharged to. In an interview on 03/11/2020 at 12:20 P.M. SW stated when a resident is discharged home she thinks nursing contacts the family and she has never sent out anything in writing for an IDT discharge care planning meeting. She stated nursing handles the discharge planning meetings and she sets up Home Health Services. In an interview on 03/11/2020 at 1:30 P.M. ADON stated she may do a discharge but it depends where she is at that point. She stated sometimes she will do a discharge summary & discuss the list with them. She stated they do not hold IDT planning meetings that she is aware of and that the nurse should teach them. She stated she has no records of discharge IDT meetings and the SW sets up Home Health care. In an interview on 03/11/2020 at 3:27 P.M. DON stated they talk about discharges in morning meetings. She stated she doesn't know who holds the IDT discharge meetings. Record review of undated Comprehensive Care Plan reflects the following: The facility will develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights that include measurable objectives and timeframes to meet

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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F 0660 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) a resident's medical, nursing, and mental psychosocial needs that are identified in the comprehensive assessment. The comprehensive assessment care plan will describe the following- -The resident's preference and potential for future discharge. The facility document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or appropriate entities, for that purpose. -Discharge plans in the comprehensive care plan, as appropriate. Interdisciplinary means that professional disciplines, as appropriate, will work together to provide the greatest benefit to the resident.
F 0759 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Ensure medication error rates are not 5 percent or greater.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure a medication error rate of less than 5 percent. There were 2 errors out of 35 opportunities which resulted in a 5.71 percent error rate involving Resident # 43. CMA D did not administer Resident #43's [MEDICATION NAME] and [MEDICATION NAME] per physician orders. This deficient practice could place Residents receiving medication at risk of not receiving the desire therapeutic effect. Findings include Review of Resident #43's face sheet revealed a [AGE] year-old female DOB 5/19/1969 with admission date of [DATE]. [DIAGNOSES REDACTED].#43's minimum data set (MDS) assessment dated [DATE] revealed a brief interview for mental status (BIMS) score of 8 indicating moderate cognitive impairment. Review of Resident #43's Care Plan dated 2/15/2019 revealed Resident #43 receives antipsychotic medication due to [DIAGNOSES REDACTED]. During medication administration observation on 03/10/20 09:08 am, the following was observed: CMA D administered the following medications to Resident #43 with a total of 11 pills and an eye drop. - [MEDICATION NAME] 125 cap 1 - [MEDICATION NAME] ([MEDICATION NAME]) 2mg 1 PO BID - [MED] 60mg 1 PO - [MEDICATION NAME] 5mg 1 PO - [MEDICATION NAME] 0.5mg 1 PO BID - Aspirin 81mg 1 PO - Fish oil 1000 mg 1 PO - Calcium + D3 600mg 10mcg (400 iu) - Multivitamin daily 1 - Vitamin D3 400 iu - Sodium [MEDICATION NAME] 10 gr (650mg) tab - Artificial Tears Review of Resident #43's consolidated physician order [REDACTED]. (may give two 125mg capsules to equal 250mg) order dated 02/20/2020 - [MEDICATION NAME] 1mg by mouth one time a day related to [MEDICAL CONDITION], order dated 0[DATE]20 In an interview on 03/10/20 at 01:04 pm, CMA D stated she has always given Resident #43 [MEDICATION NAME] 2mg in the mornings and [MEDICATION NAME] 125mg. She later stated both orders don't match the medications that are available. She also stated it is a medication error. In an interview on 03/10/20 at 03:14pm the DON stated Resident # 43, there is a cart of 1 mg and it ran out. She also stated it is considered a medication error if the wrong dosage was given. She then stated she notified the medical doctor of the medication along with Resident #43's daughter. She later stated CMA D was supposed to read the orders and compare it with the medications available. She ended by saying she was not told about the [MEDICATION NAME], she was only told about the [MEDICATION NAME]. Review of the facility's policy titled Medication Administration Procedures revised 10/25/2017 reflected: All current medications and dosage schedules are to be listed on the resident's current medication administration records. The five rights of medication should always be adhered to - Right drug - Right dose - Right resident - Right time - Right route
F 0806 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure each resident received food that accommodates residentnand preferences for one of five residents (Resident # 31) reviewed for food and preferences, in that; The facility failed to honor Resident #31's with food preferences. This failure could place residents who receive meals at risk of frustration, not enjoying meals, weight loss, and diminished quality of life. Findings include: Review of the Face Sheet for Resident # 31 reflected a [AGE] year-old male admitted on [DATE] with [DIAGNOSES REDACTED]. Review of the initial care plan for Resident #31 dated 08/26/19 reflected Resident has a diet order other than Regular and is at risk for unplanned weight loss or gain. Mostly vegetarian but will eat certain types of meat. No Pork. Review of the MDS for Resident #31 dated on 02/05/2020, reflected a BIMS 08 indicating moderate impairment. Review of Resident #31 physician diet orders dated 08/12/19 reflected no pork products. Observation on 03/09/20 at 12:03 PM revealed meals served to Resident #31 contained fried pork chops. Observation on 03/09/2020 at 12:10 P.M. revealed Resident #31 waving at staff to come look at his tray. ADON observed Resident's meal ticket with his lunch meal and removed the meal. The ADON provided an alternative meal of chicken for Resident #31. Observation on 03/09/2020 at 12:45 P.M. revealed Resident #31 approached State surveyor and provided his meal ticket which read substitution needed for the entre. Resident #31 dislikes read: pork and pork products. In an interview on 03/09/2020 at 2:02 P.M. Resident #31 stated he doesn't know why he is being served pork all the time because his culture eats different. He stated they know he does not eat pork and yet he is still being served pork and he sends it back. He stated it does not make him feel good because he has been here for six months and he has to look at his food to see if he can eat it. In an interview on 03/11/2020 at 1:57 PM the Dietary Cook stated meal tickets are printed by the Dietary Manager with Resident's meal preferences, allergies [REDACTED]. She stated she does not put any dislikes or allergies [REDACTED]. She also stated, the reason she does not put it on the tray is because they may just not prefer it, or they could have an allergic reaction which could be serious. She stated she compares the meal tickets and trays as she prepares the plates of food. In an interview on 03/11/20 2:05 PM the Dietary Manager stated he gets food preferences, allergies [REDACTED]. He stated he always puts the dietary meal ticket on the tray cart because it helps the dietary cooks prepare the residents meals according to their preferences. He stated if a resident does not like something it is enough reason not to put it on the plate. He stated his expectations are to have the cooks read the ticket and if changes need to be made he will make those changes. He stated the dietary cook did not read Resident #31's meal ticket and he was given pork, he was served chicken immediately. In an interview on 03/11/2020 at 2:23 P.M. LVN E stated when she helps with dining she tries to look at the ticket to make sure it matches the food on the tray. She stated when residents get admitted they fill out the dietary slip and give it to the kitchen. She stated Resident #31 was not supposed to get pork on his tray, there was no excuse for it. She ended by saying, if he would have eaten it, there would have been a problem. In an interview on 03/11/2020 at 02:29 P.M. the ADON stated she was helping pass trays out during lunch on Monday and checking the trays. She stated, she checks the trays and looks for their likes and dislikes. She stated she looked at Resident #31's tray and there was a pork chop that he should not have been served because it reads on his dietary meal ticket he does not like pork. Review of the facility Admission Packet, Page 24, under Food and Nutrition Services reflect the dietary manger will visit within your first 1-2 days in the facility to obtain food preferences, breakfast selections, and discuss other aspects of our meal service program. Policy Review of Nursing Responsibilities at Meal Service dated 2012 reflected Nursing Services will cooperate with the Dietary Department to ensure that each resident is served according to regulations.
F 0812 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.** Based on observations, interviews, and record reviews, the facility failed to serve food in accordance with professional standards for food service safety from the facility for 1 of 1 dining room: Multiple staff members were observed touching with food items, dinnerware, and utensils with their bare hands without performing hand hygiene. These deficient practices could place residents that receive meals at risk for food borne illnesses. The findings include: Dining Observation on 03/09/2020 at 11:53 AM to 03/09/2020 at 12:43 PM CNA A touched resident's fried pie with bare hands and did not perform hand hygiene. CNA B touched the rim of cup the residents cup and touched her pants and started feeding resident without performing hand hygiene. CNA A touched the rim of resident's cup to give resident a drink without performing hand hygiene. CNA A Alternating between residents feeding them without washing or sanitizing. COTA helped another resident with feeding and did not sanitize between residents and arm touched residents roll. CNA B -touched the rim of resident's cup with finger while serving to resident performing hand hygiene. Dining Observation on 03/11/2020 at 12:23PM to 03/11/2020 at 12:27PM CNA B Scratched side of her face and did not perform hand hygiene. CNA B touched top of resident's cup with her finger. CNA A touched the inside of resident's plate when moving plate closer to the resident. In an interview on 03/11/2020 at 11:06 AM CNA A stated she was aware that she touched the rim of the cup with her fingers on Monday 03/09/2020. She also stated is aware she touched the inside of the plate with her finger touching the greens when she moved the plate. She stated that

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F 0812 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 2) this process is not the correct process for serving food and hand hygiene and that she was aware of the correct process for serving food and hand hygiene. In an interview on 03/11/20 03:16, the DON stated staff are supposed utilize the hand sanitizer on the walls and or have it available with them. She also stated, when feeding residents staff should feed one resident with left hand and other resident with right hand. She later stated the reason for hand hygiene is for infection control. Review of the facility policy on Dietary Services Policy & Procedures Manual 2012 HR00-2.0 Section Sanitation and Food Handling reflected: --Washing your hands (with soap and hot water) before starting work, --after coughing or sneezing, --handling garbage, -- picking up an article from the floor, --after handling soaps or detergents, -- after using the toilet, --after smoking, and after all breaks. Touching something that is not clean and them handling food can cause food poisoning