STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676424	A. BUILDING _____ B. WING _____	03/06/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
FARMERSVILLE HEALTH AND REHABILITATION	205 BEECH ST FARMERSVILLE, TX 75442

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 0684 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate treatment and care according to orders, resident's preferences and goals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure a resident received treatment and care in accordance with professional standards of practice and the comprehensie person-centered care plan for one (Resident #39) of two residents reviewed for quality of care. The facility failed to ensure Resident #39's Jackson-Pratt (JP) drain care was performed according to physician orders [REDACTED]. The failure placed residents at risk for complications such as infections [MEDICAL CONDITION]. Findings included: Review of Resident #39's MDS assessment dated [DATE] revealed the resident admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The resident had severe cognitive impairment and required extensive to total assistance from staff with his activities of daily living. Review of Resident #39's care plan initiated on 02/06/20 and revised on 02/20/20 revealed Resident #39 was assessed on 02/06/20 as being at risk for infection related to his Jackson-Pratt drain. The resident's Jackson-Pratt drain required monitoring for signs of infection, monitoring of fluid extracted from drain, and allowance of the device to drain per orders/protocol. Review of Resident #39's physician orders [REDACTED]. Observation conducted on 03/04/20 at 10:29 AM revealed Resident #39 lying in his bed. The resident's JP drain not compressed, and there was greenish-brown fluid was in the bulb. Observation conducted on 03/05/20 at 10:40 AM revealed Resident #39 lying in his bed. The resident's JP drain not compressed, and there was greenish-brown fluid was in the bulb. Observation conducted on 03/06/20 at 11:30 AM reveled Resident #39 lying in his bed. The resident's JP drain not compressed, and there was greenish-brown fluid was in the bulb. Interview with the DON on 03/05/19 at 1:30 PM revealed she had not gone in to assess the JP drain since Resident #39 had returned to the facility on [DATE]. She said she did not have any reason to go down and see the JP drain since he was not currently having an issue with it. She said she did not regularly conduct any assessments of facility residents with drains or tubes as part of her monitoring. She said the Wound Nurse would look at it, empty it, and advise her of any issues. She said she was not aware there was no regular documentation of Resident #39's JP drain. She stated she had no idea what the JP drain looked like on 03/05/19. Observation of Resident #39's JP drain with the DON on 03/05/20 at 1:45 PM revealed the drain was not compressed and there was green liquid in the bulb and tubing. The DON said the staff just looked at the markings on the bulb, which she thought started at 25 ccs. She stated they emptied the contents into a cup and were supposed to document about how much the drainage there was. When asked how they ensured the amount documented was correct, the DON said they just guessed on the amount based on about how much it appears to be. Interview with the Wound Care Nurse on 03/06/20 at 11:00 AM revealed she normally did not empty the JP drain, but if she did she would uncap it, empty the contents into a cup and dispose of it. She said this morning (03/06/20) the DON told them to measure the contents with a syringe for an accurate measurement. Interview with the Administrator on 03/06/20 at 12:30 PM revealed it was her expectation that the facility nursing staff follow physician orders [REDACTED]. She said she was not aware of any lack documentation for Resident #39's JP drain. She said the DON should not have to go and assess each resident with a drain unless there was an issue with it, regardless of whether or not the resident was a new admission or a re-admission. Interview with Resident #39's Attending Physician conducted via telephone on 03/05/20 at 2:06 PM revealed she expected the facility staff to empty the JP drain every shift and accurately measure the contents. She said the goal was to monitor the drainage of the site until the output was about 1 cc per hour so the drain could be pulled, and Resident #39 could be considered for removal of his gallbladder. She said she was not aware the facility was not obtaining accurate measurements, and it was her expectation to have accurate data so that she could make informed decisions about Resident #39's care. Review of physician orders [REDACTED]. The facility was asked to provide the faciity's policy and procedure for the care of a JP drain; however, the facility did not provide a policy and procedure. Review of information obtained from https://www.drugs.com/cg/jackson-pratt-drain-care-discharge-care.html on 03/23/20 revealed the following: What is a Jackson-Pratt drain and how does it work? A Jackson-Pratt (JP) drain is used to remove fluids that build up in an area of your body after surgery. The JP drain is a bulb-shaped device connected to a tube. One end of the tube is placed inside you during surgery. The other end comes out through a small cut in your skin. The bulb is connected to this end. You may have a stitch to hold the tube in place. The JP drain removes fluids by creating suction in the tube. The bulb is squeezed flat and connected to the tube that sticks out of your body. The bulb expands as it fills with fluid. How do I change the bandage around my Jackson-Pratt drain? If you have a bandage, change it once a day. You may need to change your bandage more than once a day if it gets completely wet. Wash your hands with soap and water. Loosen the tape and gently remove the old bandage. Throw the old bandage into a plastic trash bag. Use soap and water or saline (salt water) solution to clean your JP drain site. Dip a cotton swab or gauze pad in the solution and gently clean your skin. Pat the area dry. Place a new bandage on your JP drain site and secure it to your skin with medical tape. Wash your hands. How do I empty the Jackson-Pratt drain? Empty the bulb when it is half full or every 8 to 12 hours. Wash your hands with soap and water. Remove the plug from the bulb. Pour the fluid into a measuring cup. Clean the plug with an alcohol swab or a cotton ball dipped in rubbing alcohol. Squeeze the bulb flat and put the plug back in. The bulb should stay flat until it starts to fill with fluid again. Measure the amount of fluid you pour out. Write down how much fluid you empty from the JP drain and the date and time you collected it. Flush the fluid down the toilet. Wash your hands. What should I do if the tubing becomes clogged? Use the following steps to clear your Jackson-Pratt tubing: Hold the tubing between your thumb and first finger at the place closest to your skin. This hand will prevent the tube from being pulled out of your skin. Use your other thumb and first finger to slide the clog down the tubing toward the bulb. You may have to repeat the sliding until the tubing is unclogged. When will my Jackson-Pratt drain be removed? The amount of fluid that you drain will decrease as your wound heals. The JP drain usually is removed when less than 30 milliliters (2 tablespoons) is collected in 24 hours. Ask your healthcare provider when and how your JP drain will be removed. What are the risks of having a Jackson-Pratt drain? The JP drain site may be painful. You may have trouble lying on the side with your JP drain. Your JP drain site may leak. The JP drain may be pulled out by accident. The tubing may get blocked, crack, or break. The tubing may damage your tissue. You may have a scar. The JP drain site may get infected. This infection could spread inside your body.
F 0755 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide pharmaceutical services including procedures that assure the accurate acquiring, receiving, dispensing, and administeringdispensing of all drugs or

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 0755 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 1) biologicals to meet the needs of each resident and ensure expired drugs or biologicals were not available for use in the facility's one of one medication rooms.for four (Residents #9, #12, #13,and #25) of seventeen residents reviewed for pharmacy services. The facility failed to ensure Residents #9, #12, #13,and13, and #25 were not administered expired medication B12 ([MEDICATION NAME]) injections. The failure placed residents at risk for not receiving the full therapeutic benefits of their medications. Findings included: 1. Observation on 03/06/20 at 8:30 AM of the medication room refrigerator with LVN A revealed an opened vial of [MEDICATION NAME] 25 mg/ml with an expiration date of 02/12/20 . The vial had an open date of 02/17/20 written on the bottle. LVN A stated the DON and the nurses were responsible for ensuring that the medications in the medication room and the refrigerator were not expired. She stated the Wound Care Nurse administered the Vitamin B12 injections. 2. Review of Resident #9's undated face sheet revealed she was a [AGE] year-old female who was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of Resident #9's active review of physician orders [REDACTED]. The order was to inject 5000 mcg subcutaneously on the 24th of every month. Review of Resident #9's lab results for Vitamin B12 dated 09/13/19 reflected a level of 140, which was low. The normal levels were between 180-914. Review of Resident #9's February 2020 electronic MAR indicated [REDACTED]. 3. Review of Resident #12's undated face sheet revealed the resident was an [AGE] year-old female who admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of Resident #12's active physician orders [REDACTED]. The order was to inject 5000 mcg subcutaneously every 28 days. Review of Resident #12's MAR for 02/01/20 to 02/29/20 revealed that the resident received was administered [MEDICATION NAME] on 02/21/20 given by LVN A. 4. Review of Resident #13's undated face sheet revealed that the resident was an [AGE] year old female who was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of Resident #13's's physician orders [REDACTED]. The order was to inject 5000 mcg subcutaneously every 2 weeks on Fridays. Review of Resident #13's MAR for 02/01/20 to 02/29/20 revealed the resident was administered [MEDICATION NAME] on 02/28/20 by LVN A. 5. Review of Resident #25's undated face sheet revealed the resident was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of the Resident #25's (NAME)2020 physician orders [REDACTED]. The order was to inject 5000 mcg subcutaneously every 2 weeks on Thursdays. Review of the Resident #25's (NAME)2020 electronic MAR indicated [REDACTED]. 6. Interview with LVN A on 03/06/20 at 1:15 PM revealed Vitamin B12 was given to residents with Vitamin B12 deficiency and residents who had fatigue. She stated Resident #13 used to sleep a lot and was always tired, but since she started taking the Vitamin B12 injections, she was more awake. She stated Resident #9 used to be very sad and would always stay in bed but since she started getting the Vitamin B12 injections, she was more awake and active. She stated she had administered the expired medication to Resident #9, Resident #12, Resident #13 and Resident #25 without checking the expiration date. She stated she should have checked the expiration date before administering the medication, but she assumed since the medication was brought in by the physician, then it was not expired. She stated administering expired medication put the residents at risk for receiving medications that did not have a therapeutic effect. Interview with LVN B, the Wound Care Nurse revealed she had opened the [MEDICATION NAME] multidose vial on 02/17/20. She stated she did not look at the expiration date because the physician had just brought it in on the same day. She stated the expiration date on the label of the [MEDICATION NAME] vial must have been wrong because she was sure that the medication was not expired. She stated she was going contact the pharmacy about the mistake. Interview with the DON on 03/06/20 at 9:35 AM revealed the nurses were upset with themselves for not checking the expiration date on the [MEDICATION NAME] before administering the medication. She stated the nurses assumed since the physician had just delivered the medication, then the medication was not expired. She stated the nurses were ultimately responsible for ensuring the medication was not expired before administering it to the residents. She stated expired medications have a reduced potency and do not have a therapeutic effect if administered to the residents. She provided a list of 17 residents that were taking the Vitamin B12 injections. 7. Review of the facility's undated policy on drug security revealed the following: medications which have passed the expiration date and medications which have been discontinued will be stored separately under lock and key in the director of nurse's office and be reconciled. These medications will be disposed of quarterly by the consulting pharmacist and the director of nurses and or the administrator in accordance with state and federal requirements.
F 0812 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.** Based on observation, interview, and record review the facility failed to store, prepare, distribute and serve food in accordance with professional standards for food service safety in the facility's only kitchen. Cook D failed ensure she washed hand and performed hand hygiene before handling food and clean equipment. The failure placed residents at risk for food borne illness. Findings included: Observation of the kitchen on 03/05/20 at 12:15 PM revealed Cook D did not change her gloves or perform hand hygiene when she left the serving line twice and retrieved a new scoop from a drawer in the back area of the kitchen. She returned to the serving line and resumed serving lunch utilizing the same gloves after having touched drawer handles and countertops in the kitchen. Interview with Cook D on 03/05/20 at 12:30 PM revealed she should have changed her gloves and performed hand hygiene when moving from one task to another during the meal service to prevent cross contamination. Interview on 03/05/20 at 1:30 PM the Dietary Manager revealed his expectation for dietary staff was for them to wash their hands upon entrance into the kitchen also before and after handling food items or equipment. He said the dietary staff assigned to clean the refrigerator was no longer at the facility. Review of the kitchen's cleaning schedule on 03/05/20 revealed there was a cleaning schedule for Refrigerator #2 present with most items signed as completed, except on 02/28/20, 02/29/20, and 03/01/20 which were blank. Interview with the Administrator on 03/06/20 at 11:15 AM revealed her expectations for the kitchen and kitchen staff was to adhere state policy and regulation and also the facility's policies. Review of facility's policy dated July 2017 revealed the following: Equipment Sanitation .Kitchen equipment will be cleaned and sanitized between use to prevent cross contamination and foodborne illness .Any items too large to be immersed will be wiped or sprayed with a sanitizing solution . The 2018 US Food Code reflected the following: 2-301.14 When to Wash. FOOD EMPLOYEES shall clean their hands and exposed portions of their arms as specified under 2-301.12 immediately before engaging in FOOD preparation including working with exposed FOOD, clean EQUIPMENT and UTENSILS, and unwrapped SINGLESERVICE and SINGLE-USE ARTICLES and: (A) After touching bare human body parts other than clean hands and clean, exposed portions of arms; (B) After using the toilet room; (C) After caring for or handling SERVICE ANIMALS or aquatic animals as specified in 2-403.11(B); (D) Except as specified in 2-401.11(B), after coughing, sneezing, using a handkerchief or disposable tissue, using tobacco, eating, or drinking; (E) After handling soiled EQUIPMENT or UTENSILS; (F) During FOOD preparation, as often as necessary to remove soil and contamination and to prevent cross contamination when changing tasks; (G) When switching between working with raw FOOD and working with READY-TO-EAT FOOD; (H) Before donning gloves to initiate a task that involves working with FOOD; and (I) After engaging in other activities that contaminate the hands.
F 0912 **Level of harm** - Potential for minimal harm **Residents Affected** - Some	**Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure 34 (Rooms 2, 3, 4, 6, 7, 8, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37 and 39) out of 37 multiple-resident bedrooms, measured at least 80 square feet per resident. The facility failed to ensure multiple resident Rooms 2, 3, 4, 6, 7, 8, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37 and 39 met the required minimum of 80 square feet per resident. This failure could place residents at risk of not having sufficient space. Findings included: In an interview on 03/04/20 at 9:45 AM, the Administrator revealed the facility had a room size waiver in place for the bedrooms measuring less than the required square footage. Review of Form DADS 3740 (Bed Classifications Form), completed by the Administrator on 01/22/19, revealed all 37 bedrooms in the facility had two beds and were classified as Medicare and Medicaid. Review of the facility's license on 03/04/20 at 10:00 AM revealed the facility was licensed for 74 beds. Review of undated resident bedroom measurements listing, provided by the Administrator on 03/04/20 revealed the following: 1) Resident Rooms 2, 3 and 4 measured 127 square feet; 2) Resident Rooms 6, 8 and 10 measured 132 square feet; 3) Resident room [ROOM NUMBER] measured 146 square feet; 4) Resident rooms [ROOM NUMBERS]

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F 0912 **Level of harm** - Potential for minimal harm **Residents Affected** - Some	(continued... from page 2) measured 147 square feet; 5) Resident Rooms 12, 14, 15, 16, 17 and 19 measured 156 square feet; 6) Resident room [ROOM NUMBER] measured 159 square feet; 7) Resident Rooms 20, 22, 24, 26 and 28 measured 151 square feet; and 8) Resident Rooms 23, 25, 27, 29, 30, 31, 32, 33, 34, 35, 36, 37 and 39 measured 153 square feet.