STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455570	A. Building B. Wing	12/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mineral Wells Nursing & Rehabilitation	316 SW 25th Ave Mineral Wells, TX 76067

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 0697 Level of Harm - 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** 45732 Based on observation, interview, and record review the facility failed to ensure that pain management was provided to residents who required such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences for 1 (Resident #238) of 6 residents reviewed for pain management. 1. The facility failed to ensure that Resident #238's pain was controlled for 11 days by not following physicians' orders regarding administration of hydrocodone. 2. The facility failed to ensure that Resident #238's pain was controlled for 5 days by not administering hydrocodone and fentanyl patch, due to not having the medication available. These failures affected one resident and placed all residents who require pain management at risk for further decline in their mental and/or physical functioning, unnecessary pain, and discomfort. Findings included: Review of Resident #238's electronic face sheet accessed 12/18/22 revealed a [AGE] year-old male admitted to the facility on [DATE] with diagnoses that included cancer of the esophagus (tube that connects the throat to the stomach), alcohol abuse, and heart failure. Review of Resident #238's admission MDS dated [DATE] Section C Cognitive Patterns revealed no BIMS score which indicated an assessment had not been completed yet. Review of Section J Health Conditions J0100. Pain Management revealed he had received PRN pain medications and non-medication intervention for pain in the five-day lookback period prior to the assessment. Section J Health Conditions J0400 Pain Frequency. Frequently. Review of Resident's #238's electronic care plan initiated 12/12/2022 revealed no evidence of a focus, objective, or interventions related to pain or a diagnosis of cancer. Review of Resident #238's discharge and admission paperwork from the hospital sent to the facility upon admission titled, Medication Administration Record, dated 12/09/2022 revealed: Hydrocodone Bitart/Acetaminophen 15 ml solution give 15 ml via feeding tube every 4 hours as needed for pain scale 4-6. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0697 Level of Harm - Actual harm Residents Affected - Few	Review of Resident #238's electronic physician orders accessed 12/18/22 revealed no evidence of a hydrocodone or fentanyl patch order. Further review revealed no evidence of an order for pain evaluation. Review of electronic physicians' orders revealed an order for Tylenol with Codeine #3 Tablet 300-30 MG (Acetaminophen-Codeine) Give 2 tablet via G-Tube every 4 hours as needed for Pain dated 12/12/2022. Review of the December 2022 MAR for Resident #238 revealed the following administrations: -Tylenol with Codeine #3 Tablet 300-30 MG 2 tablets given on 12/12/22 at 11:02 p.m. with an associated pain scale of 6. Follow up pain scale for this administration was listed as effective. - Tylenol with Codeine #3 Tablet 300-30 MG 2 tablets given on 12/13/22 at 5:14 p.m. with an associated pain scale of 8. Follow up pain scale for this administration was listed as effective - Tylenol with Codeine #3 Tablet 300-30 MG 2 tablets given on 12/13/22 at 10:52 p.m. with an associated pain scale of 8. Follow up pain scale for this administration was listed as effective - Tylenol with Codeine #3 Tablet 300-30 MG 2 tablets given on 12/14/22 at 3:30 a.m. with an associated pain scale of 5. Follow up pain scale for this administration was listed as effective - Tylenol with Codeine #3 Tablet 300-30 MG 2 tablets given on 12/14/22 at 2:32 p.m. with an associated pain scale of 8. Follow up pain scale for this administration was listed as effective - Tylenol with Codeine #3 Tablet 300-30 MG 2 tablets given on 12/15/22 at 7:05 a.m. with an associated pain scale of 10. Follow up pain scale for this administration was listed as effective - Tylenol with Codeine #3 Tablet 300-30 MG 2 tablets given on 12/15/22 at 8:55 p.m. with an associated pain scale of 2. Follow up pain scale for this administration was listed as effective - Tylenol with Codeine #3 Tablet 300-30 MG 2 tablets given on 12/16/22 at 8:46 a.m. with an associated pain scale of 6. Follow up pain scale for this administration was listed as effective - Tylenol with Codeine #3 Tablet 300-30 MG 2 tablets given on 12/16/22 at 2:26 p.m. with an associated pain scale of 6. Follow up pain scale for this administration was listed as effective - Tylenol with Codeine #3 Tablet 300-30 MG 2 tablets given on 12/16/22 at 10:59 p.m. with an associated pain scale of 5. Follow up pain scale for this administration was listed as effective - Tylenol with Codeine #3 Tablet 300-30 MG 2 tablets given on 12/17/22 at 6:56 p.m. with an associated pain scale of 4. Follow up pain scale for this administration was listed as effective - Tylenol with Codeine #3 Tablet 300-30 MG 2 tablets given on 12/17/22 at11:38 p.m. with an associated pain scale of 3. Follow up pain scale for this administration was listed as effective - Tylenol with Codeine #3 Tablet 300-30 MG 2 tablets given on 12/18/22 at 5:00 a.m. with an associated pain scale of 4. Follow up pain scale for this administration was listed as effective (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	- Tylenol with Codeine #3 Tablet 300-30 MG 2 tablets given on 12/19/22 at 8:05 a.m. with an associated pain scale of 10. Follow up pain scale for this administration was listed as effective Review of skilled nurse's notes for Resident #238 revealed each note included a pain assessment. These pain assessments were documented as follows: -12/16/22 7:30 a.m. pain was 8.8 out of 10 -12/17/22 9:02 a.m. pain was 4.4 out of 10 -12/17/22 10:03 p.m. pain was 4.4 out of 10 -12/18/22 9:05 a.m. pain was 4.4 out of 10 -12/18/22 9:09 p.m. pain was 4.4 out of 10 -12/19/22 9:09 p.m. pain was 10 out of 10 Record review of Resident #238's electronic nurses notes accessed on 12/18/22 revealed a nurses' note written by LVN A, dated 12/15/22 at 6:02 PM, which read: Returned from MD appointment. Transport reported the Dr. called in orders to pharmacy and that copies will be faxed tomorrow. Further review or electronic nurses' notes revealed no evidence of documentation regarding new orders or waiting for medications to arrive. During observation and interview on 12/18/22 at 2:30 PM, Resident #238 was sitting up in bed. Resident #238 was very tense and fidgety in appearance. He stated he was in pain. He stated his pain level was at a 10 in his neck and throat area. He stated he went to his oncology doctor on Thursday (12/15/22) and got an order for hydrocodone and fentanyl patches and had not received the medication yet. He stated he was waiting for the nurse to come by to talk to her about his pain medication. He stated he felt he should not have to wait this long for pain control. During an interview on 12/19/22 at 09:32 AM, Resident #238 stated he was in a lot of pain. He stated he went to the doctor last Thursday (12/15/21) and received and order for Hydrocodone and pain patches. He stated the nurses told him that the medication had not arrived from the pharmacy yet. Resident #238 stated his pain was a level 10 out of 10 and Tylenol with Codeine did nothing for his pain. He stated the facility had not offered him anything except Tylenol with Codeine. During an interview on 12/19/22 at 10:00 AM, LVN B stated she was not aware of any new orders for pain medication for Resident #238, but she would investigate it. During an interview on 12/19/22 at 10:30 AM, LVN B stated she spoke with the DON and the medication ordered by the oncologist was still not available from the pharmacy. Record review of Resident #238's electronic nurses notes accessed on 12/19/22 revealed a nurses' note written by the DON, dated 12/19/22 at 11:47 AM, which read: .Spoke with pharmacy regarding residents' fentanyl and hydrocodone from oncologist. Pharmacist states drug order should be delivered by this afternoon around 4pm . (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	During an interview on 12/20/22 at 10:00 AM, the DON stated the pharmacy did not have the medications in stock. She stated the pharmacy was supposed to receive a truck yesterday and deliver the medications. She stated she was about to go to the pharmacy and pick up the medications. DON stated Resident #238 told her his pain was controlled with the Tylenol with Codeine and he wanted to wait for his prescriptions. She stated he refused to take the hydrocodone from the emergency kit because he did not think it was the same as he was prescribed. She stated the facility can get all medications from their pharmacy within 24 hours of new orders and prescribed medications. She stated she did not try other alternatives to get his new medications because on 12/16/22 Resident #238 stated he was ok and wanted to wait for his medications from the pharmacy. She stated Resident #238's pain had been controlled. She stated it was not acceptable to let a resident hurt for 5 days. During an interview on 12/20/22 at 11:30 PM, Resident #238 stated when he was in the hospital, he received hydrocodone and it completely relieved his pain. He stated his acceptable pain level was a 2. He stated he had been in pain the whole time he had been in the facility. He stated the Tylenol with Codeine only brought his pain from a 10 to an 8. He stated he had never been offered any other medication. He stated was told that he had to wait until his medications came from the pharmacy. During an interview on 12/20/22 at 2:15 PM, LVN C stated when Resident #238 was admitted to the facility his admission orders had an order for hydrocodone, but the hospital did not send a triplicate for the medication. She stated the facility could not order the medication without the triplicate. She stated on 12/10/2022 Resident #238 asked for pain medication. She stated she called his primary care physician and he refused to order the hydrocodone because he was not the original physician that ordered that medication. She received an order for Tylenol with Codeine. She stated she did not call the oncologist or the hospital to get another order or a triplicate for the hydrocodone. During an interview on 12/20/22 at 3:00 PM, the DON stated the charge nurse was responsible for completing the admission assessment and orders. She stated admission orders were taken from the discharge and admission paperwork from the hospital sent to the facility upon admission titled, Medication Administration Record. She stated it was the DON's place to follow-up and ensure that this was done properly. She stated she called the hospital on Monday 12/13/22 to ask for a triplicate but was unable to get one. She stated she did not call the oncologist to get an order for the hydrocodone. She stated Resident #238's pain was being managed and the Tylenol with Codeine was effective. The DON did not provide a policy related physicians orders or medication availability. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	Review of facility policy titled Pain Management, Assessment Tool,' revised May 2016 revealed: pain is a subjective sensation of discomfort he received from multiple sensory nerve interactions generated by physical, chemical, biological, or psychological stimuli. Policy: complaints of pain will be assessed accordingly by the nurse and effectively managed through prescribed medications, and comfort measures, and all available resources of the facility. Goals: 1. resident identifies pain characteristics.2. Resident articulates factors that anticipatory pain. 3. Resident expresses a feeling of comfort and relief from pain. 4. Resident States and carries out appropriate pain interventions from pain relief. 5. Cognitively impaired residents will demonstrate actions of pain relief. Procedure: 1. assess residents' physical symptoms of pain, physical complaints, and daily activities . If resident complaints of pain the nurse will assess, implement relief measures as ordered and or care planned .7. Ask resident to help establish goals and develop plan for pain control. This gives resident sense of control. 8. Instruct resident in use of relaxation techniques.9. Add the resident to right pain on a scale of 1 to 10 with one being the least pain and 10 being the worst pain experience .10. Assist the resident in maintaining a pain management and reschedule, exercise program, and medication regimen .12. Talk with the resident about pain and assess for pain relief after interventions. 13. Monitor for effectiveness of pain intervention.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45732 Based on interview and record review, the facility failed to ensure that residents who required dialysis received such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences for 1 (Resident #52) of 2 residents reviewed for dialysis. The facility failed to ensure Resident #52 had orders to receive dialysis, to monitor the dialysis access site, or to monitor post-dialysis for any signs or symptoms of: infection or bleeding, edema, blood pressure, or fluid overload. This failure could place the resident who received dialysis at risk for complications and not receiving proper care and treatment to meet their needs. Findings included: Review of Resident #52's electronic face sheet, accessed 12/18/22, revealed the resident was a [AGE] year-old male admitted on [DATE] and readmitted on [DATE] with diagnosis that included chronic kidney disease stage 4 (a medical condition in which a person's kidneys cease functioning on a permanent basis leading to the need for a regular course of long-term dialysis or a kidney transplant to maintain life) dependence on renal dialysis, and Parkinson's disease. Review of Resident #52's Admission MDS, dated [DATE] revealed a BIMS score of 12 which indicated no cognition impairment. Further review revealed Section O0100. Special Treatment, procedures, and program. J: dialysis was coded-yes. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #52's Care plan initiated 12/04/22 and revised on 12/19/22 read in part: . Focus: The resident has fluid overload or potential fluid volume overload r/t Kidney failure, depends on hemodialysis 3 times. Goal: The resident will remain free of s/sx of fluid overload through review date, as evidenced by decrease in edema, anxiety, agitation, restlessness, confusion, changes in mood or behavior, nausea/vomiting, dyspnea, congestion, orthopnea, easily fatigued, jugular vein distension. Interventions: Administer medications as ordered. Monitor/document for side effects and effectiveness. Diet as ordered. Monitor and document intake and output as per facility policy. Monitor vital signs as ordered and record. Notify MD of significant abnormalities. Monitor/document/report to MD PRN s/sx of fluid overload: Anorexia, Anxiety, Mood/behavior changes, Confusion, Edema, Nausea/vomiting, Shortness of breath, difficulty breathing (Dyspnea), Increased respirations (Tachypnea), Difficulty breathing when lying flat (Orthopnea), Congestion, Cough, Fatigue, Jugular Venous Distention (JVD), Sudden weight gain. Obtain and monitor lab/diagnostic work as ordered. Report results to MD and follow up as indicated. Provide pillows; raise HOB as needed to facilitate breathing, increase comfort. The resident needs rest periods as needed/requested intervals. Focus: The resident requires Hemo-Dialysis three days a week r/t a diagnosis of End Stage Renal Failure. Goal: The resident will have no s/sx of complications from dialysis through the review date. Interventions: Encourage resident to go for the scheduled dialysis appointments. Resident receives dialysis three times weekly. Monitor for dry skin and apply lotion as needed. Monitor labs and report to doctor as needed. Monitor/document for peripheral edema. Monitor/document report to MD s/sx of depression. Obtain order for mental health consult if needed. Monitor/document/report to MD PRN any s/sx of infection to access site: Redness, Swelling, warmth or drainage. Monitor/document/report to MD PRN for s/sx of renal insufficiency: changes in level of consciousness, changes in skin turgor, oral mucosa, changes in heart and lung sounds. Monitor/document/report to MD PRN for s/sx of the following: Bleeding, Hemorrhage, Bacteremia, septic shock. Review of Resident #52's electronic physician order accessed 12/18/22 revealed no evidence of orders to receive dialysis, to monitor the dialysis access site, or to monitor post-dialysis for any signs or symptoms of: infection or bleeding, edema, blood pressure, or fluid overload. Review of Resident #52's nurses notes dated 11/30/22-12/18/22 revealed no evidence of monitoring the dialysis access site or monitoring post-dialysis for any signs or symptoms of: infection or bleeding, edema, blood pressure, or fluid overload. Review of Resident #52's Weights and Vitals accessed 12/18/22 revealed last blood pressure was taken on 12/03/19 during Resident #52's previous admission to the facility. During an interview on 12/18/22 at 11:30 AM, Resident #52 stated he went to dialysis on Tuesdays, Thursdays, and Saturdays. He stated no staff member had ever looked at his dialysis site. Resident #52 stated he had not had his blood pressure checked since he had been admitted . He stated he had a lot of edema and swelling to his lower extremities but no one had ever said anything about it. Resident #52 stated he could not remember ever having a nurse do an assessment on him before or after he received his dialysis treatment. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/20/22 at 3:30 PM, the DON stated there was no specialized monitoring for dialysis. She stated the dialysis center monitored Resident #52's access site when treatment was provided. She stated there were no required orders for monitoring. She stated the nurses monitored for edema and blood pressure daily. She stated there was no need to monitor specifically for dialysis complications. DON stated she was not aware Resident #52 had not had a blood pressure check and she thought he had an order to check for edema. The DON stated the failure ultimately occurred due to her not reviewing charts and orders as thoroughly as she should. Review of facility's policy titled; Dialysis revised November 2013 reflected in part: .Procedure: 1. Review and confirm the physicians' orders for dialysis. Follow the specifications of the medical regimen including dietary restrictions and medical management. 2. The facility will establish baseline information from the dialysis center and will monitor changes from that baseline .7. Each side will be assessed for bleeding, bruising, lack of pulsations, and aneurysm as ordered by the physician. The nurse will help palpate the access from the distal anastomosis to the proximal anastomosis. A thrill should be built along the course of the vessel. This procedure should be conducted once per shift . record the results of the examination. Report nonfunctioning accesses to the dialysis center immediately. Report any drainage, redness, or swelling around the insertion site to the dialysis center as soon as possible .14. strict intake and output will be maintained on the resident. Daily weights will be maintained unless otherwise specified by the physician. All documentation will be monitored especially by the position order. All documentation will be maintained in the residence clinical record .20. the facility will be observant of any of the following symptoms. If the resident experiences any of these symptoms, the nurse will contact the dialysis center and the attending position immediately. A. Altered mental status resident is confused or disoriented .b. Change in skin condition or color .c. distention of neck veins .d. increased edema of face or extremities .e change in color of nail beds .f. muscle twitching .

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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. 41495 Based on observations, interviews, and record reviews, the facility failed to Store, prepare, distribute, and serve food in accordance with professional standards for food service safety for 1 of 1 kitchen's reviewed for food service. The facility failed to label items in refrigerators with an identifier of the food item. The facility failed to discard items in refrigerators after 7 days. The facility failed to seal items in refrigerators and dry food storage room. These failures placed all residents at risk of food borne illnesses. Findings included: During an observation and interviews on 12/18/22 at 10:06 AM Refrigerator #2 30 individual serving dishes with foil covering with a date of 12/15. There was no label on the dishes to identify the contents. Cook said they were a Chili cornbread pot pie. She said the person that prepared them should have put a label on them to identify the food item before storing them in the refrigerator. 1 clear tub of mixed salad greens with a date of 12/8. The container was open, and Cook said that it should have been a closed container and that the item should be thrown out after 7 days. 1 clear zipper sealed gallon storage bag with prepared meat sauce and noodle mix that had a label of Spaghetti with a date of 12/8/22. Cook said it was prepared on 12/8/22 and it should only be stored for 7 days, so it should have already been thrown out. Chest Refrigerator 2 clear bowls covered in plastic wrap that contained a pink substance with a marking of 12/18. Dietary Aide said they were strawberry yogurts. She said they should have had a label on them to identify the item. Obvious build up of ice along the back half of the chest refrigerator. Cook said it would need to be defrosted and said she had not paid attention to the buildup. Dry Food Storage Room (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1 clear plastic zipper sealed bag containing Cream of Wheat had a date of 12/1. Cook said the date was from when it was received from the food company. It should have also included the date it was opened. She said all items in their original packaging should have the date received on the items and also a label that states opened. 1-3 compartment cereal dispenser that contained Raisin Bran and Rice Crispies that did not include a date they were placed in the container. Cook said the dispenser should have had a label placed on the back of each compartment to identify when each cereal was placed in them. 1 clear plastic jug drinking container that had a label Sanitizer 12/16 was sitting on a rolling cart next to the metal shelving unit that had a package of bread, flour container, sugar container, and other miscellaneous seasonings and cake mixes. Cook said the container should not have been stored next to the food items and it should have been in the storage closet with all other cleaners. She said she did not know why it had been left in the dry food storage room. 1 clear plastic zipper seal bag containing dinner rolls that was open. Cook said the bag should have been sealed. During an interview on 12/18/22 at 11:05 AM with DM, she said items in the refrigerators that had been prepared needed to be thrown out 7 days after preparation. She said any prepared item should have a label that identified the contents of the container and the date the item was prepared. DM said they had a cleaning supply storage closet directly beside the dry food storage room and the sanitizer should have been stored in that closet and not in the food storage room. Record review of facility policy labeled Storage Refrigerators dated 2012 revealed: All Storage Refrigerators shall be maintained clean . to ensure a proper environment and temperature for food storage .Food must be covered when stored, with a date label identifying what is in the container . Refrigeration equipment is to be routinely defrosted and compressor cleaned.