STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675361	A. Building B. Wing	08/18/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wharton Nursing and Rehabilitation Center	1220 Sunny Lane Wharton, TX 77488

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44128 Based on observation, interview, and record review the facility failed to treat each resident with respect and dignity and provide care in a manner that promoted maintenance or enhancement of his or her quality of life for 1 of 19 residents reviewed for resident rights. (Resident #27) NA A stood over Resident #27 while she assisted her with her lunch. NA A pulled Resident #27 backwards in her geri chair. These failures could place residents at risk for decreased quality of life and self-esteem. Findings included: Record review of consolidated physician orders dated 08/17/2021 indicated Resident #27 was [AGE] years old and admitted on [DATE] with diagnoses including cerebral palsy (a disorder of movement, muscle tone, or posture), joint contractures, and dysphagia (difficulty swallowing). Record review of the MDS dated [DATE] indicated Resident #27 was usually understood and usually understood others. The MDS indicated a BIMS (Brief Interview for Mental Status) of 8 for Resident #27, indicating moderate cognitive impairment. The MDS indicated Resident #27 was totally dependent on staff for all activities of daily living, including eating. Record review of the care plan revised on 06/15/2021 indicated Resident #27 was dependent on staff for meeting emotional, intellectual, physical and social needs. Resident #27 had an ADL self-care performance deficit. Resident #27 was totally dependent on staff for eating. During an observation on 08/16/2021 at 12:38 p.m., NA A pulled Resident #27 backwards twice while positioning the resident at the dining table. During an observation on 08/16/2021 at 12:40 p.m., NA A stood over Resident #27 while feeding her lunch. NA A was instructed by another staff member to sit down. NA A replied loudly, I can't, I can't feed her sitting down. NA A fed one food at a time. NA A fed the resident all of her meatloaf before moving onto the mashed potatoes. NA A did not converse with the resident or ask her what her wishes were. NA A did not provide drinks in between bites. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 08/16/2021 at 1:11 p.m., LVN B said it was not appropriate for NA A to stand while feeding Resident #27. She said she knew NA A had pulled Resident #27 backwards in her geri chair and she should not have done so. During an interview on 08/16/2021 at 1:24 p.m., NA A said she fed Resident #27 the way she did because of her position in her chair. She said normally when she feeds Resident #27, she was in her bed and she sits in a chair beside her bed. She said she has received in-services and trainings on how to feed a resident. She said she had been taught to not stand over the residents. She said she didn't know it was wrong to pull a resident backwards in their chair. She said she had never been in-serviced on not pulling a resident backward. During an interview on 08/18/2021 at 8:35 a.m., Resident #27 said staff does not stand over her often when they feed her, but when they do it does bother her. She said she did not like how she was fed on 08/16/2021. During an interview on 08/18/2021 at 10:30 a.m., the DON said resident's requiring feeding assistance; the care plan should be followed, staff should make sure they have the right tools and the diet is the right consistency. She said staff should never stand over a resident. She said one bite of food at a time should be given and give fluids between bites. She said a variety of different bites of food should be given. She said residents still had taste buds. She said the NA A should have not pulled the resident backwards. She said if she saw someone pull a resident backwards in their chair it would be addressed. During an interview on 08/18/2021 at 12:54 p.m., the administrator said nurse's aides should be seated while feeding the residents and be mindful of the amount of food they give in each bite. During an interview on 08/18/21 at 01:58 p.m., the administrator said when they have no facility policy, they just follow CMS guidelines. She said there was no facility policy related to dignity. Record review of the Residents' Rights Nursing Facilities, Title 40, Part 1, Texas Administrative Code Chapter 19, Subchapter E Resident Rights indicated, Residents of Texas nursing facilities have all the rights, benefits, responsibilities, and privileges granted by the Constitution and laws of this state and the United States .be treated with dignity, courtesy and respect .

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44596 Based on observation, interview, and record review the facility failed to ensure residents had the right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents for 1 (Resident # 26) of 18 residents reviewed for reasonable accommodation of needs. The facility failed to evaluate Resident #26 for adaptive eating equipment. The facility failed to ensure Resident #26 had full access to halo transfer bars for bed mobility. These failures could place the residents at risk for continued weight loss and decreased quality of life. Findings included: Record review of the face sheet dated 8/18/2021 indicated Resident #26 was a [AGE] year-old male admitted on [DATE] with the diagnoses of cerebral infarction (stroke), hemiplegia to the left side of the body (paralysis that follows a stroke), and diabetes. Record review of the MDS dated [DATE] indicated Resident #26 is sometimes understood and sometimes understood others. The MDS also indicated a moderate impairment of Resident #26's cognitive ability to make daily decisions. Resident #26 required extensive assistance with ADLs, including bed mobility and eating. The MDS indicated that Resident #26 weighed 173 pounds, had a significant weight loss, and was not a physician's prescribed weight loss plan. Record review of the weight summary dated 8/18/2021 listed Resident #26's weights as follows: 2/5/2021- 215.8 pounds 3/9/2021- 174.6 pounds 4/5/2021- 174.0 pounds 5/20/2021-171.0 pounds 6/8/2021- 173.4 pounds 7/6/2021- 175.1 pounds No August weight was listed on the summary. Record review of the MD order for Resident #36 dated August 2021 indicated a diet order for regular diet with fortified foods, ice cream to be served with lunch and supper, and a house shake 120ml once per day. The MD orders also revealed an order for bilateral halo bars to serve as an enabler and promote independence. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of therapy evaluations revealed March of 2021 as the last time therapy evaluated Resident #26. Feeding was not addressed in the evaluation. During an observation on 8/16/2021 at 9:18am, Resident #26 was lying in bed with his torso pressed against the left halo bar with a large amount of scrambled eggs noted to his gown and to the floor beside the bed. The bed had bilateral halo bars noted. The bed that belonged to Resident #26 was pushed up against the wall on the right side. The use of the right halo bar was restricted because Resident #26 was unable to get his non paralyzed right hand around the halo bar to pull himself over in the bed. Resident #26 attempted several times to grip the right halo bar but could not get his fingers around the bar. Resident #26 responded with a head nod when asked if he wanted to be pulled over in the bed. During an observation on 8/16/2021 at 12:20 pm, CNA C brought a lunch tray into the room and set it up for Resident #26 to eat in his bed. No ice cream noted on tray. CNA left the room. Resident #26 struggled to eat 25% of lunch meal and consumed no liquid. Resident #26 pushed food off the side of his plate when attempting to load his spoon. Resident #26 dropped food on himself and the floor when he was able to get food on the spoon. Resident #26 became visibly frustrated from spilling his food. He slammed his spoon down and pushed the tray away. The tray was left in his room from 12:20 pm to 12:45 pm. The CNA returned to the room and retrieved the tray. CNA C did not offer assistance to complete meal or any supplementation. The MDS indicated Resident #26 required extensive assistance for eating. During an observation and interview on 8/17/2021 at 8:22am, Resident #26 was lying in bed with a large amount of eggs noted to his gown. Fluids were still covered on the tray. Resident #26 indicated with a head nod that he was thirsty when asked. Resident #26 indicated with a head nod that he was still hungry when asked. CNA C came in room and removed tray without aiding Resident #26 to finish the meal at 9:10am. During an interview on 8/17/2021 at 10:11am CNA C stated Resident #26 fed himself. CNA C stated he rarely ate more than 50% of a meal and they had him on a special soup but Resident #26 refused the soup. CNA C stated he dropped food all the time because his good hand was not very steady. CNA C stated she thought it best to have the residents do as much for themselves as possible when asked why she did not assist Resident #26 with meals. CNA C stated she reported to the nurses and ADON that Resident #26 did not eat well and spilled most of what he tried to eat. During an interview on 8/17/2021 at 11:22am ADON stated Resident #26 was put on fortified foods because he had a weight loss a few months ago. ADON stated the facility was aware that he dropped food when he ate. The ADON stated they did not intervene with Resident #26 because the facility wanted the resident to do as much for themselves as they could. ADON stated therapy was responsible for evaluating and recommend adaptive equipment. When asked how Resident #26 could improve his self-feeding the ADON stated she would send a referral to therapy for adaptive equipment and was unaware of the last time therapy evaluated Resident #26. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and interview on 8/18/2021 at 9:00am, Resident #26 was noted to be yelling from his bed for 10 minutes. Resident #26 was noted to be lying with his torso against the left halo bar and struggled to pull himself back to the right side of bed. Resident #26 made several attempts to grip the right halo bar with no success. Resident #26's bed was pushed against the wall on the right side and he was unable to get his hand around the halo bar. CNA C walked into room and asked Resident #26 if he needed to be adjusted in the bed. Resident #26 nodded yes. CNA C stated that Resident #26's bed was up against the wall to save space in the room and she had not thought about how Resident #26 was supposed to reach his halo bar to pull himself over when asked why the bed was pushed against the wall. During an interview on 8/18/2021 at 12:10pm the DON stated she expected the staff to assist any resident that was unable to feed themselves. The DON stated she expected the nurses to notify therapy when a resident needed adaptative equipment to improve their quality of life. The DON stated she expected CNA's to ensure all adaptative equipment was available to the residents when needed and it was the nurse's jobs to ensure that happened each shift. During an interview on 8/18/2021 at 1:27pm the Administrator stated she expected the nursing staff to ensure the resident's that needed adaptative equipment had access to it. The Administrator expected staff to communicate with therapy when a referral was needed for adaptative equipment. The Administrator stated there are no policies currently in place at the facility related to adaptative equipment. The facility went by CMS guidelines.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44596 44933 Based on observation, interview and record review the facility failed to provide a safe, functional, sanitary, and comfortable environment for 2 (Resident #8, Resident #25) of 19 residents reviewed for environment. The facility failed to clean Resident #8's splattered brown stain wall near his bed. The facility failed to clean splattered dried brown substance on the mattress, bed frame, tube feeding pole and wall of Resident #25. These failures could place residents at risk of an unsafe or uncomfortable environment and a decrease in quality of life and self-worth. Findings included: 1. Record review of the consolidate physician orders dated 8/18/21 revealed Resident #8 was [AGE] years old, male and admitted on [DATE] with diagnoses including chronic obstructive pulmonary disease, type II diabetes mellitus, stage 3 chronic lung disease, acquired absence of left leg below knee, acquired absence of other right toe(s), muscle wasting and atrophy (waste away of body tissue) and pain. Record review of the MDS dated [DATE] revealed Resident #8 was able to understand others and make himself understood. Resident #8 had adequate hearing, clear speech, and impaired vision. The MDS revealed Resident #8 had intact cognitive response. The MDS revealed Resident #8 required extensive assistance with dressing, toilet use, and bathing. Record review of the undated care plan revealed Resident #8 had ADL self-care performance deficit related to lower leg amputation and generalized weakness. The care plan indicate Resident #8 had impaired cognitive function or impaired thought process. During an observation and interview on 8/16/21 at 9:38 a.m., Resident #8 was sitting in his wheelchair next to his bed. On the wall next to the bed, splattered dried brown stains covered 1/3 of the wall. Resident #8 said it was spit and had been there for months. During an observation and interview on 8/17/21 at 8:34 a.m., Resident #8 was sitting on the edge of his bed. On the wall next to the bed, splattered dried brows stains covered 1/3 of the wall. Resident #8 said he was told by nursing staff not to spit in towels, so he started spitting on the wall. Resident #8 said he does not like seeing the brown stains on his wall. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and interview on 8/18/21 at 8:52 a.m., Resident #8 was sitting on the edge of his bed eating breakfast. On the wall next to the bed, splattered dried brows stains covered 1/3 of the wall. Resident #8 said housekeeping came last night to clean the floors but did not offer to clean his wall. During an interview on 8/18/21 at 10:26 a.m., LVN F said she had noticed Resident #8's brown stained wall. She said she thought it was coffee on his wall not spit. LVN F said she expected housekeeping to clean the wall. 2. Record review of the face sheet dated 8/18/2021 indicated Resident #25 was a [AGE] year-old male that admitted on [DATE] with the diagnoses of anemia, congestive heart failure and hypertension. Record review of the MDS dated [DATE] indicated Resident #25 was usually understood and usually understands. Resident #25 has a Brief Interview of Mental Status Score of 10 on a scale of 00-15. The score of 10 indicated he had mild cognitive impairment. The MDS indicated Resident #25 had an abdominal feeding tube and received greater than 51% of his nutrition through the feeding tube. The MDS indicated Resident #25 required extensive to dependent assist with ADLs. During an observation on 8/16/2021 at 9:53am the mattress, bed frame, tube feeding pole and wall of Resident #25 was splattered with a dried brown substance that appeared to be enteral feeding. During an observation on 8/17/2021 at 2:43pm the dried brown substance remained to the mattress, bed frame, tube feeding pole and wall of Resident #25. During an observation on 8/18/2021 at 11:00 am the dried brown substance remained to the mattress, bed frame, tube feeding pole and wall of Resident #25. During an interview on 8/18/2021 at 11:15am, the Housekeeping Supervisor stated that it was the responsibility of the housekeeper assigned to that hallway to clean all tube feeding poles, the bed frames and the mattresses daily. The housekeeping supervisor stated the walls were wiped down when the staff provided a deep clean for the room. The last deep cleaning of Resident # room was on 8/12/2021. The housekeeping supervisor stated she did random checks ups behind the housekeeping staff to ensure they did a thorough clean. The housekeeping supervisor stated she did not check behind the deep clean for the room of Resident #25. During an interview on 8/18/2021 at 12:00pm the DON stated she expected the housekeeping department to keep the rooms clean and home like in appearance. She also stated she expected the nursing department to aid the housekeepers in cleaning and tidying up. During an interview with on 8/18/2021 at 1:45pm the Administrator stated she expected the housekeeping department to keep all the rooms in the facility clean and home like. The Administrator stated she expected the nurses to clean up any spills or report areas that needed to be cleaned to the housekeeping department. The Administrator stated the company had no policies and went by CMS guidelines.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36672 44128 44596 Based on observation, interview, and record review the facility failed to ensure a resident who was unable to carry out activities of daily living received the necessary services to maintain good grooming and personal hygiene for 7of 18(Residents #274,#23,#8,#26, #25, #70, and #3) residents reviewed for ADLs. The facility failed to ensure Residents #274, #23, and #8 were provided with assistance in receiving a routine bath. The facility failed to ensure Residents #70, #26, #25, #3, and #274 were provided assistance with grooming to remove facial hair. The facility failed to ensure Resident #25 was assisted with routine nail care. These failures could place residents at risk of not receiving care and services to meet their needs. 1. Record review of a face sheet dated 8/18/2021 indicated Resident #274 was a [AGE] year-old female that admitted on [DATE] with the diagnoses of cerebral infarction due to blood clot (stroke), personal history of traumatic brain injury, and heart failure. Record review of a MDS dated [DATE] indicated Resident #274 was usually understood and usually understood others. Resident #274 had a Brief Interview of Mental Status score of 06 on a scale of 00-15. This indicated Resident #274 had a moderate cognitive deficit. The MDS indicated Resident #274 required extensive assistance with ADLs. During an observation and interview on 8/17/2021 at 9:00am, Resident #274 was noted to have several long grey chin hairs approximately 2-3 inches in length and a thin black moustache to her upper lip. Resident #274's family member was at her bedside and stated that Resident #274 had gotten 1 bath per week for the last 2-3 months. The family member stated she came to the facility and sat with the resident every bath day since the facility opened back up to visitors. The family member stated she must do this to ensure Resident #274 was bathed. Resident #274's family member stated she had asked several different staff members ranging from the CNA all the way up to the DON, multiple times in the past month for her mother's facial hair to be shaved and her baths to be given. Resident #274 stated she could smell herself, so she knew she smelled bad to others. Resident #274 stated she felt ugly with facial hair and wanted it removed. 2. Record review of the consolidated physician orders dated 8/18/21 revealed Resident #23 was [AGE] years old, male and admitted on [DATE] with diagnoses including dementia without behavioral disturbance, cerebral infarction (stroke), type II diabetes mellitus, epilepsy(seizures), heart failure, and hemiplegia (paralysis of one side of the body). (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the MDS dated [DATE] revealed Resident #23 was able to make himself understood and usually understands others. Resident #23 had minimal difficulty hearing, unclear speech, and adequate vision. The MDS revealed Resident #23 had intact cognition. Resident #23 required extensive assistance for dressing, toilet use, and personal hygiene. The MDS revealed Resident #23 self-performance and support for bathing the activity itself did not occur or family and/or non-facility staff provided care 100% of the time for that activity over the entire 7-day period. Record review of the undated care plan revealed Resident #23 was dependent on staff for meeting emotional, intellectual, physical, and social needs. Resident #23 had self-care performance deficit related to impaired physical mobility. The care plan revealed Resident #23 requires extensive-total assistance with bathing/shower (Mondays, Wednesdays, and Fridays), dressing, and personal hygiene. The care plan revealed Resident #23 had impaired cognitive function or impaired thought process related to dementia. Resident #23 was a fall risk and had two unwitnessed falls from the bed. Record review of the ADL tracking sheet dated 8/1/21 revealed Resident #23 had 3 shower/bed baths out of 18 days. During an observation and interview on 8/16/21 at 9:38 a.m., Resident #23 was in his bed with a hospital gown on eating breakfast. Resident #23 had a full mustache and medium length beard. He was sometimes hard to understand because of his unclear speech. Resident #23 said his handwriting was not that good either when asked. Resident #23 said he does not get his baths 3 times a week. During an interview on 8/17/21 at 8:34 a.m., Resident #23 said he asked the evening CNAs for a bath and did not get a shower yesterday which was his bath day. During an interview on 8/17/21 at 11:43 a.m., a family member of Resident #23 said he felt his family member was not getting his showers because his facial hair was getting too long. During an interview on 8/18/21 at 8:54 a.m., Resident #23 said he finally got a bath last night. Resident #23 said not getting his shower/bed baths made him feel miserable. 3. Record review of the consolidate physician orders dated 8/18/21 revealed Resident #8 was [AGE] years old, male and admitted on [DATE] with diagnoses including chronic obstructive pulmonary disease, type II diabetes mellitus, stage 3 chronic lung disease, acquired absence of left leg below knee, acquired absence of other right toe(s), muscle wasting and atrophy (waste away of body tissue) and pain. Record review of the MDS dated [DATE] revealed Resident #8 was able to understand others and make himself understood. Resident #8 had adequate hearing, clear speech, and impaired vision. The MDS revealed Resident #8 had intact cognitive response. The MDS revealed Resident #8 required extensive assistance with dressing, toilet use, and bathing. Record review of the undated care plan revealed Resident #8 had ADL self-care performance deficit related to lower leg amputation and generalized weakness. Resident #8 requires extensive assistance by 1 staff member for showering on Tuesday, Thursday, and Saturday. The care plan indicate Resident #8 had impaired cognitive function or impaired thought process. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the ADL tracking sheet dated 8/1/21 revealed Resident #8 had 2 showers out of 18 days. Resident #8 last shower charted was 8/17/21. During an interview on 8/16/21 at 9:38 a.m., Resident #8 said he had not received a shower in 3 days. He said they were short staffed. During an interview on 8/17/21 at 8:34 a.m., Resident #8 said he did not get a shower yesterday. He said he thought they were scared to give him a shower because he was so weak. 4. Record review of the consolidated physician orders dated 8/18/21 revealed Resident #70 was [AGE] years old, female and admitted [DATE] with diagnoses including mild intellectual disabilities, hypertension, muscle wasting and atrophy (wasting away of body tissue), lack of coordination, Parkinson's disease, schizophrenia, dementia, nuclear cataract, extrapyramidal (a movement disorder caused by defects in the basal ganglia) and movement disorder and pain. Record review of the MDS dated [DATE] revealed Resident #70 was usually understood and usually understands others. Resident #70 had adequate hearing, unclear speech, and adequate vision with corrective lenses. The MDS revealed Resident #70 had moderately impaired cognition. Resident #70 required supervision for dressing, toilet use, and personal hygiene. The MDS revealed Resident #70 required physical help in a part of bathing activity. Record review of the undated care plan revealed Resident #70 was PASRR (federal requirement to help ensure individuals are not inappropriately placed in nursing homes for long term care) II level due to intellectual development disability. The care plan revealed Resident #70 was dependent for meeting emotional, intellectual, physical and social needs. Resident #70 has ADL self-performance deficit related to impaired cognition and congenital malformation of left elbow. The care plan revealed Resident #70 required supervision assistance by 1 staff member for personal hygiene and oral care. Resident #70 had limited physical mobility related to generalized weakness. Record review of the ADL tracking sheet revealed Resident #70 had 10 out of 18 with no dressing/grooming noted. The ADL tracking sheet revealed Resident #70 received dressing/grooming on 8/15/21. During an observation on 8/16/21 at 10:16 a.m., Resident #70 was in her room and noted to have several long strands of hair, approximately 0.5 inches long on her upper lip and chin. During an observation on 8/17/21 at 7:29 a.m., Resident was standing in her doorway with several long strands of hair, approximately 0.5 inches long on her upper lip and chin. During an interview on 8/17/21 at 8:05 a.m., Resident #70 said she got a shower on Sunday and cannot remove her chin hair because the mirror was too small in the shower room. Resident #70 said she does not like her facial hair and needs help. 5. Record review of the face sheet dated 8/18/2021 indicated Resident #26 was a [AGE] year-old male admitted on [DATE] with the diagnoses of cerebral infarction (stroke), hemiplegia to the left side of the body (paralysis that follows a stroke), aphasia (difficulty speaking) and diabetes. (continued on next page)

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	675361	A. Building B. Wing	08/18/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wharton Nursing and Rehabilitation Center	1220 Sunny Lane Wharton, TX 77488

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the MDS and care plan dated 6/8/2021 indicated Resident #26 was sometimes understood and sometimes understood others. The MDS also indicated a moderate impairment of Resident #26's cognitive ability to make daily decisions. Resident #26 required extensive assistance with ADLs, including bathing and grooming. The care plan did not indicate any refusal of bathing or grooming. During an observation and interview on 8/16/2021 at 9:22am Resident #26 was noted to have a large amount of facial hair covering his face and neck. Resident #26 indicated no by moving head from side to side when asked if he wanted to have a beard. Resident #26 mimicked shaving his face and nodded when asked if he wanted to be shaved. During an observation and interview on 8/18/2021 at 3:45pm Resident #26 was still noted to have a large amount of facial hair. CNA A stated he should be shaved on his bath day and they were Tuesday, Thursday and Saturday. CNA A stated she was unsure why he had not been shaven. CNA A stated sometimes we cannot get to all the bathes on a hall because we get busy and there was only one aide on the hall. CNA stated she just attempted to give them a bath on their next scheduled day if they missed one. 6. Record review a face sheet dated 8/18/2021 indicated Resident #25 was a [AGE] year-old male that admitted on [DATE] with the diagnoses of anemia, congestive heart failure and hypertension. Record review on 8/18/2021 a MDS and care plan dated 6/11/2021 indicated Resident #25 was usually understood and usually understands. Resident #25 has a Brief Interview of Mental Status Score of 10 on a scale of 00-15. The score of 10 indicated he had mild cognitive impairment. The MDS indicated Resident #25 required extensive to dependent assist with ADLs. The care plan did not mention any resistance or refusals for ADL care, grooming or bathing. During an observation, interview, and record review on 8/16/2021 at 9:21am Resident #25 was noted to have long jagged (approximately 2 inches past the tip of his fingers) fingernails to both hands with a thick brown substance underneath the nails. Resident #25 had a large amount of unkept facial hair covering his entire face and neck. Resident #25 stated he had not had a bath in a week. A review of the August bathing documentation sheets showed he had a bath the day before. When asked if he had a bath the day before he stated he did not remember having a bath the day before. He stated he wanted his beard shaved off. Resident #25 stated all that facial hair itched. During an observation and interview on 8/18/2021 at 3:45pm Resident #25 was noted to still have the unkept facial and neck hair and was scratching it with his dirty long jagged fingernails. Resident #25 stated he wanted to have his nails cleaned and cut and his beard shaved, and he stated he felt dirty. During an interview on 8/18/2021 at 3:48pm CNA A stated the CNA's were responsible for shaving and grooming on bath days. She explained that at times it was difficult to get to everyone on bath day because she was the only aide down the hallway. CNA A stated it was the nurse's job to cut all nails. CNA A stated Resident #25 liked to be shaved when he had a bath. CNA A stated she did not work on his side the last day he was scheduled for a bath and she was unaware of why he was not groomed. 7. Record review on 8/18/2021 a face sheet indicated Resident #3 was a [AGE] year-old female that admitted on [DATE] with the diagnoses of atrial fibrillation (irregular heartbeat), hypertension, and insomnia. (continued on next page)

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	675361	A. Building B. Wing	08/18/2021

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review on 8/18/2021 a MDS dated [DATE] indicated Resident #3 was usually understood and usually understood others. Resident #3 had a Brief Interview of Mental Status score of 10 on a scale of 00-15. The score indicated a mild cognitive impairment. The MDS indicated Resident #3 required extensive assistance for ADLs including bathing and personal hygiene. During a record review on 8/18/2021 a care plan dated 7/30/2021 indicated that Resident #3 required extensive assist with personal hygiene. The assigned bath days for Resident #3 were Monday, Wednesday and Friday on the days shift. Grooming was to take place during this time. During an observation and interview on 8/16/2021 at 9:33am Resident #3 was noted to have a patch of long gray hair to her chin. Resident #3 became tearful and stated she could see the whiskers when she talked, and it embarrassed her to have such long whiskers coming from her chin. During an interview on 8/18/2021 at 9:45 am the ADON stated she was aware that bathes were not being given as scheduled. The ADON stated it was the nurse's responsibility to assist and ensure bathing and grooming is being completed. She stated the CNAs had flow records they record bathing and grooming on in the computer. The ADON stated it was the responsibility of the nurses to trim nails on bath days or when needed. During an interview on 8/18/2021 at 12:10pm the DON stated the right side of the hall was bathed on Monday, Wednesday and Friday and the left side of the hall bathed on Tuesday, Thursday and Saturday. She stated A beds are done on morning shift and B beds are done on the evening shift. The DON stated it was the responsibility of the nurses to ensure the CNA's knew their bathing assignments and completed them. The DON stated she was unaware of a problem with missed baths and grooming. The DON stated it was not acceptable when asked about the lack of bathing and grooming for Resident #274, #25, #26 and #3 and she would find out why it is not happening as it should. During an interview on 8/18/2021 at 1:45pm the Administrator stated the DON and ADON were responsible to monitor the nurses and CNA's to ensure bathing schedules were followed. The Administrator stated they did not have a policy about bathing and grooming and followed CMS guidelines. CMS guidelines were not provided prior to exit of the survey team. 44933

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F 0689 Level of Harm - Actual harm Residents Affected - Few	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** 44120 Based on interview and record review the facility failed to ensure the resident environment remained as free of accident hazards as is possible for 1 of 3 residents reviewed for transfers (Resident #274). NA G initiated a mechanical lift transfer without the assistance of additional staff for Resident #274. The facility did not make sure two staff members were always available during a mechanical lift transfer for Resident #274 who sustained a fractured left femur. This failure could place residents who required assistance with transfers at risk for discomfort, pain and injury. Findings included: Record review of physician orders dated [DATE] indicated Resident #274 was [AGE] years old readmitted on [DATE] (original admitted [DATE]) with diagnoses including cerebral infarction (stroke), history of traumatic brain injury, cortical blindness of the left and right side of the brain, lack of coordination and muscle wasting and atrophy. Record review of the MDS dated [DATE] indicated Resident #274 was severely impaired cognitively, usually understood other and sometimes made herself understood. The MDS indicated Resident #274 BIMS (Brief Interview of Mental Status) was 06 on a scale of ,d+[DATE] which indicated her cognition was severely impaired. The MDS indicated she required limited assistance with bed mobility, dressing, eating, toilet use and personal hygiene. The MDS indicated Resident #274 required extensive assistance with transfers requiring 2-person (staff) assistance. Resident #274 was totally dependent on staff for bathing. Record review of an undated care plan indicated Resident #274 was dependent on staff for meeting emotional, intellectual, physical and social needs related to cognitive deficits and immobility. The care plan indicated Resident #274 had an ADL self-care performance deficit related to confusion, impaired balance, history of CVA (cerebral vascular accident), generalized weakness, muscle atrophy and wasting, and poor safety awareness. One of the interventions to this ADL performance self-care deficit was during transfers the resident was totally dependent on two staff and required a mechanical lift that required 2 staff for transfers. The care plan indicated Resident #274 had limited physical mobility related to neurological deficits, weakness, traumatic brain injury, impaired mobility and impaired cognition and thus, the resident was non-weight bearing (she could not bear weight on her legs). The care plan indicated Resident #274 had osteoporosis related to inadequate calcium intake and was at risk for fractures and the interventions included to monitor the resident for falls and injuries. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	A record review of the facility's undated investigation report revealed on [DATE] Resident #274 complained of pain and had discoloration noted to her lower left extremity. The investigation report indicated Resident #274 was assessed by nurse and treated for pain. The nurse updated the resident's provider and the provider ordered STAT x-rays. The report indicated x-rays completed on [DATE] returned with a finding of a left femoral diaphyseal fracture and the provider was updated on the findings. The report indicated the provider ordered the resident to be sent to local hospital via ambulance for further treatment. The report indicated the resident's responsible party was notified and a full investigation was in progress. The report revealed NA G provided care to resident on the morning shift of [DATE] and was placed on suspension pending the investigation. The report indicated the facility provided staff education related to findings of the investigation. A record review of a facility investigation interview dated [DATE], the Interim DON documented a conversation with CNA L . CNA L was working on 300 Hall and helped transfer Resident #274 back to bed with the help of RN J. CNA L noted the swollen area to the posterior thigh of the resident's left leg and alerted the charge nurse, LVN K and the DON. Upon assessment of the area it was noted that there was localized soft tissue swelling approximately 7 inches by 4 inches . A record review of a facility investigation phone interview on [DATE], the Administrator documented .NA G worked the 6 a.m. to 2 p.m. shift on [DATE] and was assigned to work the 300 Hall. NA G did care for Resident #274 who required to be transferred with a mechanical lift. NA G said she did get Resident #274 up to her wheelchair with the sling and mechanical lift. When asked if there was any incident during this transfer or if the resident had any complaints of pain, NA G denied any incident. When asked who completed the transfer with her, she indicated the used the mechanical lift by herself . A record review on an incident report dated [DATE] indicated Resident #274 was up in her chair and asked to go back to her bed. The report revealed CNA L and RN J transferred resident to her bed and when the resident's pants were removed to check and change her there was swelling seen to the outer aspect of the left upper leg. The incident report indicated the resident was unable to describe what happened and only said she was hurting in her leg. The incident report indicated no witnesses to this event and the DON and administrator were notified and made aware of the requested x-rays that were ordered STAT (immediately). The incident report indicated the x-ray was not completed that day and was completed the next day and revealed a femur fracture. The incident report indicated this finding was confirmed with a radiologist at 6:40 p. m., and the Nurse Practitioner was notified and gave orders to have resident sent to local hospital, via ambulance, for further treatment. A record review of NA G employment record dated [DATE] indicated NA G was trained and checked off on the proper use of a mechanical lift. This employment record check-off sheet was signed and dated by NA G. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During a phone interview on [DATE] at 10:36 a.m., NA G said that the morning of [DATE] she needed to get Resident #274 up from bed and into her geriatric chair. She said the resident's family member came to the facility every day and she wanted the resident out of bed. NA G said the resident required total assistance with transfers and required a mechanical lift. She said she knew the mechanical lift required a mandatory of two staff to operate but she could not find anyone to help her. She said she CNA H was working with her and she was busy giving a resident a bath and she could not assist at that time. She said she knew the mechanical lift always required two staff to operate and she should have left the resident in the bed until she could get help. She said completed the mechanical lift transfer on Resident #274 without additional staff assistance and the transfer was successful and without incident. She said the resident never complained of pain and was comfortably placed in her geriatric chair. She said Resident #274 could communicate needs by answering yes/no to questions. She said she had been trained on abuse, neglect, fall prevention but had not been trained by facility on mechanical lift proper procedure. She said she was a CNA at this facility from [DATE] to [DATE] and then returned to work at the facility on [DATE] and was put on suspension [DATE], due to the inappropriate transfer with use of the mechanical lift. She said she was then terminated from her employment at this facility after investigation was completed. During an interview on [DATE] at 10:56 a.m., CNA L said when she walked by Resident #274's room the morning of [DATE] the resident was sitting in the wheelchair crying and complaining of pain to her left thigh and lower left leg. She said the resident could not tell her what happened because the resident was severely cognitively impaired, but she can answer yes or no questions appropriately. She said she went an informed the charge nurse, LVN K, of the resident's pain complaints and asked RN J to help transfer the resident back to bed at the resident's request. She said the resident required a mechanical lift for transfers and this type of mechanical lift always required two staff members. She said they transferred the resident to the bed successfully and without incident. She said she was going to preform person hygiene care for Resident #274 and when she pulled her pants down, she noticed swelling on the resident's left thigh and left knee. She said she also noticed bruising around her left shin area. She said she went and reported the findings to RN J and the DON. She said she had never seen NA G be aggressive towards any residents. She said Resident #274 can use the side rails of her bed to reposition herself in bed. CNA L said she had been trained on using a mechanical lift and checked off on this skill after hire. She said she understood it required two staff to operate and transfer a resident using the mechanical lift. During an interview on [DATE] at 11:10 a.m., CNA H said she was working 300 and 400 Hall on [DATE] with NA G. She said she did not recall NA G asking her for help with the mechanical lift to transfer Resident #274 to her wheelchair. CNA H said she had been trained on proper mechanical lift procedures and knew it required two staff members to operate during a resident transfer. During an interview on [DATE] at 11:24 a.m., LVN K said Resident #274 could communicate her needs with yes and no questions, and she could say when she was feeling pain. She said RN J did report to her that Resident #274 was crying and complaining of pain. She said after lunch when the RN J and CNA L reported the swelling and bruising to the resident's left leg. She said she and the DON went in and assessed the resident's leg and found swelling at the left thigh and knee. She said there was also a bluish-purple bruise seen at the resident's left shin. She said she called the NP, reported the findings and obtained new orders for STAT (immediate) x-rays and administered pain medication as ordered. She said she notified the family member as well. She said the findings of the x-ray revealed a left femur fracture and the resident was sent to local hospital for further treatment. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During an interview on [DATE] at 11:50 a.m., the DON said on [DATE] it was reported to her by LVN K that Resident #274 had swelling and bruising to her left thigh and knee. She said she assessed the resident and instructed LVN K to call the NP and family representative. She said the resident could not say what happened to her leg and she reported that injury of unknown origin to the Administrator immediately. The DON said they began an investigation immediately and went back 72 hours talking to nursing staff. She said she spoke with NA G on [DATE] and NA G admitted to using the mechanical lift without additional staff assistance but said there was not an incident and the resident did not complain of any pain. She said the facility then suspended NA G due to the inappropriate transfer using mechanical lift until the investigation was complete. She said all nursing staff including CNAs were trained on mechanical lifts as part of the on-boarding process and there were check off lists that must be completed. She said once the facility found Resident #274 had a fracture of her left femur, they then terminated NA G from employment. She said since NA G was just recently employed in [DATE] and then re-employed in [DATE] the training that was given in the first employment term upheld because it was within 6 months of the previous employment. She said she expected staff to follow proper procedures and not to inappropriately use the mechanical lift, because it could cause injury to the residents. During an interview on [DATE] at 12:15 p.m., the Administrator said she was notified of the resident's injury on [DATE] when the injury was found. She said she and the DON began the investigation and reported the injury to the state agency. She said NA G certified nurse's aide license had expired and she was working under a waiver until she could get certified in [DATE]. She said NA G had worked for the facility back in [DATE] until [DATE] and then restarted employment [DATE]th, 2021. She said they suspended NA G for the inappropriate transfer when using the mechanical lift and then terminated NA G when the investigation was complete. She said the investigation never determined the root cause of Resident #274 fracture. She said she expected staff to follow proper procedures and not to inappropriately use the mechanical lift, because it could cause injury to the residents. She said in-service training on appropriate transfers and using the Hoyer lift was conducted on [DATE] to all nursing staff. During an interview on [DATE] at 10:30 a.m., the Nurse Practitioner said he remembered being advised of the injury initially and that the resident had to wait until the next day for x-ray due to the staffing at the radiology company. He said when the fracture was discovered he gave orders to staff to have Resident #274 sent to the local hospital for further evaluation. He said he spoke with the surgeon that performed the resident's surgery and it was discovered that the resident had advanced osteoporosis. He said the surgeon told him, She could roll over in bed and break a bone. He said Resident #274 bones were extremely brittle. He said he expected all nursing staff to follow proper procedure when using the Hoyer lift and any resident care. During an interview on [DATE] at 11:00 a.m., Resident #274 family member said she knew NA G had done an inappropriate transfer with the Hoyer lift and felt the facility handled the situation appropriately. She said she was informed about everything that had happened. She said the surgeon told her that Resident #274's bones were very brittle, and she could bump her elbow and it would break. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Record review of the facility policy Safe Lifting and Movement of Resident, revised ,d+[DATE], indicated .In order to protect the safety and well-being of staff and residents, and to promote quality of care, this facility uses appropriate techniques and devices to lift and move residents .resident safety, dignity, comfort and medical condition will be incorporated into goals and decisions regarding the safe lifting and moving of residents .manual lifting of residents shall be eliminated when feasible .the use of a mechanical lift with residents requires the assistance of two staff members .

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44128 Based on observations, interview, and record reviews the facility did not implement interventions for a new significant weight loss for 1 of 19 residents (Resident #62), reviewed for nutritional status. LVN E did not report the significant weight loss of 11.11% for Resident #62 which resulted in a lack of intervention to prevent further weight loss. The failure could place the residents at risk for significant weight loss and further decline in nutritional status. Findings included: Record review of the consolidated physician's orders dated 08/17/2021 indicated Resident #62 was a [AGE] year-old female, admitted on [DATE] with diagnoses of dementia, anxiety disorder, and osteoarthritis. The orders indicated a regular diet. There were no orders after 07/06/2021 for additional supplements, changes to diet, appetite stimulant or labs to be drawn. Record review of the MDS dated [DATE] indicated Resident #62 was sometimes understood and sometimes understood others. The MDS indicated a BIMS (Brief Interview for Mental Status) was not conducted due to the resident rarely being understood. The MDS also indicated Resident # 62 required extensive assistance from staff with ADLs. The MDS indicated Resident #62 weighed 135 pounds and her height was 64 inches. Record review of a care plan dated 01/29/2021 indicated Resident #62 was dependent on staff for meeting emotional, intellectual, physical, and social needs. The care plan indicated Resident #62 was at risk for potential a nutritional problem related to dementia. Record review of a weight summary indicated Resident #62 weighed 128.4 pound upon admission on 01/07/2021. On 04/05/2021 Resident # 62 weighed 130.2 pounds. On 05/18/2021, 06/08/2021, and 07/06/2021 Resident # 62 weighed 135.0 pounds. On 08/05/2021 Resident #62 weighed 120.0. Record review of labs for Resident #62 did not indicate any labs drawn since 05/24/2021. Record review of meal intake documentation for Resident #62 dated 5/31/2021 - 8/15/2021 indicated on 5/31/2021 the resident ate between 26% - 50%, on 7/19/2021 the resident refused her morning meal. The records did not indicate any further meals refused by the resident. There were many dates with no information documented. All other meals were documented at 51% to 100% meal intake. During an observation on 08/16/2021 at 12:38 p.m., Resident #62 sitting in dining room. The resident was assisted by staff with her meal. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 08/17/2021 at 11:46 a.m., the dietician said he follows up on residents in the facility once a month. He said he sees those with a significant weight loss, pressure wounds, and new admissions. He said he was usually notified by email by the DON, administrator, or dietary manager of any residents with a significant weight loss. He said he had not been notified and was not aware of a significant weight loss for Resident # 62. He said LVN E usually kept him in the loop. He said he could not say what his recommendations would be for Resident #62 without reviewing her information and history. During an interview on 08/18/2021 at 9:21 a.m., CNA L said Resident #62 required full assistance with eating. She said Resident # 62 eats good and has a really good appetite. She said the resident never refuses to eat. She said she usually eats 75% of her meals. During an interview on 08/18/2021 at 9:27 a.m., LVN B said Resident #62 had a good appetite. She said she normally eats 50% to 100% of her meals. She said she is not the nurse that weighs Resident #62. She said if there had been a weight loss the nurse should have notified the doctor. She said for a 15 pound weight loss in one month, the dietician should have been notified. During an observation on 08/18/2021 at 10:00 a.m., LVN E weighed Resident #62. Resident #62 weighed 120.6 pounds. During an interview on 08/18/2021 at 10:14 a.m., LVN E said she was the one that weighed Resident #62 at the first of the month. She said normally when there was a weight loss it was reported to the dietician. She said she had not reported Resident #62's weight loss to the dietician. She said once weights were obtained on all residents for the month they would be reported to the dietician. During an interview on 08/18/2021 at 10:30 a.m., the DON said there were a few CNA's that weighed residents and LVN E helps obtain weights. She said the dietician and nurse managers should look at weight changes. She said LVN E probably should have reported the weight loss of Resident #62 when she weighed the resident. She said once a month the dates are written down and reported to the appropriate person. She said she felt the meals that were not documented on the meal intake record were just not documented and that meals were consumed by the resident. During an interview on 08/18/2021 at 12:54 a.m., the administrator said anytime there was a significant weight changes the dietician, nurse practitioner, and doctor should be notified so changes could be made and discussed in the interdisciplinary risk committee. She said the resident should also be re-weighed to clarify the weight. Record review of the Weighing and Measuring the Resident facility policy dated 05/2017 indicated, The purpose of this procedure are to determine the resident's weight and height to provide a baseline and ongoing record of the resident's body weight as an indicator of the nutritional status and medical condition of the resident . Record review of the Weight Monitoring and Calculation of Significant Weight Changes facility policy dated 01/01/2013 indicated, .monthly weights should be completed by the fifth day of each month .all significant weight losses and gains will be reviewed by an interdisciplinary weight or risk committee .the consultant dietitian will attend the weight committee meetings .the weight committee will discuss possible interventions and agree on a plan of care for the client .

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	675361	A. Building B. Wing	08/18/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43817 Based on observation, interview and record review, the facility failed to ensure that respiratory care was provided consistent with professional standards of practice for 4 of 11 residents reviewed for respiratory care. (Resident #274, #10, #58, and #13). The facility failed to provide respiratory care to Resident #274, Resident #10, Resident #58, and Resident #13 consistent with professional standards of practice. This failure could place residents at risk of not receiving respiratory care. 1. Record review of the face sheet dated 8/18/2021 indicated Resident #274 was a [AGE] year-old female that admitted on [DATE] with the diagnoses of cerebral infarction due to blood clot (stroke), personal history of traumatic brain injury, and heart failure. Record review of the MDS dated [DATE] indicated Resident #274 was usually understood and usually understood others. Resident #274 had had a severe cognitive deficit. Record review of an order summary report dated 8/18/2021 indicated Resident #274 had an order for oxygen at 2 liters per minute via nasal canula and ipratropium-albuterol solution 3 milliliters every 6 hours. During an observation on 8/16/2021 at 10:20 am an undated nasal canula was laying on top the nightstand of Resident #274 uncovered. An undated nebulizer mask was laying uncovered on top the nightstand. During an observation on 8/17/2921 at 9:00 am an undated nasal canula was laying on top the nightstand of Resident #274 uncovered. An undated nebulizer mask was laying uncovered on top the nightstand. 2. Record review of the face sheet dated 8/18/2021 indicated Resident #10 was a [AGE] year-old female that admitted on [DATE] with the diagnoses of acquired absence of left leg above the knee, anemia, and bipolar disorder. Record review of the MDS dated [DATE] indicated Resident #10 was understood and understood others. Resident #10 was cognitively intact. Record review of an order summary report dated 8/18/2021 indicated Resident #10 had an order for oxygen at 2-4 liters per minute via nasal canula from 8pm-8am and ipratropium-albuterol solution 3 milliliters every 6 hours as needed for shortness of breath. During an observation on 8/16/2021 at 10:20 am an undated nasal canula was laying on the floor beside the bed of Resident #10 uncovered. An undated nebulizer was laying on nightstand uncovered. (continued on next page)

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	675361	A. Building B. Wing	08/18/2021

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 8/17/2021 at 9:00 am an undated nasal canula was wrapped around the transfer bar of the bed of Resident #10 uncovered. An undated nebulizer was laying on nightstand uncovered. 3. Record review of the face sheet dated 1/28/2021 indicated Resident #58 was a [AGE] year-old female that admitted on [DATE] with the diagnoses of congestive heart failure, schizophrenia, and diabetes mellitus. Record review of the MDS dated [DATE] indicated Resident #58 was usually understood and usually understood others. Resident #58 had a Brief Interview of Mental Status score of 04 on a scale of 00-15. This indicated Resident #58 had a severe cognitive deficit. Record review of an order summary report dated 8/18/2021 indicated Resident #58 had an order for oxygen at 4 liters per minute via nasal canula and ipratropium-albuterol solution 3 milliliters every 6 hours as needed. During an observation on 8/16/2021 at 9:20 am an undated nasal canula was being used by Resident #58. An undated handheld nebulizer was laying uncovered on top the nightstand. During an observation and interview on 8/17/2021 at 9:45 am an undated nasal canula was connected to and used by Resident #58. Resident #58 stated it had been over a month since someone brought her a new cannula. An undated handheld nebulizer laid uncovered on the nightstand. 4. Record review of the face sheet dated 8/18/2021 indicated Resident #13 was a [AGE] year-old female that admitted on [DATE] with the diagnoses of dementia, schizophrenia, and emphysema. Record review of the MDS dated [DATE] indicated Resident #13 was usually understood and usually understood others. Resident #13 was moderately impaired. An undated care plan indicated Resident #13 had an order for oxygen at 2 liters per minute via nasal canula. During an observation and interview on 8/16/21 at 9:41 am Resident #13 did not know when her oxygen tubing and filter were changed out. Resident #13's oxygen tubing was not labeled or dated. The filter was dirty on the oxygen concentrator. During an observation on 8/16/21 at 1:00 pm Resident #13's oxygen tubing was not labeled or dated, and filter was dirty on the oxygen concentrator. During an observation on 8/17/21 at 8:10 am Resident #13's oxygen tubing was not labeled or dated, and filter was dirty on the oxygen concentrator. During an observation on 8/17/21 at 1:10 pm Resident #13's oxygen tubing was not labeled or dated, and filter was dirty on the oxygen concentrator. During an observation on 8/18/21 at 8:56 am Resident #13's oxygen tubing was not labeled or dated, and filter was dirty on the oxygen concentrator. (continued on next page)

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	675361	A. Building B. Wing	08/18/2021

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 8/18/2021 at 9:00 am the ADON stated that all oxygen tubing, cannulas, nebulizer tubing and masks were changed weekly on nightshift. The ADON stated all respiratory equipment that was not in use should be stored in a plastic zipper bag to keep the items clean and dry. The ADON stated they do not put the changing of respiratory equipment on the MARs and TARs. During an interview on 8/18/2021 at 11:45am the DON stated all respiratory equipment should be stored in a plastic zipper bag when not in use for sanitary reasons. Oxygen tubing and nebulizers should be changed on Sunday on night shift each week. During an interview on 8/18/21 at 9:30 am LVN F said night shift nurse was responsible for labeling, dating, of oxygen tubing and changing out the filters on oxygen. She said if she saw it was not done, she would report to the ADON or DON, whoever was working. She said any staff who went into Resident #13's room would be responsible for reporting if filter was dirty and if the tubing was not labeled and dated. During an interview on 8/18/21 at 9:46 am Director of Nursing said night shift nurses were responsible for labeling and dating of tubing and cleaning of filters. She said if day shift sees it has not been done, they would be responsible for doing. She said the guardian angels do rounds each morning and check those things. She said it was her expectation that if this was not being done that this be reported to the DON so it can be corrected. During an interview on 8/18/21 at 9:51 am Administrator said she would need to check with DON but believed the oxygen tubing was to be labeled and dated weekly and filter changed out. She did not know which staff was responsible for performing these tasks. She said it would be her expectation if the oxygen tubing was not labeled and dated properly and the filters were not clean this would be reported to the DON or herself so that it could be corrected. During an interview on 8/18/2021 at 2:00 pm the Administrator stated she expected the DON and ADON to mandate how often respiratory equipment was changed and how it was stored. The Administrator stated the facility did not have a respiratory policy they followed CMS guidelines.

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	675361	A. Building B. Wing	08/18/2021

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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. 44128 Based on observation, interview, and record review the facility failed to store, prepare, distribute and serve food in accordance with professional standards in 1 of 1 kitchen reviewed for food service safety. 1. The facility failed to ensure all food items were labeled and dated in the refrigerator, freezer and pantry. 2. The facility failed ensure the ice machine and chilled juice beverage dispenser was maintained and cleaned. 3. The facility failed to ensure cardboard boxes were stored at least 6 inches off the floor. These failures could place residents at risk of foodborne illness. Findings include: 1. During an observation on 08/16/2021 at 9:21 a.m., revealed in the refrigerator near the ice machine one package of undated American cheese open to air with 3 slices touching the refrigerator shelf. There was a 1-gallon storage bag full of unknown fruit slices, no date or label. There was a plastic container with red fruit in a thick pie filling, covered with plastic wrap with no date or label. There was a half full 1-gallon storage bag with unknown fruit slices with no date or label. During an observation on 08/16/2021 at 9:28 a.m., revealed there was a prepared rice dish with tomatoes in a metal pan covered in plastic wrap with no date or label in the refrigerator along the back wall of the kitchen. During an observation on 08/16/2021 at 9:29 a.m., revealed in the freezer an undated package of smoked sausage and an unknown package of frozen meat on the bottom shelf with no date or label. There were three packages of pork loin with no date. During an interview on 08/16/2021 at 9:30 a.m., the dietary manager said there was no date on the cheese and no date or label fruit. She said it was the dietary aide's job to label the food. She said they were working five people short and right now I am the dietary aide. During an observation on 08/16/2021 at 9:37 a.m., revealed in the refrigerator in the pantry 8 containers of strawberries with no dates. There was a used whipped topping in a bag, the tip covered with plastic wrap, with no date. During an observation on 08/16/2021 at 9:40 a.m., revealed 3 boxes of carrot cake mix with no date and 5 boxes of Devil's food cake mixes with no date in the pantry. (continued on next page)

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	675361	A. Building B. Wing	08/18/2021

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 08/18/2021 at 8:52 a.m. with the Dietary Manager revealed the cook was responsible for labeling and dating food in the pantry, refrigerator, and freezer. She said food items should be dated as they are stocked. She said the refrigerator should be checked daily. She expects staff to rotate item. She said it should be a first in first out system. She said out of date items could make a resident sick. During an interview on 08/18/2021 at 9:15 a.m., Cook M revealed it was all of the dietary staff's job to make sure all food was dated and labeled. During an interview on 08/18/2021 at 12:54 p.m., the administrator revealed all food items to be dated and labeled. She said dietary staff was responsible for dating and labeling foods. She said foods should be dated and labeled to prevent illness caused by contamination. Record review of a facility Food Storage policy dated 12/01/2011 reflected, .to ensure freshness, opened and bulk items are stored in tightly covered container. All containers are labeled and dated. The first in, first out rotation method is used. Packages are dated .all refrigerated foods are stored per state and federal guidelines .all refrigerated foods are dated, labeled and tightly sealed, including leftovers . 2. During an observation on 08/16/2021 at 9:20 a.m., revealed the top door compartment of the ice machine had a black substance scattered on the walls and door. There was a pink slime present on the mechanism in front of flowing water. The door was not attached to the ice machine and fell to the floor when opened. During an observation on 08/16/2021 at 9:32 a.m., revealed the left side of the chilled juice beverage dispenser was covered with splatters of different colors of beverages. The outside was covered in a sticky residue. During an interview on 08/18/2021 at 8:52 a.m. with the Dietary Supervisor revealed she agreed the ice machine needed to have been cleaned. She said she has only been the manager for one month and she was told the maintenance department was responsible for cleaning the ice machine. She said she was not sure how often it should be cleaned. She said the chilled beverage machine should be cleaned daily by the dietary aid. She said she does have a cleaning schedule. She said both the ice machine and beverage machine should be kept clean for sanitation purposes. She said contaminated machines could make residents sick. During an interview on 08/18/2021 at 9:15 a.m., with Cook M revealed there was a daily cleaning schedule of who cleans what each day. She said whoever makes the drinks for the day should be cleaning the beverage dispenser. She said this would be a dietary aide. During an interview on 08/18/2021 at 09:05 a.m. with the Maintenance Supervisor revealed he was responsible for cleaning the ice machine. He said it was done quarterly. He said he was not sure when it was last cleaned. He said he does have a log he keeps. During an observation on 08/18/2021 at 10:00 a.m., a work history report of the ice machine revealed the ice machine had last been cleaned on 05/31/2021. A daily cleaning schedule for the kitchen revealed equipment should be cleaned daily after each use. There was no indication of the cleaning schedule for the ice machine. (continued on next page)

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	675361	A. Building B. Wing	08/18/2021

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 08/18/2021 at 12:54 p.m., with the Administrator revealed it was the Dietary Manager's and the Maintenance Supervisor's job to make sure the ice machine was clean. She said she would expect it to have been kept clean. She said it was important to have a clean ice machine for sanitation purpose to prevent illness in residents. She said she wasn't sure how often the beverage machine should be cleaned but should at least be cleaned on an as needed basis by dietary department staff. Record review of a facility policy General Kitchen Sanitation dated 12/01/11 reflected, .all food preparation areas, food-contact surfaces, dining facilities and equipment are cleaned and sanitized after each use . 3. During an observation on 08/16/2021 at 9:35 a.m. revealed there was 1 cardboard box of disposable cup lids stored on the floor next to the refrigerator. The box was marked with a received dated on 08/07/2021. During an interview on 08/18/2021 at 8:52 a.m., the dietary manager revealed boxes should be kept 6 inches off of the floor. She said this was the cook's responsibility. She said it was important to store boxes off the floor, so the items were not contaminated by dirt or rodents. During an interview on 08/18/2021 at 9:15 a.m., Cook M revealed boxes should be stored 6 inches off the floor. She said there were two men that work in the kitchen, one was a cook and one was an aide. She said they were usually the ones to make sure boxes were not stored on the floor. Record review of the Texas Food and Establishment Rules indicated 228.69. Preventing Contamination from the Premises. Food in packages and working containers may be stored less than 15 cm (6 inches) above the floor on case lot handling equipment .228.79 .Food packaged in a food establishment, shall be labeled as specified in law . Label information shall include: the common name of the food, or absent a common name, an adequately descriptive identity statement . 228.75 .refrigerated, ready-to-eat, TCS food prepared and held in a food establishment for more than 24 hours shall be clearly marked to indicate the date or day by which the food shall be consumed on the premises, sold, or discarded when held at a temperature of 5 degrees Celsius (41 degrees Fahrenheit) or less for a maximum of 7 days. The day of preparation shall be counted as day 1 . the day or date marked by the food establishment may not exceed a manufacturer's use-by date if the manufacturer determined the use-by date based on food safety .A refrigerated, ready-to-eat TCS food ingredient or a portion of a refrigerated, ready-to-eat, TCS food that is subsequently combined with additional ingredients or portions of food shall retain the date marking of the earliest-prepared or first-prepared ingredient .marking the date or day of preparation, with a procedure to discard the food on or before the last date or day by which the food must be consumed on the premises, sold, or discarded .228.104 . Nonfood-contact surfaces shall be free of unnecessary ledges, projections, and crevices, and designed and constructed to allow easy cleaning and to facilitate maintenance .228.113 equipment food-contact surfaces and utensils shall be clean to sight and touch . the food-contact surfaces of cooking equipment and pans shall be kept free of encrusted grease deposits and other soil accumulations. Nonfood-contact surfaces of equipment shall be kept free of an accumulation of dust, dirt, food residue, and other debris.

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	675361	A. Building B. Wing	08/18/2021

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44120 Based on observation, interview, and record review the facility failed to maintain a safe environment for residents, staff, and the public for 4 of 4 halls, 1 of 1 dining rooms and 1 of 1 Activity Room reviewed for environment. The facility failed to ensure the air conditioning vents were clean, sanitary and free from black, spotted stains on all four halls, the dining area and the activity room. These failures could place the residents, staff and the public by placing them at risk for diminished quality of life due to the lack of a clean and well-kept environment. Findings included: During an observation on 8/18/2021 at 9:30 a.m., on Hall 100 the following was observed: -Strong smell of mildew when walking onto the hall. -4 out of 7 air conditioning vents and surrounding sheetrock in the Hall 100 hallway were spotted with a black substance that could not be wiped off. -In room [ROOM NUMBER] one out of two air conditioning vents were spotted with a black substance that could not be wiped off. -In room [ROOM NUMBER] two out of two air conditioning vents were spotted with a black substance that could not be wiped off. -In room [ROOM NUMBER] one of two air conditioning vents were spotted with a black substance that could not be wiped off. -In the shower room on Hall 100, 1 of 1 air conditioning vents were spotted with a black substance that could not be wiped off. There were three cracks coming from air conditioning vent in the sheet rock, all cracks measuring approximately 8 inches in length. During an observation on 8/18/2021 at 9:45 a.m., on Hall 200 the following was observed: - 2 of 6 air conditioning vents on Hall 200's hallway was seen with black spotted stains that were scattered on vent and sheetrock surrounding the vent. -In room [ROOM NUMBER] 1 of 2 air conditioning vents were seen with black spotted stains that were scattered on vent and sheetrock surrounding the vent. - In room [ROOM NUMBER] 1 of 2 air conditioning vents were seen with black spotted stains that were scattered on vent and sheetrock surrounding the vent. (continued on next page)

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	675361	A. Building B. Wing	08/18/2021

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	- In room [ROOM NUMBER] 1 of 2 air conditioning vents were seen with black spotted stains that were scattered on vent and sheetrock surrounding the vent. During an observation on 8/8/2021 at 10:00 a.m., on Hall 300 the following were observed: -1 of 6 conditioning vents on Hall 300's hallway was seen with black spotted stains that were scattered on vent and sheetrock surrounding the vent. -In room [ROOM NUMBER] 1 of 2 air conditioning vents were seen with black spotted stains that were scattered on vent and sheetrock surrounding the vent. - In room [ROOM NUMBER] 1 of 2 air conditioning vents were seen with black spotted stains that were scattered on vent and sheetrock surrounding the vent. - In room [ROOM NUMBER] 1 of 2 air conditioning vents were seen with black spotted stains that were scattered on vent and sheetrock surrounding the vent. During an observation on 8/8/2021 at 10:15 a.m., on Hall 400 the following were observed: -2 of 6 conditioning vents on Hall 400's hallway was seen with black spotted stains that were scattered on vent and sheetrock surrounding the vent. -In room [ROOM NUMBER] 1 of 2 air conditioning vents were seen with black spotted stains that were scattered on vent and sheetrock surrounding the vent. - In room [ROOM NUMBER] 1 of 2 air conditioning vents were seen with black spotted stains that were scattered on vent and sheetrock surrounding the vent. During an observation on 8/8/2021 at 10:25 a.m., in the main dining hall, the following were observed: -3 of 7 conditioning vents on Hall 400's hallway was seen with black spotted stains that were scattered on vent and sheetrock surrounding the vent. During an observation on 8/18/2021 at 10:32 a.m., the Activity Hall had 7 of 7 air conditioning vents were seen with black spotted stains that were scattered on vent and sheetrock surrounding the vent. During an observation on 8/18/2021 at 10:37 a.m., the Activity Director's office was seen to have a powder-green like substance growing on the metal shelving that housed the activity items for residents. This green-powdery substance could be wiped off with finger. During an observation on 8/18/2021 at 10:45 a.m., an office labeled Director of Nurses was seen to have a green-powdery substance growing on the underside of the middle drawer of the desk. This office was also observed to have COVID-19 testing supplies stacked in the corner. (continued on next page)

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	675361	A. Building B. Wing	08/18/2021

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 8/18/2021 at 10:50 a.m., the MDS nurse said she was very upset because of the mold that was in the building. She said she noticed it about a year ago. She said she noticed the black-spotted substance on and around the air vents and then a green-powdery mold was growing on her things she kept in her office such as, her pictures, desk, cork board, and jacket she kept on the back of her chair. She said she reported it in tales (the electronic maintenance log) and to her administrator. She said it was not the administrator they have now. The MDS nurse said she had to go to the doctor and was referred to an allergy doctor and they tested her. She said she tested allergic to all mold spores and she felt this building was the main cause. She said she had to be put on mediation including an inhaler. She said the maintenance supervisor will spray a bleach spray on the vents and the sheetrock around it and sometimes paint over the black spots. She said the mold always came back and she had to by an air purifier for her office. The MDS nurse said she had not any residents complain about mold or mildew to her. She said she had not reported her issues to the new administrator because she had already done that and felt everyone already knew and was not doing anything to correct the issue. During an interview on 8/18/2021 at 11:15 a.m., the Activities Director said she had the noticed the mold problem on her metal shelving for a few months that she could remember. She said she cleaned it with a bleach wipe, but it kept coming back. She said she reported it to the maintenance supervisor and the previous administrator. She said the maintenance supervisor was spraying the air conditioning vents with bleach spray today and he did that every few months, throughout the building. She said she had not had any health issues so far and she had not had any residents complain of about the air conditioning vents. She said when they had an issue that needed to be reported to the maintenance crew, they would enter it electronically into a system called, TELS. She said there was never any follow up to the staff to make sure the items were completed, that she was aware of. During an interview on 8/18/2021 at 11:27 a.m., the Social Worker said the building had a problem with mold and the maintenance man and previous Administrator knew about the issue. He said all they do is spray a bleach spray on the areas and will sometimes paint over the black spotted sheetrock. He said he had not had any health issues that he knew about. He said he had not had any residents complain to him about the blackened areas around the air conditioning vents or any health-related issues. He said when there was an issue that had to be reported to maintenance, they would enter the problem electronically into a system called TELS. He said they would enter the issue and there not a follow up for the reporting staff to make sure it was done. During an interview on 8/18/2021 at 11:40 a.m., the Maintenance Supervisor said he was not aware of a mold issue in the building. He said the black-spotted substance on multiple air vents and surrounding sheetrock was due to the condensation in the vent and the water mixed with the dirt and created the black substance. He said this was just dirt and not mold and he said I just know it is just wet dirt. He said he used bleach spray on these vents and the black substance just for disinfection purposes, not as a mold treatment. He said this was a housekeeping issue and he felt the housekeepers were not cleaning the air conditioning vents like they were supposed to. He said he reported this to the previous Administrator and hoped she would have addressed that with the housekeeping staff. He said he did not follow up to see if this issue was addressed but he assumed it was not because he was still having to clean the air vents himself. He said he had not had any residents complain about mold or mold related symptoms to him. He said staff would enter maintenance request into an electronic system called TELS, and he would check that report daily to monitor what needed attention. He said he did not recall anyone entering anything into this system regarding concerns of mold. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675361	A. Building B. Wing	08/18/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wharton Nursing and Rehabilitation Center	1220 Sunny Lane Wharton, TX 77488

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 8/18/2021 at 11:50 a.m., the Regional Clinical Coordinator said she was not aware of a mold problem throughout the building. She said she knew the Director of Nurses office flooded about a year ago and they did have a mold issue in that room, but they had taken care of that. She said they treated the room and all the furnishings for mold and was unaware of any lingering issues. She said she they were using the office for COVID-19 testing of staff and was not aware of the green-powdery mold-like substance that was found underneath the desk, growing on the bottom of the middle drawer. She said she would move the COVID-19 testing supplies out of that room and use another room for the testing. During an interview on 8/18/2021 at 12:00 p.m., the Administrator said she was not aware of any mold issues in the building. She said she was still new to this facility and has only been here around a month and had missed a week or two in that time due to moving from another state to this area. She said she had not had any employee or resident complaints of any mold or mold related health symptoms. She said she had not had any complaints of any black substances growing on the air conditioning vents or the surrounding sheetrock. She said she would investigate that immediately and see what she could get done. She said she expected the residents to live in an environment that was clean, sanitary and free from any substances that affect the health of the residents. Record review of a maintenance log dated 8/18/2020 to 8/19/2021 with a status of completed revealed the following undated entries: 1.Work order #8441: Mold growing back on vent and sheetrock in office. 2. Work order #5670: Please check chairs in conference room for mold, back of chair fell off yesterday and has green mold on the back. Bottoms of chairs are black and rippled from moisture. [NAME] asked me to message you and see if needed to get involved. Thank you. 3.Work order #8021: Water dripping from ceiling. 4.Work order #7957: Ceiling leak in common area. 5.Work order #8047: Ceiling leaking again. 6.Work order #8371L Leak in office. An environment policy was requested on 8/18/2021 and not given to survey team by facility by the administration.