STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455486	A. Building B. Wing	05/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ennis Care Center	1200 S Hall St Ennis, TX 75119

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 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews the facility failed to ensure that two (2) residents (Resident #1 and Resident #2) of six residents reviewed for transfer or discharge had the required documentation in the resident's medical record made by the physician for a safe and effective transition of care. The facility discharged Resident #1 on 3/20/2025 and Resident #2 on 3/19/2025 without physician documentation in the EMR. This failure could put residents at risk for inappropriate discharge from the facility and cause psychological harm due to feelings of anger and sadness. The findings included: Review of Resident #1's face sheet date 5/16/2025 revealed he was a [AGE] year-old male admitted on [DATE] with diagnoses that included seizures (abnormal electrical activity in the brain), dementia (progressive memory loss disorder) Epilepsy (seizure disorder), congestive heart failure, (chronic condition in which the heart does pump blood as well as it should), mood disorder and chronic obstructive pulmonary disease (group of breathing disorders). Review of Resident #1' s annual MDS assessment dated [DATE] reflected he had a BIMS of 15 suggesting he was cognitively intact. Review of Resident #1's closed care plan dated 3/27/2025 reflected he had a problem [Resident #1] sometimes have behaviors which include: cursing at staff/other resident refuses care at times, [Resident #1] hit another resident.' Review of Resident #1's progress notes dated 3/18/2025 at 12:15 pm revealed: Resident [#1] was attempting to walk past the nurses station but was unable to move past freely due to another resident [#2] sitting in front of the nurses station in a wheelchair. Resident became frustrated; the two male residents exchanged words. Then [Resident #1] struck the other male resident [Resident #2] in the shoulder/upper arm area. The other resident responded by swinging at [Resident #1]. Review of Resident #1's progress notes dated 5/19/2025 reflected a late MD note dated 5/19/2025 with an effective date of 3/20/2025 that stated, Late entry - Resident discharged secondary to life threatening aggressive behaviors affecting the safety of other residents. (continued on next page)

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

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #1's discharge notice dated 3/20/2025 related medical reason for discharge due to aggressive behaviors. Notice was signed by MD on 3/20/2025. Review of Resident #2's face sheet dated 5/16/2025 reflected he was a [AGE] year-old male admitted on [DATE] with diagnoses that included: cerebral infarction (occurs when blood flow to the brain is blocked), dementia (progressive memory loss disorder), hemiplegia (paralysis affecting one side), a cognitive social or emotional deficit following cerebral infarction, major depressive disorder, and anxiety disorder. Review of Resident #2' s quarterly MDS assessment dated [DATE] reflected he had a BIMS of 14 suggesting he was cognitively intact. Review of Resident #2's closed care plan dated 4/2/2025 reflected he had a problem [Resident #2] sometimes has behaviors which include inappropriate verbalizations and behaviors towards staff and other residents, making sexual remarks [to] staff/residents, taking other residents belongings without permission, refuses care including showers/grooming, urinates on floor and pours urine from urinal on floor invades personal space of other residents that are [cognitively] impaired, blocks hallways so others cannot pass, giving other residents food outside their diet, [Resident #2] hit another resident. Review of progress note dated 3/18/2025 at 11:00 am s for Resident #2 revealed: [Resident #2] was seated in his wheelchair at the nurses station. He was obstructing another resident's pathway around the nurses station. The two residents exchanged words not heard by this nurse. The other resident [Resident #1] was observed striking [Resident #2] in the right upper arm. [Resident #2] was noted striking back at the other resident [Resident #1] with his right arm. Review of Resident #2's progress notes dated 5/19/2025 reflected a late MD note dated 5/19/2025 with an effective date of 3/20/2025 that stated, Late entry - Resident discharged secondary to life threatening aggressive behaviors affecting the safety of other residents. Review of Resident #2's discharge notice dated 3/19/2025 related medical reason for discharge due to aggressive behaviors. Notice was signed by MD on 3/19/2025. During an interview on 5/19/2025 at 11:24 am, FM of Resident #1 stated Resident #1 was not happy with the transfer to another facility. They stated Resident #1 enjoyed being at the facility and was his own RP. FM stated she believes Resident #1 was treated unfairly and it broke his heart to be discharged . She stated he was so sad, had tears in his eyes and was visibly upset as he liked his roommate and had a relative in the building. She stated she had gone to see him at the other facility, and he is still very sad and angry. FM of Resident #1 stated he was at another facility but did not have a phone for the surveyor to contact him. She stated they were not aware of the appeal process for the discharge and wasn't sure if Resident #1 knew he could appeal. (continued on next page)

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/19/2025 at 1:07 pm, FM of Resident #2 stated the facility told her they were taking Resident #2 to the hospital after the incident with Resident #1. She stated the facility sent him to a local hospital and then discharged him - she stated she asked the facility to keep him until they could find another place, but he is still at the same hospital two months later, as the hospital has not been able to find placement and the facility refuses to take him back. She stated the hospital called yesterday and is stating they are going to discharge him to a homeless shelter. FM of Resident #2 stated he is very quiet and depressed and worried because the hospital is telling him they are sending him to a homeless shelter. She stated he has vision problems since his stroke and cannot do any of his own business - FM of Resident #2 stated they handle all his paperwork, bills - any business and is worried about him being in shelter. FM for Resident #2 stated they were not aware there was an appeal process and wasn't sure Resident #2 could even navigate the appeal process if he was aware. FM of Resident #2 stated resident was still at the local hospital and did not have a phone for the surveyor to contact him. During an interview on 5/16/2025 at 1:30 pm, DON stated Resident #1 and Resident #2 had a history of going back and forth verbally, but it escalated on 5/18/2025 so both residents were issued discharge notices. She stated Resident #1 was accepted and transferred to another nursing facility but Resident #2 was taken to a local hospital. She stated after the incident, residents were separated, assessed and put on 1:1 supervision. During an interview with the ADM on 5/16/2025 at 5:15 pm he stated he checked but did not see any documentation in the EMR from the MD regarding the facility-initiated discharges of Resident #1 and Resident #2. He stated they were both discharged due to the incident on 3/18/2025. He stated he was unaware the MD had to put in a progress note regarding the reason for the discharge since they both posed a threat of harm to other residents. During an interview on 5/19/2025 at 12:13 pm, the MD stated she was aware of the incident on 3/18/2025 and approved of the discharges for both Resident #1 and #2. She stated she did not put any progress notes concerning the reason for the discharges for either resident in the EMR I failed to write a note, I apologize. She further stated, I didn't know I had to do this - I am sorry, I apologize. The MD stated she will revisit this and put this in our education slide deck for our meeting on 5/22/2025. She stated she was notified of the discharges but failed to write a note in the EMR. Review of facility incident report dated 5/16/2025 reflected Resident #1 and Resident #2 were listed under Resident to Resident Incidents with the date 3/18/2025. Review of facility self-report revealed there was a resident-to-resident incident on 3/18/2025 involving Resident #1 and Resident #2 and immediate discharged notices were issued to both residents. Resident #1 was discharged to another nursing facility and Resident #2 was discharged to a local hospital. Review of facility policy dated October 2022 entitled Transfer or Discharge, Facility-Initiated reflected: Once admitted to the facility, residents have the right to remain in the facility. Facility-initiated transfers and discharges, when necessary, must meet specific criteria and require resident/representative notification and orientation, and documentation as specified in this policy. (continued on next page)

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1. Each resident will be permitted to remain in the facility, and not be transferred or discharged unless: c. the safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident; d. the health of individuals in the facility would otherwise be endangered; Facility-Initiated Transfer or Discharge 1. Facility-initiated transfer or discharge means a transfer or discharge which the resident objects to, or did not originate through a resident's verbal or written request, and/or is not in alignment with the resident's stated goals for care and preferences. 2. Documentation of Facility-Initiated Transfer or Discharge 1. When a resident is transferred or discharged from the facility, the following information is documented in the medical record: a. The basis for the transfer or discharge; (1) If the resident is being transferred or discharged because his or her needs cannot be met at the facility, documentation will include: a) the specific resident needs that cannot be met; b) this facility's attempt to meet those needs; and (continued on next page)

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	c) the receiving facility's service(s) that are available to meet those needs; 3. Should the resident be transferred or discharged for any of the following reasons, the basis for the transfer or discharge will be documented in the resident's clinical record: a. The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident; or b. The health of individuals in the facility would otherwise be endangered.