

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  455554	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/15/2024
NAME OF PROVIDER OR SUPPLIER  Coral Nursing and Rehabilitaion MC Gregor		STREET ADDRESS, CITY, STATE, ZIP CODE  414 Johnson Dr MC Gregor, TX 76657	

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)
<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45070</b></p> <p>Based on observation, interview and record review, the facility failed to ensure each resident received adequate supervision and assistance devices to prevent accidents for 3 (Resident #1, Resident #2 and Resident #3 ) of 14 residents reviewed for accident hazards/supervision.</p> <p>There was one staff member in the memory care unit of the facility supervising 14 residents by herself., limiting adequate supervision for preventing accidents.</p> <p>An IJ was identified on 04/12/24. The IJ template was provided to the facility on [DATE] at 6:00PM. While the IJ was removed on 04/15/24, the facility remained out of compliance at a scope of pattern and a severity level of no actual harm with potential for more than minimal harm that is not immediate jeopardy, due to the facility continuing to monitor the implementation and effectiveness of the corrective systems.</p> <p>This failure could affect all the memory care residents and place them at risk of not receiving the appropriate level of supervision to prevent physical harm, pain and accidents.</p> <p>Findings Included:</p> <p>Record review of resident roster on 04/03/24, dated 04/03/24, revealed 14 residents resided on the memory care unit (Hall 6).</p> <p>Record review of Resident #1's face sheet revealed an [AGE] year-old female admitted to the facility on [DATE]. Her diagnoses included Bipolar Disorder, Major Depressive Disorder, Anxiety Disorder, Urinary Tract Infection, Dementia and Abnormal weight Loss.</p> <p>Record review of Resident #1's quarterly MDS assessment dated [DATE] revealed a BIMS score of 03 indicating Resident #1's cognition was severely impaired.</p> <p>Review of section E, G, H, J, N, O, P of the MDS reflected, Resident #1 did not have any hallucinations or Delusions however the frequency of behavior symptoms (not directed towards others.) were occurred 4 to 6 days/ week. She needed one person's extensive physical assistance for bed mobility, eating and toilet use and received 5 days of occupational therapy every week (at least 15 minutes/day)</p> <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Record review of Resident #1's care plan dated 01/12/2024 revealed Resident #1:</p> <p>1. Resident #1 wandered around facility with/without purpose related to dementia.</p> <p>The relevant interventions were, providing redirection as needed when observing Resident #1 out of room for wandering in/out of other room or wandering to unauthorized area and Offering verbal cues and redirection as needed to find own room, dining areas, activities area as needed.</p> <p>2. Resident #1 was at risk for fall due to unsteady gait, decreased balance, medications, and poor safety awareness.</p> <p>The relevant intervention was promoting the use of a mobility device.</p> <p>3. Resident #1 was impulsive and would get up and walk without walker.</p> <p>The interventions were assisting resident to bed after evening meal for safety and fall management and Encouraging Resident #1 to change positions slowly.</p> <p>4. Resident #1 was at risk for decreased nutritional deficits and complications related to weight loss and dementia.</p> <p>The relevant interventions were, encouraging resident to eat in an upright position, to eat slowly, and to chew each bite thoroughly and Monitor/document/report to nurse/dietitian and MD PRN for difficulty swallowing, holding food in mouth, prolonged swallowing time, repeated swallows per bite, coughing, throat clearing, drooling, pocketing food in mouth.</p> <p>5. Resident #1 displays conflictual behavior with other persons related to severe mental illness.</p> <p>The relevant intervention was, when any inappropriate behavior is observed, inform the resident that behavior is inappropriate and will not be tolerated.</p> <p>6. Resident #1 was incontinent of bladder.</p> <p>The relevant interventions were, using disposable briefs and change per schedule and PRN and Clean peri-area with each incontinence episode.</p> <p>Record review of Resident #2's face sheet revealed a [AGE] year-old female admitted to the facility on [DATE]. Her diagnoses included Mood Disorder, Major Depressive Disorder, Anxiety Disorder, Dementia, Type 2 Diabetes, Memory Deficit and Seizures.</p> <p>Record review of Resident #2's quarterly MDS assessment dated [DATE] revealed a BIMS Score of 11 indicating Resident #2's cognition is moderately impaired.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Review of section E, G, H, J, N, O, P of the MDS reflected, Resident #3 was on total dependence with eating and toilet use, and extensive assistance with bed mobility and transfer. He required two persons' support to accomplish these activities (for transfer and eating needed the help of one person).</p> <p>Record review of Resident #3's care plan dated 02/06/24 revealed:</p> <ol style="list-style-type: none"> <li>1. Resident #3 has mixed bladder incontinence related to dementia</li> </ol> <p>The relevant intervention was checking the resident every 2 hours and as required for incontinence.</p> <ol style="list-style-type: none"> <li>2. Resident #3 had an ADL self-care performance deficit.</li> </ol> <p>The relevant interventions were, dedicate one staff to provide bath/shower, extensive assist for repositioning and turning in bed, dressing, helping with eating, personal hygiene and oral care, incontinent care and transferring.</p> <p>Observation on 04/12/24 from 10:30 AM to 11:00AM of the memory care unit revealed there were 14 residents in the unit and only CNA A was scheduled for providing nursing care for them from 6AM to 2PM (verified with Daily Staffing Schedule records). There were no other staff member was present in the unit during that period. All the residents except Resident #3 were relaxing in the unit at various locations, out of their rooms. Resident #2 was in her wheelchair and stayed at the entrance door. She was in an elevated mood and talking to herself loudly. At about 10:45AM, Resident #1 approached Resident #2 in an intimidating manner and then they had heated arguments in between them. CNA A who was at the nursing station, situated at the middle of the unit and about 25 ft away from Resident #1 and Resident #2, walked towards them. Resident #1 raised her hand with the intention to hit Resident #2. CNA A rushed towards them, intervened and distracted Resident #1 from hitting Resident #2. CNA A then redirected Resident #1 to the sitting area near the nursing station and encouraged her to sit with other residents. 3 the residents were in and out of the courtyard together as well as various occasions without any supervision and the door towards the courtyard remain opened for their convenience.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>During an interview on 04/12/24 at 10:30AM CNA A stated she had worked at the facility for about 6 years and currently was 7 months pregnant. She was the only staff in the memory care unit to take care of 14 residents. She stated she managed to take care of them by herself during her shift for a while however the quality of care was compromised. When HHSC investigator requested her to elaborate further, she stated since she had to take care of everything about all the 14 residents in the unit, she had to compromise the care. When investigator asked her to give examples of compromised care, she said, there were occasions when she could not provide residents who needed shaving while giving them shower due to other nursing care commitments for other residents. She said, she kept open the shower room door while providing shower to the residents so that she could have an eye on other residents on the unit to ensure safety. CNA A stated she rarely got time to communicate therapeutically with residents due to other priority tasks. She added, from her experience, therapeutic communication resulted in better mental health and had positive impact on residents' behavioral problems. CNA A stated when she was alone at the unit, she had to spend some exclusive time to take care of Resident #3's needs including feeding. She stated he was a hospice resident and needed full support with ADLs including bed mobility and transfer. When investigator asked her who supervises other residents while providing 1:1 care to residents, CNA A stated, there was no one. She stated, in such situations there was potential risk of incidences like falls, resident to resident altercations, choking of food while eating or any other kinds of accidents. When the investigator asked about the supervision of residents while they were in the courtyard, CNA A stated she always had an eye on them from inside as she was unable to leave other residents alone in the unit and go out to supervise them in the courtyard. CNA A stated some days there were more than one staff and those days it was easier to accomplish all her tasks without safety concerns.</p> <p>During an interview on 04/12/24 at 11:00 CNA B stated she came to the unit to relieve CNA A for her break and found it difficult to supervise them by herself. CNA B stated this happens when more than one residents needed care and attention at the same time. CNA B stated she was asked to stay at the memory care only during CNA A's break time and provide care pertain only to that period of time.</p> <p>Observation on 04/12/24 at 10:55AM of Resident #3's room situated in the memory care unit revealed Resident #3 was laying in his bed and the door remained opened.</p> <p>Observation on 04/12/24 at 12:20PM revealed 10 residents including Resident #1 were having lunch in the dining room, unattended for about 5 minutes, until CNA A arrived from another area that was away from the dining room in the memory care unit. CNA C who was present in the unit was busy with administering afternoon medications.</p> <p>Observation and interview on 04/12/24 at 12:30PM of Resident #3 revealed, CNA D was feeding Resident #3. CNA D stated she was the Restorative Aide at the facility and mostly busy with helping residents with physiotherapy however took over some of the CNA's tasks at the facility, whenever she had time. CNA D stated she helps with the task of feeding Resident #3 once in a while to support the staff in the memory care unit.</p> <p>Record review of the Staffing Schedule between 03/17/24 and 04/12/24 revealed, on 6AM to 2PM shift in Hall 6 (memory care unit), there was only one CNA scheduled on 03/17, 03/18, 03/19, 03/21, 03/22, 03/23, 03/24, 03/26, 03/27, 03/28, 04/01, 04/02, 04/03, 04/04, 04/07, 04/08, 04/12. On 2PM to 10PM shift, there was only one CNA on 03/17, 03/19, 03/20, 03/21, 03/22, 03/23, 03/24, 03/25, 03/26, 03/27, 03/28, 03/29, 03/30, 04/01, 04/02, 04/03, 04/04, 04/08 and 04/11.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>During an interview on 04/12/24 at 5:00PM LVN A stated she was responsible for making the daily staffing schedule at the facility. When the investigator asked if one staff was enough considering the memory care nursing demands, LVN A stated though there was only one CNA scheduled for some days, on those days, other CNA's went to the memory care unit from time to time to help the CNA there. She stated on 04/12/24, CNA C was designated to work in her free time after the completion of medication administration.</p> <p>During observations and interview on 04/12/24 at 5:15PM CNA C stated she was the Medication Aide at the facility for many years and worked at the facility from 8:00 AM to 8:00PM shift. She stated, after the completion of her medication administration task, she worked in the memory care to support the CNA there. During observations at 9:30AM, 10:30AM and 12:15PM, CNA C was busy with administering medications. At 3:30PM and 5:00PM, CNA C was present at the nursing station located outside the memory care unit of the facility.</p> <p>During an interview on 04/12/24 at 5:30PM ADM stated he did not believe the nursing care at the memory care was compromised on the days when only one CNA was working there. He stated, CNAs from the other side went and supported the CNA at the memory care on such days. He stated, recently two staff members were terminated from the facility as part of a disciplinary action, and they might be behind this baseless allegation of supervision issue in memory care. He stated the safety of the residents at the facility was his priority and did not do anything that compromises the quality of care.</p> <p>Record review on 04/15/24 of facility policy Safety and Supervision of Residents revised in July, 2017 reflected:</p> <p>Our facility strives to make environment as free from accident hazards as possible. Resident safety and supervision and assistance to prevent accidents are facility wide priorities.</p> <p>. Our individualized resident centered approach to safety addresses safety and accident hazards for individual residents.</p> <p>Record review on 04/15/24 of facility policy Staffing revised in October, 2017 reflected:</p> <p>Our facility provides sufficient number of staff with the skills and competency necessary to provide care and services for all residents in accordance with resident care plans and the facility assessment</p> <p>. staffing numbers and skill requirements of direct care staff are determined by the needs of residents based on each resident's plan of care.</p> <p>Record review on 04/15/24 of facility's undated job description for Certified Nursing Assistant reflected:</p> <p>Major Duties and Responsibilities:</p> <p>Provides supportive services to nurse(s) and other staff as needed and performs duties as assigned.</p> <p>Assists resident with or perform Activities of daily living for resident in accordance with care plans and established policies and procedures.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>The administrator has created a scheduling audit to monitor the staffing of the facility with an emphasis on the secure unit on 04/12/2024. The administrator, staffing coordinator, or designee will ensure the new staffing schedule is correctly adhered to daily for two weeks, weekly for two weeks and monthly for two months. Any negative findings will be taken to the administrator for immediate correction. Administrator or ADON will continue to audit the schedule daily in the morning standup meeting as an ongoing process. The results of the new audit process will be reported to the QAPI team.</p> <p>The Medical Director was notified of the deficiency (F689) on 04/13/2024 and an Ad-Hoc (When necessary) QAPI meeting was held on 04/13/2024 to discuss the findings.</p> <p>All findings will be reported to the QAPI team monthly for quality assurance.</p> <p>When Actions will be complete:</p> <p>The facility will have completed education by 04/13/2024, if any staff member working on the unit is unable to be educated, they will be removed from the schedule until training has been provided. All staff that will work on the unit will receive this training whether full, part time or contract,</p> <p>The facility requests the removal of the immediate jeopardy on 04/13/2024.</p> <p>The surveyor confirmed the facility implemented their plan of removal sufficiently from 04/12/24 through 04/15/24 to remove the IJ by:</p> <ol style="list-style-type: none"> <li>1. Record review of the staffing schedule and interview of ADM on 04/15/24 revealed the staffing was done carefully and appropriately. There were two staff on 6AM to 2PM and 2PM to 10PM shifts on 4/13, 4/14 and 4/15 in the locked unit.</li> <li>2. During interview on 04/15/24 at 12:45pm LVN A stated she had done an assessment on staffing demands on 04/15/24 and said on that day there were two staff members in the memory care unit as two residents at the unit were hyper.</li> <li>3. Observation on 4/15/24 at 12:50 pm revealed CNA E and CNA D were scheduled at memory care unit. Residents were engaged in coloring activities with CNA D, and it appeared they were enjoying it. CNA E was supervising other residents. LVN A was in the memory care monitoring the staff performance.</li> <li>4. Record review on 04/15/24 of the In-services Log revealed all staff members completed the Inservice.</li> <li>5. The following staff members interviewed on 04/13/24 to confirm their attendance.  CNA E, CNA F, LVN A, CNA C, CNA G , CNA H , CNA I</li> </ol> <p>The following staff members were interviewed on 04/15/24.</p> <p>LVN A, ADM</p> <ol style="list-style-type: none"> <li>6. Record review of the QAPI meeting attendance revealed the meeting was conducted on 4/12/24. MD, ADM, LVN A, MD, BO and DR attended.</li> </ol> <p>(continued on next page)</p>		

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