STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455638	A. Building B. Wing	06/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Greenview Nursing and Rehabilitation	401 Owen LN Waco, TX 76710

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49099 Based on interview, and record review, the facility failed to develop and implement a comprehensive person-centered care plan for each resident that included measurable objectives and timeframes to meet a resident's medical, nursing, mental, and psychosocial needs for 1 (Resident #1) of 1 resident reviewed for care plans in that: 1. The comprehensive care plan did not reflect Resident #1's behaviors of refusing HD along with interventions. 2. The facility failed to notify the kidney center on 05/09/24 and 05/11/24 about the resident refusing treatment and not making it to his appointments as reflected in the care plan. These failures could result in residents at risk of receiving inadequate interventions not individualized to their care needs. Findings include : Record review of Resident #1's face sheet dated 06/04/24 revealed a [AGE] year-old male admitted on [DATE] with a diagnoses of type 2 diabetes mellitus (long term medical condition in which the body doesn't use insulin properly, resulting in unusual blood sugar levels) without complications, acute metabolic acidosis (condition in which too much acid accumulates in the body), hyperkalemia (high potassium levels in the blood), end stage renal disease (AKA end stage kidney disease or kidney failure is final, permanent kidney failure that requires a regular course of dialysis or a kidney transplant), fluid overload unspecified, and patients noncompliance with other medical treatment and regimen due to unspecified reason. Record review of Resident #1's MDS assessment dated [DATE] reflected Section O titled Special Treatments, Procedures, and Programs marked for dialysis while a resident. Section I reflected active diagnosis of Renal Insufficiency, Renal Failure, or End Stage Renal Disease (kidney failure). MDS assessment reflected a BIMS score of 14 suggesting cognition intact. Record review of Resident #1's care plan last revised 06/01/24 reflected identified problem alteration in kidney function with intervention notify physician and dialysis center if [Resident #1] is unable to make appointment. The care plan did not identify any behaviors related to dialysis. (continued on next page)

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

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

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #1's nursing progress notes dated 05/07/24 reflected , Resident refused to go to dialysis today due to nausea. PRN administered for the nausea. Resident still refusing to go to dialysis. NP notified. The nursing note reflected the NP was notified but not the KC. Record review of Resident #1's nursing progress notes dated 05/10/24 reflected , Resident is non-compliant with HD, resident was sent to the ER yesterday due to refusal to go to dialysis. The nursing note did not reflect that the KC was notified. Record review of KC medical records requested for Resident #1's hospitalization reflected an encounter date 05/14/24 and reflected, brought from NH for missing HD for >1 wk. Found to have volume overload and hyperkalemia. Received multiple sessions of HD in hospital. DC back to NH. Nephrology consult notes reflected, [Resident #1] declined to go to dialysis subsequently due to some stomach upset. Finally transported to dialysis but instructed to get ER clearance and found to have potassium 6.1 chronically volume overloaded but not dyspneic (short of breath). In an interview on 06/04/24 at 10:27 AM with the KC ADM she stated Resident #1 missed HD treatments on 05/07/24 , 05/09/24, and 05/11/24. The KC ADM stated they attempted to contact the facility and called 05/09/24, 05/10/24, 05/11/24, and 05/14/24 to ask why Resident #1 was missing treatments but received no response and no call back. The KC ADM stated Resident #1 eventually showed up on 05/14/24 for treatment but due to missing so many sessions Resident #1 was sent to the emergency room where he was admitted to the hospital and received his HD there. The KC ADM stated while being transported to the ER for HD clearance, Resident #1's vitals were normal, he denied shortness of breath, weakness, and dizziness. She stated Resident #1 did not appear in any apparent distress based on nursing assessments. In an interview on 06/04/24 at 02:22 PM with Resident #1, he stated he knew he was supposed to go to dialysis, but he usually wakes up feeling sick and declines to go. Resident #1 stated both the KC and the NF have educated him on the importance of attending dialysis. In an Interview on 06/04/24 at 03:14 PM with the MDS Coordinator, she stated if care plans were not implemented it could affect the resident in a negative way. The MDS Coordinator said that a negative outcome of not receiving dialysis would cause the resident's body to fill with toxins. The MDS Coordinator stated it was the residents right to refuse care and services but if they are frequently refusing care, it should be care planned . The MDS Coordinator stated she was new to the facility and they were still in the process of completing audits for care plans. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 06/04/24 at 03:58 PM with the DON, she stated it was her expectation that the care plans were made to address each residents' unique needs and every aspect of their care. She stated that based on the documentation available the KC was not notified of Resident #1 refusing HD and not making his appointments. She said the expectation has been that the nursing staff contact the dialysis center if a resident isn't able to make it and then document it- she said, they are usually good about documenting these things. The DON stated that the nursing notes did reflect he frequently refused HD, that the NP was notified, and he received HD at the hospital. The DON stated the nursing staff is responsible for notifying the KC when Resident #1 is unable to attend his appointments. The DON added that they were having phone issues at the facility briefly during this time which could be why the KC was not able to get through, however, nothing was documented to show an attempt was made to reach out to them for the two days in question. The DON stated that she was not sure what interventions were in place because she did not see anything in the care plan to reflect Resident #1 refusing HD. She stated both of her MDS Coordinators are new, and they will be receiving training on the expectations because she expects that refusal of care is reflected in the care plan. The DON also stated that they had not completed care plan audits for the last month but have been in discussions in the morning meetings of those that need to be updated and are working on them. In an interview on 06/04/24 at 04:15 PM with the ADM he stated it was his expectation that each resident has an individualized care plan. The ADM stated that refusal of care or services should be a part of the care plan. He stated if it were his family member refusing dialysis, he would expect it to be care planned so that he knew there were interventions in place. The ADM stated it was the responsibility of the nursing staff to initialize care plans and the MDS Coordinator's responsibility to keep up with any changes. The ADM stated if the resident is not able to make it to the KC for HD it is his expectation that nursing staff, or the assigned van driver notify the KC. The ADM stated he did not have a clinical answer to a negative outcome that could occur from missing dialysis, but he said, it is not good. Record review of the facility policy, Care Plans, Comprehensive Person-Centered last revised March 2022 reflected: Policy statement: A comprehensive, person- centered care plan that includes measurable objectives and timetables to meet the residents physical, psychosocial and functional needs is developed and implemented for each resident. - The interdisciplinary team (IDT), in conjunction with the resident and his/her family or legal representative, develops and implements a comprehensive, person-centered care plan for each resident. - The care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment. - The comprehensive, person-centered care plan: a. includes measurable objectives and timeframes; b. describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, including: (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	(1) services that would otherwise be provided for the above, but are not provided due to the resident exercising his or her rights, including the right to refuse treatment; (2) any specialized services to be provided as a result of PASARR recommendations; and (3) which professional services are responsible for each element of care; c. includes the resident's stated goals upon admission and desired outcomes; d. builds on the resident's strengths; and e. reflects currently recognized standards of practice for problem areas and conditions. continues - Care plan interventions are chosen only after data gathering, proper sequencing of events, careful consideration of the relationship between the resident's problem areas and their causes, and relevant clinical decision making. - When possible, interventions address the underlying source(s) of the problem areas, not just symptoms or triggers. - Assessments of residents are ongoing and care plans are revised as information about the residents and the residents' conditions change.