

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455838	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/22/2024
NAME OF PROVIDER OR SUPPLIER Robstown Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 603 E Ave J Robstown, TX 78380	

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 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50039</p> <p>Based on interviews and record review, the facility failed to ensure that all alleged violations involving the reasonable suspicion of a crime were reported immediately to a law enforcement entity for its political subdivision, within two hours if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, for 1 (Resident #1) of 7 residents reviewed for abuse/neglect.</p> <p>The facility failed to report Resident #1's allegations of abuse to the local law enforcement agency within the allotted time frame of 2 hours on 08/18/24 when Resident #1 was injured in a physical altercation initiated by Resident #2 at around 2 PM, sustaining a skin tear to his right forearm.</p> <p>This failure could place all residents at increased risk for potential abuse due to unreported allegations of abuse.</p> <p>The findings included:</p> <p>Resident #1</p> <p>Record review of Resident #1's face sheet reflected an [AGE] year-old male with an admitted [DATE]. Pertinent diagnoses included Alzheimer's Disease (a brain disorder that causes a gradual decline in memory, thinking, and behavioral abilities), Major Depressive Disorder (a serious mental disorder that can affect how someone feels, thinks, and acts characterized by a depressed mood and loss of interest in activities that were normally enjoyable), Generalized Anxiety Disorder (a mental disorder that causes people to experience excessive, persistent, and uncontrollable worry for months to years).</p> <p>Record review of Resident #1's quarterly MDS assessment section C, Cognitive Patterns, dated 07/17/24 reflected a BIMS score of 3 (severe impairment). Further review revealed section E, Behavior, showed no history of aggressive behaviors.</p> <p>Record review of Resident #1's care plan revealed no history of planning for aggressive behaviors.</p> <p>Record review of a Change of Condition assessment dated [DATE] noted a resident-to-resident altercation with a skin tear to right arm of Resident #1.</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 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of a Wound assessment dated [DATE] noted a right forearm skin tear length of 6 cm and width of 4 cm to Resident #1.</p> <p>In an interview with Resident #1 at 9:30 AM on 09/20/24, Resident #1 stated he enjoyed his time at the facility. Resident #1 stated the nurses were good and that he got along with all the other residents. Resident #1 stated he did not remember ever having an altercation or incident with Resident #2.</p> <p>Resident #2</p> <p>Record review of Resident #2's face sheet reflected an [AGE] year-old male with an original admitted [DATE] and a current admitted [DATE]. Pertinent diagnoses included Unspecified Psychosis (used when someone has psychotic symptoms that don't meet the criteria for a specific psychotic disorder) and Major Depressive Disorder.</p> <p>Record review of Resident #2's Comprehensive MDS assessment section C, Cognitive Patterns, dated 07/25/24 reflected a BIMS score of 7 (severe impairment). Further review revealed section E, Behavior, showed physical behaviors such as hitting, kicking, pushing and grabbing occurred daily while verbal behaviors such as threatening others, screaming at others and cursing occurred 1 to 3 days per week. Further review of section E revealed Resident #2 experienced hallucinations (perceptual experiences in the absence of real external sensory stimuli) and delusions (misconceptions or beliefs that are firmly held, contrary to reality). Further review of section E revealed Resident #2's behaviors have improved since his prior assessment.</p> <p>Record review of Resident #2's care plan revealed the problem [Resident #2] is potential to be verbally aggressive r/t ineffective coping skills, poor impulse control initiated on 09/15/23. Interventions listed for this problem included Analyze of key time, places, circumstances, triggers, and what de-escalates behavior and document, and Assess and anticipate resident's needs: food, thirst, toileting needs, comfort level, body positioning, pain, etc.,.</p> <p>Record review of the provider investigation report dated 08/24/24 revealed on 08/18/24, LVN A was told that Resident #2 stated his roommate and him were arguing over the tv remote in their room. Resident #2 stated Resident #1 pushed him and they both fell . Resident #2 stated he got Resident #1 up and they shook hands afterwards. Resident #2 denied any pain or discomfort at the time of reporting. Resident #2 was immediately placed on a one-to-one with constant supervision and moved to a room in a different hall. Resident #1 stated that he was in his bed when Resident #2 came over to him and grabbed both of his arms, shaking him and yelling at him. Resident #1 had a skin tear to his right forearm that required treatment. Resident #1 denied pain and stated he was not fearful or felt like he was in danger. Provider investigation report did not provide any evidence that a local law enforcement agency was notified of this incident. Further review revealed In conclusion, [Resident #2] admitted to wanting the TV remote and attempted to take it from roommate causing a skin tear. [Resident #2] placed on one-to-one monitoring. No further behavior from [Resident #2]. He remained in his room. Continue to monitor his well-being. No new orders from physician. [Resident #1] admitted that he had a TV remote, and the roommate grabbed it and him as well, trying to take it. He denies pain to arm. [Resident #2] moved immediately to another hall. [Resident #1] denies feeling fearful and continues to come to dining for all meals. Continue to monitor his well-being. No further behaviors from resident and no new orders from physician.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview with Resident #2 at 9:36 AM on 09/20/24, Resident #2 stated some nurses were not good at their jobs. Resident #2 stated he had issues with a roommate in the past but could not remember his name. Resident #2 stated he grabbed the remote from his roommate, but that his roommate then lunged at him and hit him in the head. Resident #2 stated that he hit his roommate back in self-defense and they ended up struggling on the floor for a few minutes. Resident #2 stated he won the fight, and then afterwards held out his hand to make peace.</p> <p>In an interview with the DOS at 1:29 PM on 09/19/24, the DOS stated Resident #1 did not remember the incident the following day after it happened. The DOS stated Resident #2 lived with severe schizophrenia and did not like having a roommate. The DOS stated the two residents had only been roommates for a few weeks at the time of the incident. The DOS stated they have struggled to find a roommate for Resident #2. The DOS stated Resident #1 had never had any issues with roommates in the past. The DOS stated he had never observed Resident #2 be physical or rude to another resident.</p> <p>In an interview with the DON at 3:00 PM on 09/19/24, the DON stated Resident #1 had never been aggressive with other residents or staff. The DON stated Resident #2 had been verbally aggressive with others before, but never physically aggressive. The DON stated the initial assessment performed after the incident by LVN A determined that Resident #2 grabbed the arms of Resident #1, which caused bruising to both arms and a skin tear to Resident #1's right arm. The DON stated Resident #2 was immediately put on a one-to-one. The DON stated the remote control to the television in their room was found in Resident #2's pocket, but the batteries and battery cover were found in the bed of Resident #1. The DON stated the two residents have never encountered each other in the facility since they switched rooms because Resident #2 spent most of his time in his new room. The DON stated the administrator made the decision on whether to call the police after the incident. The DON stated she believed this incident did meet the definition of an assault.</p> <p>In an interview with LVN A at 9:01 AM on 09/20/24, LVN A stated she was working on 08/18/24, the day of the incident. LVN A stated Resident #2 came up to the nurse's station and asked for batteries for the remote control for the television in his room. LVN A stated she went into their room and saw the skin tear on Resident #1's right forearm and bruising on his left forearm. LVN A stated she performed the head-to-toe assessment on both of the residents and only noted injuries to Resident #1. LVN A stated Resident #1 told her that he had the remote, but Resident #2 walked over to him while he was in bed and grabbed his arms. LVN A stated, based on the injuries and stories of the residents, she concluded that Resident #2 caused the injuries to Resident #1's arms. LVN A stated that Resident #2 never admitted to causing the injuries to Resident #1. LVN A stated that this incident probably would be considered assault. LVN A stated the two residents have not interacted since this incident because Resident #2 stayed in his new room all the time. LVN A stated Resident #2 only left his new room for coffee, ice, and milk.</p> <p>In an interview with the ADON at 10:36 AM on 09/20/24, the ADON stated she did not feel Resident #2 was a danger to Resident #1 anymore. The ADON stated she was not at the facility on the day of the incident. The ADON stated assuming the injuries to Resident #1 were caused by Resident #2, then it would qualify as abuse. The ADON stated the most reasonable conclusion to draw based on the evidence was that Resident #2 caused the injuries to Resident #1's arms.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview with the ADM at 11:36 AM on 09/20/24, the ADM stated the police were not initially notified after this incident between Resident #1 and Resident #2 on 08/18/24. The ADM stated she did notify the local police department on 09/19/24 of the incident and obtained the case number. The ADM stated she met with her regional team shortly after the incident, and as a team, concluded the incident did not rise to the level necessitating notifying the police department. The ADM stated they did not have a policy addressing the conditions in which notifying a local law enforcement agency regarding an incident at the facility was necessary. The ADM stated she did not think there was reasonable suspicion that a crime had occurred during the incident. The ADM stated she thought it was more likely than not that abuse had not occurred during this incident. The ADM stated she did not believe Resident #2 intended to cause the injuries to Resident #1. The ADM stated the most likely cause of the injuries to Resident #1 was Resident #2 grabbing him.</p> <p>Record review of the facility policy titled Abuse, Neglect and Exploitation dated 08/15/22 reflected the following:</p> <p>VII. Reporting/Response</p> <p>A. The facility will have written procedures that include:</p> <p>1. Reporting of all alleged violations to the Administrator, state agency, adult protective services and to all other required agencies (e.g., law enforcement when applicable) within specified timeframes:</p> <p>a. Immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or</p> <p>b. Not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury.</p>		