STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675076	A. Building B. Wing	04/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Llano Nursing and Rehabilitation Center	800 W Haynie St Llano, TX 78643

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42600 Based on interview and record review the facility failed to ensure residents had the right to request, refuse, and/or discontinue treatment, to participate in experimental research, and to formulate advance directives for 2 of 4 residents (Residents #1 and #2) reviewed for advanced directives. 1. The facility failed to ensure that Resident #1's out of hospital do-not-resuscitate (OOH-DNR) was dated by the physician and was witnessed by two people or notarized. 2. The facility failed to ensure Resident #1 had a designated medical power or attorney (MPOA) documented via MPOA form. 3. The facility failed to ensure that Resident #2's out of hospital do-not-resuscitate (OOH-DNR) included second signatures by witnesses and the second signature of a guardian/agent/proxy/relative. These failures could place residents at-risk of having their wishes dishonored, delay necessary medical treatment or intervention due to confusion and not have medical decisions be made on their behalf by a legally authorized representative. Findings included: Review of Resident #1's face sheet reflected an [AGE] year-old female admitted on [DATE] with diagnoses of Alzheimer's disease (neurodegenerative disorder that gradually damages memory and thinking skills), cardiomyopathy (disease that affects the heart muscle, making is harder for the heard to pump blood effectively), unspecified hydronephrosis(a condition where the kidney becomes swollen due to a buildup of urine), gastrointestinal hemorrhage (bleeding that occurs within the digestive tract, from the mouth to the anus), dementia (a general term for memory loss and other cognitive decline that is severe enough to interfere with daily life), cognitive communication deficit (communication difficulties stemming from problems with underlying cognitive processes, rather than issues with speech or language production itself), aphasia (loss of ability to understand or express speech, caused by brain damage), major depression disorder (a mood disorder characterized by persistent sadness, loss of interest or pleasure in activities) and anxiety disorder (excessive worry, fear, and other physical and behavioral symptoms that interfere with daily life). Review also reflected resident's FM A listed as POA - health care. (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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #1's significant change MDS dated [DATE] reflected no BIMS completed due to the resident was rarely or never understood. Further review reflected Resident #1 had a memory problem with her short-term and long-term memory and Resident #1 was moderately impaired for daily decision making. Review of Resident #1's care plan reflected her code status as do not resuscitate with a start date of 03/10/2025. Review of the resident's care plan dated 04/09/2025 reflected the resident's family members had difficulties getting along with the goal the resident will express/exhibit satisfaction and family members will be respectful of one another in her presence. The approach included Respect [FM B] decisions regarding hospice selection. Further review reflected Resident #1 had impaired judgement and though process related to dementia. Review of Resident #1's OOH-DNR order reflected the document was signed by the resident's adult child on 02-27-2025. Further review reflected there were no dated witnesses' signatures or notary signature, stamp and date. Review revealed the physician's signature was also not dated. Review of section All persons who have signed above must sign below, acknowledging that this document has been properly completed reflected that there was only one witness signature (not two) or notary signature. Review of Resident #1's medical chart reflected a Statutory Durable Power of Attorney (SDPOA) form in place dated 02/24/2020. Review of SDPOA form reflected this document does not authorize anyone to make medical and other health-care decision for you and designated FM A. Review of Resident #1's medical chart reflected there was not a medical power of attorney (MPOA) document. Review of Resident #1's admission agreement dated 02/26/2022 revealed The Resident designates the following persons to be notified of any significant changes in the Resident's condition: Agent/ Legal Representative/ Responsible Party/ Resident Representative (circle one). No option was circled, but FM A was named. Review of the section did not reveal the document to be a MPOA document and did not specify information regarding medical decision making. Review of Resident #1's progress note dated 02/15/2025 by RN D revealed an order was received by the MD for referral to [name] hospice for evaluation with family in agreement with same. Review of Resident #1's progress note dated 02/19/2025 by the DON revealed Resident #1's FM B was confused that FM A chose a different hospice provider. Further review reflected the DON provided FM A with choices. Review of Resident #1's OOH-DNR received via email from ADM on 04/10/2025 reflected previously reviewed OOH-DNR with notary stamp and signature that was undated and date of 02/27/2025 filled in by physician's statement signature. Review of section All persons who have signed above must sign below, acknowledging that this document has been properly completed included notary signature, one witness signature, guardian/agent/proxy/relative signature and physician's signature. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 04/09/2025 at 10:34 AM, FM B stated that there was an ongoing issue to make medical decisions by FM A. FM B stated there was an MPOA document completed but FM B had never seen it. FM B was not aware an MPOA document existed. FM B stated FM A handed him a SDPOA document. FM B stated there was a preference for a specific hospice company to care for Resident #1 due to Resident #1 being familiar with staff who worked with other residents in the facility. FM B stated they attempted to be involved in choosing the hospice provider but another provider was still chosen by FM A. During an interview on 04/09/2025 at 2:25 PM, the LMSW stated he had worked at the facility for two weeks. He stated that for residents who did not have a medical power of attorney and had a decline in cognition, the facility brought in a primary care physician and family who may have been able to guide decisions. The LMSW stated laws came down to whoever had medical power of attorney to make decisions. The LMSW stated for a resident who did not have an MPOA in place and was no longer able to make their own decisions, the facility brought in a doctor to complete an evaluation and discussed with their adult children. The LMSW stated an entity such as APS may have been brought in as well and ensured nothing legal was being brushed under the rug. The LMSW stated the SDPOA was able make decisions if it was designated in the document that they were able to make financial and medical decisions. The LMSW reviewed Resident #1's face sheet and stated that it appeared FM A was the power of attorney of health care. The LMSW stated from his understanding FM B did have MPOA, but that information was updated by the administration team a while ago. The LMSW stated he had not reviewed Resident #1's power of attorney document before. The LMSW reviewed Resident #1's SDPOA document and stated that the documented allowed whoever was designated the authority to make financial and medical decisions and stated FM A was listed. LMSW further reviewed Resident #1's SDPOA and stated he saw where the document reflected this power of attorney does not authorize anyone to make medical decision for you. The LMSW stated that due to Resident #1's cognitive status decisions would default to FM A. The LMSW stated it looked like the facility needed to review who had MPOA status because based on the SDPOA document FM A had financial power of attorney. Review of Resident #2's face sheet reflected an [AGE] year-old female readmitted on [DATE] with diagnoses of Alzheimer's disease (a progressive brain disorder that primarily affects memory, thinking, and reasoning abilities, ultimately leading to a loss of independence), essential hypertension (persistently elevated blood pressure), bipolar disorder (a mental illness characterized by extreme and persistent shifts in mood, energy, and activity levels, including periods of mania and depression), cognitive communication deficit (communication difficulties stemming from problems with underlying cognitive processes, rather than issues with speech or language production itself), anxiety disorder (excessive worry, fear, and other physical and behavioral symptoms that interfere with daily life), dysphagia (difficulty swallowing), and aphasia (loss of ability to understand or express speech, caused by brain damage). Review of Resident #2's annual MDS dated [DATE] reflected no BIMS score because resident was rarely or never understood. Review reflected resident had a short-term and long-term memory problem and Resident #3's cognitive skills for daily decision making were severely impaired. Review of Resident #2's care plan dated 03/27/2025 reflected she had impaired communication due to aphasia and dementia with decrease ability to comprehend complex information. Further review reflected code status as do not resuscitate date 03/27/2025. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #2's OOH-DNR order dated 12/18/2020 reflected there was no second guardian/agent/proxy/relative signature and no second signatures from the two witnesses. During an interview on 04/09/2025 at 3:15 PM, RN C stated she was able to determine code status of a resident by her knowledge from having worked with the residents and stated she was aware of who was a DNR and who was not. She stated if she did not know, there was a list she viewed posted at the nurse's station. RN C stated she looked at the orders on the resident's chart too. She stated if a resident was new, she looked at the OOH-DNR document. RN C stated that the OOH-DNR document usually had POA signatures, physician and witnesses included. RN C stated it should have been dated. She stated if it was missing any of the mentioned it was not valid. RN C stated she was able to determine who to contact for medical decisions or a change of condition by who was listed on the resident's face sheet for an emergency contact or next of kin. She stated that the resident's documents were reviewed by a lot of people and that the facility was very small, so they had good communication. During an interview on 04/09/2025 at 3:47 PM, the LMSW stated that prior to his start at the facility, OOH-DNRs were reviewed by the business office manager and moving forward they would be his responsibility since he was familiar with the document. The LMSW stated that an OOH-DNR needed to contain witnesses (that did not have ties to inheritances or estates and could be confirmed as trust individuals), and also needed to be notarized. The LMSW stated typically the best way to go about the form was to get two doctors who did not provide direct care. The LMSW stated Texas had its own OOH-DNR. The LMSW stated the form required patient information, family information, witnesses or to have the document notarized. The LMSW reviewed Resident #1's OOH-DNR and stated it looked like it had everything it needed. The LMSW stated the risk of an incomplete document was that it would be an invalid document. The LMSW stated for example if the document were sent to a medical facility if emergency responders were not made aware of document and not aware of interventions but if provided interventions, there could be financial implications and could go against a resident's direct wishes. The LMSW stated he tried to audit advanced directives often but would try to audit them when he completed quarterly assessments and during care conference he also asked about code status. During an interview on 04/09/2025 at 5:03 PM, the DON stated that she was the interim DON at the facility. The DON stated that Resident #1's document was put into place when she was admitted to the facility. The DON stated she found Resident #1's SDPOA so she reached out to FM A and asked if FM A provided a document other than the SDPOA. The DON stated whomever uploaded the document in Resident #1's chart mislabeled it as MPOA and did not select SDPOA. The DON stated that Resident #1 signed her admission packet in 2020 and designated FM A to be notified of any changes of condition. The DON stated that the document signed in the admission packet listed who the facility should have contacted for decisions and changes because it was signed by Resident #1 when she admitted . The DON stated that there was disagreement on the hospice provider between FM A and FM B. She stated FM B's spouse was employed by a hospice agency and they wanted to go with that agency, but FM A did not want to mix family and the provider to avoid conflict. The DON stated that she believed Resident #1's OOH-DNR was obtained through hospice when Resident #1 was admitted to their service. The DON stated an OOH-DNR included resident representative or resident signature and witnesses (who were not employees that provided direct care). The DON stated Resident #1's form did not have witness signatures. The DON stated the facility could have gotten the form notarized because their business office manager was a notary and did not have direct resident care. The DON stated the facility could get Resident #1's OOH-DNR form regenerated. The DON stated ideally the LMSW would review advance directives but he had only been at the facility two weeks. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 04/09/2025 at 5:23 PM, the ADM stated any clinical documents such as advanced directives were reviewed by the DON. The ADM stated if an advanced directive was obtained during an admission, then the central intake team reviewed it. If it was obtained at the facility, it was reviewed by the DON. The ADM stated the DON reviewed residents' charts daily. The ADM stated she expected documents to be completed fully and accurately. The ADM stated if residents were no longer able to make medical decisions, the facility would reach out to the medical power of attorney. If there was not a MPOA, then the facility would call the representative listed on the face sheet in the resident's chart. The ADM stated upon admission, the representative was determined and selected by the resident. Review of the facility policy with revision date of 02.29.2024 and titled Advanced Directives reflected It is the policy of this facility to adhere to residents' rights to formulate advance directives. The presence of an Advanced Directive or any physician directives related to the absence or presences of an Advance Directive shall be communicated to Social Services as applicable. A code status audit will be conducted by the DON designee quarterly or as needed. Review of undated OOH-DNR form instructions for issuing an OOH-DNR order revealed the OOH-DNR order must be signed and dated by two competent adult witnesses. Optionally, a competent adult person or authorized declarant may sign the OOH-DNR Order in the presence of a notary public. Review of health and safety code 166.083(b)(4)(6) dated 09/01/1999 revealed an OOH-DNR order at minimum must contain statement that the physician signing the document is the attending physician of the person and that the physician is directing health care professionals acting in out-of-hospital settings, including a hospital emergency department, not to initiate or continue certain life-sustaining treatment on behalf of the person and places for the printed names and signatures of the witnesses or the notary public's acknowledgment and for the printed name and signature of the attending physician of the person and the medical license number of the attending physician Further review of health and safety code 166.089(3) dated June 16, 1995 revealed an OOH-DNR order form appears valid when it includes the signature or digital or electronic signature of the declarant or persons executing or issuing the order and the attending physician in the appropriate places designated on the form for indicating that the order form has been properly completed. Review of health and safety code 313.004 (a)(2) dated 09/01/1993 reflected If an adult patient of a home and community support services agency or in a hospital or nursing home, or an adult inmate of a county or municipal jail, is comatose, incapacitated, or otherwise mentally or physically incapable of communication and does not have a legal guardian or an agent under a medical power of attorney who is reasonably available after a reasonably diligent inquiry, an adult surrogate from the following list, in order of priority, who has decision-making capacity, is reasonably available after a reasonably diligent inquiry, and is willing to consent to medical treatment on behalf of the patient may consent to medical treatment on behalf of the patient: (1) The patient's spouse; (2) the patient's adult children