STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675183	A. Building B. Wing	04/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Twin Oaks Health and Rehabilitation Center	1123 N Bolton St Jacksonville, TX 75766

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 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure residents were able to remain in the facility and not discharge resident from the facility unless the discharge is necessary for the resident's welfare and the resident's needs cannot be met by the facility. 1 of 3 residents (Resident #1) reviewed for discharge rights. The facility failed to ensure Resident #1's discharged was necessary for his welfare and failed to show the facility could not met his needs. This failure could place residents at risk of unsafe or improper discharge, placing residents at risk of not having appropriate services when discharged . Findings included: Record review of Resident #1's face sheet dated 04/14/25 indicated he was a [AGE] year-old male, admitted on [DATE], and his diagnoses included altered mental status, (cognitive mental disorder), restlessness and agitation, chromic kidney disease, hypertension, (high blood pressure), lack of coordination, muscle weakness and atrophy, and Hypothyroidism (underactive thyroid). Record review of Resident #1's MDS assessment dated [DATE] indicated he was admitted with a BIMS score of six, which indicated he had impaired cognitive ability. He was sometimes able to express his ideas and wants and was able to respond adequately to simple and direct communication. He was independent with bathing, dressing, toileting and eating. He was able to ambulate without assistance. Record review of Resident #1's care plan dated 04/09/25 indicated he sometimes displayed verbally aggressive behaviors. Interventions included social services to evaluate and visit with me, activity staff to visit with the resident, provide diversional activities, and remove the resident from public area when their behavior was disruptive and unacceptable. Interventions included discuss behavior, monitor behavior episodes, and attempt to determine underlying causes. The interventions did not include resident specific interventions or supervision to prevent resident physical aggression towards others. Record review of Resident #1's elopement assessment dated [DATE] indicated he understood and verbalized the need for him to be in a skilled nursing facility. He was restless and showed behaviors of pacing and wandering. (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 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #1's nurse's notes dated 03/27/25, indicated he displayed behaviors of wandering, non-compliance with medication, treatment and was resistant to care. Record review of Resident #1's physician's orders dated 03/27/25 revealed his behaviors were to be monitored and behaviors were to be documented in the progress notes. Record review of Resident #1's progress note dated 03/27/25 documented by RN C revealed Resident #1 was on 15-minute checks due to a history of elopement, per the family member; no s/s of elopement but the family member said he did like to wander and had gotten out house and another nursing home. Record review of Monitoring Chart for Resident #1, dated 03/27/25 and 03/28/25 revealed staff monitored his behavior and documented every 15 minutes. Review of medical records showed there was no documentation made by Resident #1's physician as to the need for the discharge or that the discharge or that the facility could not meet Resident #1's needs. Record review of Resident #1's progress note dated 03/28/25 at 6:00 p.m. documented by RN A revealed, Continue to monitor resident. The resident was noted to be more aggressive trying to get out .I'm leaving get out of my way.jerking and rattling door, alarm sounding. Threw table in lobby everything replaced. Given Ativan. Family called. family member said she would be out there as soon as we can. 7:50 p.m. continue to monitor. Resident stated he is going to throw a rock and break the door. Tried to get a planter in the lobby and throw at window. Removed from grip and replaced. Reached across nurse's station tore fire extinguisher off wall. Went outside to patio and refused to return. Trying to find a way off the premises. Continued to try to get resident to come in and wait for family. Resident refused. NP notified of behavior. Family came while outside on patio and resident came in with them. 9:00 p.m. Family states resident does not need to be discharged to the hospital, they won't do anything for him, they didn't last time. Requested resident be discharged home with them. Talked to family member by phone, who is out of town, and she agreed. NP was notified. Orders received for the resident to be discharged with family with belongings, meds counted and sent with resident. During an interview on 04/14/25 at 12:40 p.m., the Administrator said Resident #1 was discharged home with his family on the evening of 03/28/25 which was on a Friday. The Administrator said she was not notified of the discharge until the next Monday morning. The Administrator said staff did not follow facility policy regarding Resident #1's discharge. The Administrator said there was no discharge plan, and the ombudsman was not notified of the discharge. The Administrator said Resident #1 was sent home with a family member. The Administrator said she was told that Resident #1 was attempting to elope and was seeking a way out of the facility. The Administrator said it was reported that Resident #1 turned over a table in the lobby, but she could find no evidence of a table in the lobby. (continued on next page)

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 04/14/25 at 12:58 p.m., RN B said she was the compliance nurse. She said she was not saying that Resident #1 was properly discharged . RN B said it was reported to her that Resident #1 was exit-seeking and wanted to leave. RN B said in addition to the exit seeking behavior, Resident #1 was upset and throwing stuff. RN B said the Director of Nursing made the decision to call the family and tell them to come get him. RN B said the DON no longer worked at the facility. RN B said the DON texted the Administrator but did not call to report Resident #1 was being discharged nor was the ombudsman notified of the discharge. RN B said Resident #1 needed to be in a secure unit due to his exit seeking behaviors, but the facility did not assist in locating an alternative placement. RN B said she was told it was the family's decision to discharge Resident #1. During an interview on 04/14/25/25 at 1:38 p.m., RN D said she contacted by RN A that Resident #1 was turned over a table in the lobby and had broken a shelf. RN D said RN A told her Resident #1 was trying to get out and she needed her to come to the facility. RN D said she worked at the facility but was also a family member for Resident #1 and one of his emergency contacts. RN D said when she arrived at the facility, Resident #1 was in the smoking area and was calm. RN D said Resident #1 was not displaying any behaviors at the time. RN D said the DON told RN A to call the police if RN D did not take Resident #1 home with her. RN D said she did not want RN A to call the police, so she took Resident #1 to her house, and he stayed there for two nights and slept on her sofa. RN D said she signed a form when Resident #1 was discharged with his medication. RN D said one of the medications was for his behaviors. The sign medication release form could not be located. RN D said she did not see Resident #1 showing aggressive behaviors when she arrived at the facility and that RN A did not want to deal with Resident #1 and wanted him out of the facility. RN D said Resident #1 went to live with a family member after he left her home. RN D said Resident #1 will remain at the famiily member's until another facility can be found. During an interview on 04/14/25 at 3:59 p.m. Ombudsman said she had not received any notification concerning the discharge of Resident #1. During an interview on 04/14/25 at 5:50 p.m., RN A said she was the charge nurse on the evening of 03/28/25 when Resident #1 was discharged . RN A said Resident #1 was displaying aggressive behaviors, turning over a table in the lobby and was looking for something to throw at the glass in the window. RN A said she gave Resident #1 an Ativan, and he was cooperative in taking the medication. RN A said the medication did not appear to work and Resident #1 continued to show exit-seeking behaviors. RN A said she called the DON and was told to contact Resident #1's family. RN A said she attempted to call Resident #1's family member but she could not reach her. RN A said she called RN D, who was also a family member. RN A said RN D and her husband came to the facility. RN A said when RN D and her husband arrived at the facility, Resident #1 was on the patio. RN A said they went to the patio to talk with Resident #1. RN A said she called the NP and the NP said to send him to the hospital for evaluation if the family agreed. RN A said RN D said there was no need to send Resident #1 to the hospital because he was not showing signs of aggression and there was nothing that the hospital could do. RN A said RN D agreed to take Resident #1 home with her. RN A said she gave Resident #1's medication to RN D and she signed for them. RN A said she did not contact the Administrator or the ombudsman. RN A said the facility did not attempt other interventions other than to have him removed from the facility. (continued on next page)

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's Discharge Planning Process Policy dated 11/28/16. .Facility must complete discharge planning when .discharging a resident to a private residence .Discharge planning includes A) Assessing the resident's continuing care needs, including: 1. Consideration of the resident's and family caregiver's preference for care; 2. How services will be accessed; and How care should be coordinated among multiple caregivers. B) Developing an interdisciplinary team discharge plan designed to ensure that the resident's needs will be met after discharge from the facility, including resident and family/caregiver educational needs; . D) Assisting the resident and family/caregivers in locating and coordinating post-discharge services Discharge summary must include: .2. A post-discharge plan of care will help the resident adjust to their new living environment Review of an undated facility's Discharge or transfer to another facility indicated Facility initiated discharge . The facility will permit each resident to remain in the facility, and not transfer or discharge the resident from the facility. The following limited circumstances, this facility may initiate transfers or discharges: A. The transfer or discharge is necessary for the resident's welfare and the resident's needs can not be met in the facility .C. The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident; . For circumstances A .the resident's physician must document information about the basis for the transfer or discharge. Additionally, for circumstances A .the inability to meet the resident's needs, the documentation made by the resident's physician must include: The specific resident needs the facility could not meet; The facility efforts to meet those needs; and the specific services the receiving facility will provide to meet the needs of the resident which cannot be met at the current facility. Documentation regarding the reason for the transfer or discharge may be completed by a nurse practitioner or other non-physician practitioner according to state law .