STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675399	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Navasota Nursing & Rehabilitation	1405 E Washington Navasota, TX 77868

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 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48314 Based on interviews, observations, and record review, the facility failed to ensure residents who were trauma survivors received culturally competent, trauma-informed care in accordance with professional standards of practice, and accounted for residents' experiences and preferences in order to eliminate or mitigate triggers that may cause re-traumatization for 1 (Resident #1) of 1 resident reviewed for trauma informed care. The facility had Resident #1 in a shared room with Resident #2, when his care planning for Post-Traumatic Stress Disorder (PTSD) documented that having roommates triggers his PTSD. This failure could place residents at increased risk for psychological distress due to re-traumatization. Findings included: Review of Resident #1's Face Sheet dated 07/17/2024 reflected a [AGE] year-old male initially admitted to the facility on [DATE] with the following diagnoses: chronic / acute post-traumatic stress disorder (mental health condition that can affect anyone who has experienced a traumatic event, such as military combat, sexual or physical assault, or a natural disaster - chronic suffers my experience symptoms such as flashbacks, nightmares, and severe anxiety that can interfere with daily life), dementia (loss of cognitive functioning -thinking, remembering, and reasoning), and major depressive disorder (persistent feeling of sadness and loss of interest that can interfere with daily life). Review of Resident #1's Quarterly MDS assessment dated [DATE] reflected that he had a BIMS Score of 11, indicating moderate cognitive impairment. The MDS reflected that Resident #1 did not exhibit any behavior indicating rejection of care. The MDS reflected that Resident #1 had an active diagnosis for post-traumatic stress disorder (PTSD). Review of Resident #1's Comprehensive Care plan reflected the following focus area with revision on 09/14/2023, [Resident #1] has PTSD or other similar diagnosis related to military service Date Initiated: 11/06/2022. Resident #1's Interventions included: [Resident #1] needs his own room. Having roommate triggers his PTSD, Date Initiated: 11/06/2022; Identify situation/event/images that trigger recollections of the traumatic event and limit [Resident #1] exposure to these as much as possible, Date Initiated 11/06/2022. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #1's Psychological Services Supportive Care Progress Note, Service Date 7/10/2024, DX: F43.11 post-traumatic stress disorder acute; Summarize Progress and plan: (include significant developments since last session, session gains, additional recommendations, comments) Clinician {health professional who works one-on-one with patients, diagnosing or treating illness. A clinician might be a physician or nurse, a psychologist, or a speech-language pathologist} met with resident for weekly session. Resident was engaged with clinician and responded well to therapy. Clinician conducted supportive therapy to encourage patient to engage in meeting therapeutic goals. Resident expressed his frustration about being moved to yet another room. Resident stated that it would be better if he did not have to live with his current roommate. Review of Resident #2's Face Sheet dated 07/17/2024 reflected a [AGE] year-old male admitted to the facility on [DATE] with the following diagnoses: cerebral palsy (abnormal brain development or damage to the developing brain that affects a person's ability to control their muscles), depressive episodes (person experiences a depressed mood (feeling sad, irritable, empty) that last most of the day, nearly every day, for at least two weeks), and anxiety disorder (persistent and excessive worry that interferes with daily activities). Review of Resident #2's Quarterly MDS assessment dated [DATE] reflected that he had a BIMS Score of 15 indicating cognition was intact. Interview and observation on 07/11/2024 at 1:04 PM, revealed the resident identifier on the outside of room indicated it was occupied by Resident #1 and Resident #2. Resident #2 was out of the room and Resident #1 was lying in his bed awake. Resident #1 was greeted and quickly sat up in his bed, spun around to face the door, and requested to know what was needed. Resident #1 stated he did not want to speak and lied back down in bed. In an interview on 07/11/2024 at 2:16 PM, LVN A stated care plans were utilized by staff to ensure the needs of the resident were met. LVN A stated she did not know whether Resident #1 had a diagnosis of PTSD, but stated if he does it should be care planned. LVN A stated that Resident #1 can be very moody. LVN A stated if Resident #1 was care planned to not have a roommate, then he should not have had anyone in his room. LVN A stated that Resident #1 and Resident #2 have been in the room together for over a month with no issues . In an interview on 07/11/2024 at 2:34 PM, the MDS Coordinator stated she put together the residents' care plan with the assistance of the interdisciplinary team, which were signed off on by the DON. The MDS Coordinator stated care plans set measurable goals and were utilized for the overall care of the resident. The MDS Coordinator stated PTSD and triggers should be care planned and followed through with. The MDS Coordinator in review of the care plan stated Resident #1 did have a known trigger that he should be in a room by himself and currently had a roommate. The MDS Coordinator stated that the failure to follow his intervention could result in a physical altercation with the roommate or cause Resident #1 to be re-traumatized . (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 07/11/2024 at 2:53 PM, the SW stated she facilitates the care plan meetings and takes care of social work concerns if the resident has any. The SW stated she would be involved in the planning of residents with a diagnosis of PTSD and that it should be care planned. The SW stated she worked in coordination with psychological services to find out the root cause of PTSD to identify triggers. The SW stated failure to follow the plan of care for triggers could result in the resident experience flashbacks and possibly hurting themselves or others. The SW stated she was not aware that Resident #1 had a diagnosis of PTSD and had never seen any triggers or behaviors. The SW stated in review of the care plan for Resident #1 that he should not currently have a roommate and knew that he had been annoyed by having to switch rooms. In an interview on 07/11/2024 at 3:10 PM, the DON stated care plans give a picture of the resident, their needs, and were to be utilized by staff to provide proper care for residents. The DON stated if a resident has an active diagnosis of PTSD, it should be care planned and should include triggers. The DON stated if a resident was triggered it could lead to bad consequences and re-traumatization. The DON stated Resident #1 and Resident #2 have been in room together for approximately one month . In an interview on 07/11/2024 at 3:35 PM, Resident #2 was in a common area working with building blocks after having exited room . Resident #2 stated that he liked it in the facility but wanted to move back into his old room in a different hallway. Resident #2 stated that he has not had any problems with Resident #1 but wants to move out of the room because it was off the main hallway of the facility. In an interview on 07/11/2024 at 4:34 PM, the Regional Compliance Nurse stated care plans direct care of the residents and that PTSD and triggers should be specifically care planned. The Regional Compliance Nurse stated that staff need to know what care to provide for the resident and to ensure they were not triggered, which could lead to adverse effects and re-traumatization. The Regional Compliance Nurse stated in review of Resident #1's care plan that no one should be in the room with him . In an interview on 07/11/2024 at 5:05 PM, the Administrator stated care plans were based on what was triggered during MDS assessments and to address resident needs. The Administrator stated care plans were to be adjusted and modified to make the residents as happy and comfortable as possible. The Administrator stated that Resident #1's care plan should have been followed for his PTSD and known trigger until it was ruled out and then changed if it was no longer a concern. The Administrator stated that Resident #1 should not have had a roommate. Review of progress and behavior notes for Resident #1 and Resident #2 from 2024 revealed no physical or verbal incidents between the two residents. Review of the facility's provided resident roster dated 7/17/2024 revealed that Resident #1 was in room and Resident #2 was in room together. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's Trauma-Informed Care Policy dated 10/2022 revealed, I. Purpose: The facility must ensure that residents who are trauma survivors receive culturally competent, trauma-informed care by professional standards of practice and accounting for residents' experiences and preferences to eliminate or mitigate triggers that my cause re-traumatization of the resident. IV. Assessment Facilities should use a multi-pronged approach to identifying a resident's history of trauma as well as his or her cultural preference. This would include asking the resident about triggers that may be stressors or may prompt recall of a previous traumatic event, as well as screening and assessment tools such as the Resident Assessment Instrument (RAI) Admission Assessment, the history and physical, the social history/assessment, and others. Triggers Facilities must identify triggers that may re-traumatize residents with a history of trauma. A trigger is a psychological stimulus that prompts a recall of a previous traumatic the event, even if the stimulus itself is not traumatic or frightening. For many trauma survivors, the transition to living in an institutional setting (and the associated loss of independence) can trigger profound re-traumatization. While most [NAME] are highly individualized, some common [NAME] may include: Experiencing a lack of privacy or confinement in a crowded or small space; Exposure to loud noises, or bright/flashing lights' Certain sights, such as objects that are associated with those that used to abuse, and/or Sounds, smells, and even physical touch. Care Planning to Address Past Trauma: The facility should collaborate with resident trauma survivors, and as appropriate, the resident's family, friends, and any other health care professionals (such as psychologists, mental health professionals) to develop and implement individualized interventions. In some cases, if a facility has more than one trauma survivor, social services might consider establishing a support group that is run by a qualified professional, or allowing a support group to meet in the facility. In situations where a trauma survivor is reluctant to share his or her history, facilities are still responsible to try to identify triggers that may re-traumatize the resident and develop care plan interventions that minimize or eliminate the effect of the trigger on the resident. Trigger-specific interventions should identify ways to decrease the resident's exposure to triggers that re-traumatize the resident, as well as identify ways to mitigate or decrease the effect of the trigger on the resident.