STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675424	A. Building B. Wing	01/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Advanced Rehabilitation and Healthcare of Athens	121 Commons Drive Athens, TX 75751

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35340 Based on observation, interview, and record review, the facility failed to protect the residents' right to be free from verbal and physical abuse for 2 of 14 residents reviewed for abuse. (Resident #s 1 and 2) The facility failed to ensure Resident #1 was free from abuse when Resident #2 hit Resident #1 with an open hand to the back of the neck area on 04/08/24. The facility failed to ensure Resident #2 was free from abuse when Resident #1 intentionally rammed his wheelchair into Resident #2's wheelchair and then threatened to kill Resident #2. This failure could place the residents at risk for increased risk for abuse and neglect. Findings included: 1) Record review of Resident #1's admission record, printed on 1/5/25 indicated he was an [AGE] year-old male who initially admitted to facility on 7/31/23 and readmitted on [DATE] and on 12/18/23 and discharged on [DATE] with diagnoses including metabolic encephalopathy (is a change in how your brain works due to an underlying condition. It can cause confusion, memory loss and loss of consciousness), myocardial infarction (also known as a heart attack, occurs when blood flow to the heart is blocked, depriving the heart muscle of oxygen). Record review of Resident #1's annual MDS dated [DATE] indicated he had clear speech and was able to make self-understood by expressing ideas and wants; had clear comprehension. Resident #1 had a Brief Interview for Mental Status (BIMS) score of 11, which indicated he had moderately impaired cognition. Record review of Resident #1's progress notes indicated the following: (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- 4/8/24 at 11:44 am written by LVN B indicated I [LVN B] responded to a verbal altercation in the dining room between [Resident #1] and [Resident #2]. [Resident #1] accused [Resident #2] of hitting him in the back of the neck and head following a verbal altercation between the two. Residents separated and the abuse coordinator informed of the altercation. Both residents were assessed for injury and both residents interviewed for their accounts of the incident. [Resident #1] stated I [Resident #1] was headed to the coffee pot and [Resident #2] was in the way. I [Resident #1] asked him to move out of the way and [Resident #2] became aggressive. [Resident #2] reached out to grab me [Resident #1] and I [Resident #1] told [Resident #2] I would kill him [Resident #2] if he touched me [Resident #1]. I [Resident #1] went around [Resident #2] and started to pour my coffee and he [Resident #2] came up behind me and hit me in the back of the head and neck. - 4/8/24 at 11:59 am written by LVN B indicated a head to toe assessment performed following incident. No redness or bruising noted to back of the head and back of the neck. No swelling noted. No other visible evidence of trauma to the rest of the body. No complaints of pain or discomfort voiced at this time. - 4/9/24 at 3:43 am written by LVN C indicated [Resident #1] resting quietly in bed at this time. Follow up post physical altercation 4/8/24. [Resident #1] denied any pain following incident and no residual injuries noted. [Resident #1] in no distress post incident and does not feel he was in danger. 2) Record review of Resident #2's admission record, printed on 1/5/25 indicated he was an [AGE] year old male who admitted to the facility on [DATE] with diagnoses including hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side (refers to a medical condition where a person experiences weakness or paralysis on the left side of their body due to a stroke), major depressive disorder (a mental illness that can impact how a person feels, thinks, and functions). Record review of Resident #2's annual MDS dated [DATE] indicated he had clear speech and was able to make self-understood by expressing ideas and wants; had clear comprehension. Resident #2 had a Brief Interview for Mental Status (BIMS) score of 11, which indicated he had moderately impaired cognition. Record review of Resident #2's progress notes indicated the following: - 4/8/24 at 10:55 am written by RN D indicated Alerted to physical aggression by this patient vs another resident after verbal confrontation happened. [Resident #2] stated he said he [Resident #1] would kill me [Resident #2] twice, so when he [Resident #1] came near me [Resident #2] I hit him on his back. [Resident #2] denied injuries but further elaborated with I [Resident #2] need armed guards here because he [Resident #1] may have a knife, gun, or bat. [Resident #2] was assured that no harm will come to him in the facility to which he [Resident #2] verbalized understanding. [Resident #2] responsible party was notified along with the doctor. [Resident #2] assessed with no sign or symptoms of acute distress besides anger issues. 1:1 observation initiated. Addendum: [Resident #2] re-directed not 1:1, calm/cooperative at this time with no further behaviors at this time. - 4/8/24 at 12:27 pm written by RN D indicated [Resident #2] calm/cooperative at this time, received new orders from Nurse Practitioner and alerted [hospice agency] as well as [Resident #2's] responsible party. Lexapro from 5 mg QD to 10mg QD and Ativan from 0.5mg QHS to am and HS. (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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- 4/9/24 at 4:24 am written by LVN E indicated [Resident #2] has been resting quietly during the night with no behavior issues. During an observation and interview on 1/5/25 at 6:49pm Resident #2 was lying in bed and just finished dinner. He said Resident #1 bumped him and threatened him so he hit Resident #1. Resident #2 said it happened a while back and did not know why it was being brought back up. Record review of facility's provider investigation report dated 4/12/24 indicated facility reported to HHSC on 4/8/24. Alleged victim: Resident #1. Alleged Perpetrator: Resident #2 Description of Allegation: [Resident #2] was blocking the coffee pot and was asked to move. [Resident #1] chair hit [Resident #2] chair and [Resident #2] hit [Resident #1] in the back of the head/neck. Provider Response: The AD was engaged in an activity in the dining room when [Resident #1] came in to get a cup of coffee. [Resident #1] requested that [Resident #2] move out of the way. [Resident #2] did not respond fast enough and [Resident #1] chair hit [Resident #2] chair. A verbal altercation occurred, and the AD intervened. After intervening [Resident #1] went on to the coffee pot, and [AD] went to report to the charge nurse that the two had a verbal interaction. Upon arriving back to the dining room [Resident #2] was witnessed behind [Resident #1] when he [Resident #2] hit [Resident #1] in the back of the head/neck area. The charge nurse intervened and separated the two residents and completed assessments of both residents revealing no injury to either resident. The SW spoke with both residents regarding the incident and completed referrals to on-site psych services for evaluation . The tables were rearranged in the dining room allowing additional aisle space to get to the beverage bar. The beverage bar was rearranged allowing easy access to the coffee. No changes made to resident rooms as they resided on different halls. On 4/10/24, [Resident #1] requested to make a report to law enforcement of the incident. An officer came onsite and completed a [police] report . Investigation Summary: In reviewing the statements completed and the camera in the dining room it appeared that both residents contributed to the interaction. [Resident #1] initially bumped into [Resident #2] after requesting him to move allowing him to pass by. Subsequently [Resident #2] then reacted, after the AD intervened by approaching [Resident #1] and hitting him with an open hand in the back neck area. There were no injuries to either party. Both residents were assessed by the nurse following the incident and visited with the SW. Both parties denied any issues related to the incident. On 4/10/24 [Resident #1] requested to files charges against [Resident #2] for hitting and the facility assisted him with the process. Both residents were referred to on-site psych services for assessment and assistance with the development of coping skills related to allow frustration tolerance as the facility is a shared living environment. On 4/10/24, the ombudsman visited the facility and spoke with Resident [Resident #1], and he had no complaints or concerns during her visit. The nurse spoke with the NP regarding the incident, new orders received to change Ativan and Lexapro for [Resident #2]. [Resident #2] also had UTI and received antibiotics. The dining room was rearranged allowing easier access to the coffee pot and beverages. The facility completed in-services on behavior de-escalation, abuse/neglect, and providing an intervention when a situation is occurring. Investigation Findings: Confirmed. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of undated handwritten statement provided by the facility from LVN B indicated the following: I [LVN B] responded to a verbal altercation in the dining room between [Resident #1 and Resident #2]. [Resident #1] accused [Resident #2] of hitting him in the back. I [LVN B] asked [Resident #2] if he his [Resident #1] and he [Resident #2] replied yes, I hit him [Resident #1] after he threatened to kill me [Resident #2], and I [Resident #2] take that seriously. I [LVN B] had the two residents separated and informed administrator of incident. I [LVN B] interviewed [Resident #1] about the incident, and he claimed that he [Resident #1] was on his way to the coffee in the dining room. He [Resident #1] claimed that [Resident #2] became agitated and lunged his hand at [Resident #1]. [Resident #1] then said, I'll kill you if you ever touch me! Once [Resident #1] moved past [Resident #2], he [Resident #1] claimed that [Resident #2] then came up behind him and hit him on the back of his he and neck. The verbal altercation that followed is what I [LVN B] came upon when I [LVN B] entered the dining room. [Resident #1] was assessed by this nurse for injury related to getting hit. [Resident #2] denied pain to neck and back of head stating, it only hurt when it happened, it does not hurt not. No redness or bruising noted to back of neck or back of head. No swelling present. [Resident #1] did not wish to press charges. I [LVN B] interviewed [Resident #2] regarding the incident. He [Resident #2] claimed that [Resident #1] aggressively told him to move out of the way to the coffee. He [Resident #2] then claimed that [Resident #1] rammed his wheelchair into his [Resident #2] and threatened I'll kill you if you put your hand on me. [Resident #2] claimed that those are fighting words. [Resident #2] then admitted to coming up behind [Resident #1] and hitting him with an open hand in the back of the head. [Resident #2] stated I have the right to defend myself when someone threatens to kill me. [Resident #2] had nothing further to say after that. Record review of typed statement dated 4-8-24 and signed by DON indicated the following: Spoke with [Resident #1] and he stated I [Resident #1] went in the dining room to get a cup of coffee and that man [Resident #2] was in the middle not even up at the table drinking the coffee, so I [Resident #1] asked him [Resident #2] to move. He [Resident #2] said something, and I [Resident #1] couldn't understand him, be he [Resident #2] didn't move, so I [Resident #1] bumped into his [Resident #2] chair. He [Resident #2] grabbed for me [Resident #1] or something but didn't touch me as I pulled back, so the lady that does the activities pulled my [Resident #1] chair to the coffee pot so I could get some coffee, and that sorry [NAME] waited until I [Resident #1] turned and hit me on my back, not hard and it didn't hurt but I [Resident #1] don't have anything for a [NAME]. I [Resident #1] am a navy seal, and we believe in that. Resident denied any distress, pain or discomfort at this time. Resident separated and notifications completed. Record review of typed statement dated 4-8-24 and signed by DON indicated the following: Spoke with [Resident #2] and he stated that man [Resident #1] was upset where I was blocking the isle and drinking my coffee and didn't move fast enough for him. So, he [Resident #1] bumped my [Resident #2] chair and threatened me [Resident #2]. I [Resident #2] slapped him in the back of his head. I [DON] explained that we can't hit people and he [Resident #2] stop me [DON] and says they can't threaten me [Resident #2] I know the law. Residents [Resident #1 and #2] were separated and assessed with no distress or injuries noted at this time. Only concerned with his cup of coffee. Notifications completed. (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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of typed witness statement dated 4-8-24 and signed by AD indicated the following: I [AD] witnessed an altercation between [Resident #1 and Resident #2] in the dining room around 11:00am. [Resident #2] was sitting in the walkway when [Resident #1] was trying to get to the coffee pot. [Resident #2] would not move to let [Resident #1] through to the coffee pot. I [AD] heard some arguing and looked up and [Resident #3] was trying to slap [Resident #1] in the face, there wasn't any contact. I [AD] stopped my activity to redirect [Resident #2 and Resident #1], I [AD] separated them so I could get some help. When I [AD] came back with help they [Resident #1 and Resident #2] were fighting again. [LVN B] was the nurse that came to help, he [LVN B] provided further intervention to the residents. During an interview on 1/6/25 at 5:24 p.m., the AD said the incident between [Resident #1 and Resident #2] happened a while back and she could not recall all the details. AD said she provided a witness and the information on her statement was accurate. The AD said she remembered she was doing a group activity in the dining room, neither Resident #1 nor Resident #2 attended the group meeting. She said she saw and overheard Resident #1 and Resident #2 having a verbal argument, she separated them and left to go get a nurse for help. The AD said whenever she returned with help, she saw Resident #2 hit Resident #1 in the back of the head; she said herself and LVN B separated Resident #1 and Resident #2 and then she went back to doing her group activity and LVN B took over. The AD said Resident #1 and Resident #2 had similar personalities, no other issues she recalled. During an interview on 1-6-25 at 8:00 p.m., the Administrator said she was the abuse coordinator and followed their abuse policy. The Administrator said following their investigation it was confirmed the abuse incident did occur and they had not had any similar issues since. Record review of revised abuse policy dated 9/6/24 indicated the following: It is the policy of this facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675424	A. Building B. Wing	01/06/2025

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35340 Based on interview and record review the facility failed to ensure that residents received care and services in accordance with professional standards of practice for 1 of 14 residents (Resident #3) reviewed for quality of care. The facility failed to follow up with a cardiologist and neurologist referral for Resident #3 for 30 days. This failure could place residents at risk for not receiving appropriate care and treatment and or decline in their health. The findings included: Record review of Resident #3's admission record, printed on 1/5/25 indicated she was an [AGE] year-old female who initially admitted to facility on 10/09/24 and discharged on [DATE] with diagnoses including chronic kidney disease stage 3B (a moderate to severe loss of kidney function), hypothyroidism (also called underactive thyroid, is when the thyroid gland doesn't make enough thyroid hormones to meet your body's needs), Type 2 diabetes (is a chronic condition that happens when you have persistently high blood sugar levels), and hypertension (a chronic condition that occurs when your blood pressure is consistently too high). Record review of Resident #2's admission MDS dated [DATE] indicated she had clear speech and was able to make self-understood by expressing ideas and wants; had clear comprehension. Resident #3 had a Brief Interview for Mental Status (BIMS) score of 05, which indicated severe cognitive impairment. Record review of Resident #3's after visit summary from the hospital, printed on 10/09/24 indicated Resident #3 was in the hospital from 9/26/24 to 10/09/24 due to stroke like symptoms. Other instructions: ambulatory referral to Cardiology and ambulatory referral to neurology. Follow up instructions: Acute encephalopathy and fall likely multifactorial in setting of UTI .There was elevated protein in the urine, with the creatinine however falsely elevated, need to follow up with PCP in 3-5 days and follow up with neurology in 1-2 weeks. Resident had leg swelling, a test was ordered to check for heart failure, Resident #3 has diastolic dysfunction so could be developing heart failure, Resident #3 has sleep apnea and pulmonary hypertension, the swelling could be from this depending on severity. Resident #3 to follow up with cardiology in 1-2 weeks. Record review of Resident #3's medical records from 10/09/24 to 11/08/24 did not reveal any referrals for cardiologist and neurologist. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 1/6/25 at 7:41 p.m., the DON said she looked through Resident #3's chart and did not see where a referral was made for cardiologist and neurologist. She said the transportation driver normally set up appointments for the residents and wrote down the appointments in the transportation book, but the transportation driver at the time of the incident no longer worked at the facility and the transportation book went missing after she left . The DON said the nurse managers were responsible for making sure referrals were made and she could not recall if any referral was made for Resident #3, and the information was not documented in her chart. The DON explained it was possible since that was not her admitting diagnosis then a referral for the cardiologist and neurologist was not made, but she was not sure. The DON said if Resident #3 admitted from hospital with discharge instructions for a follow up with cardiologist and neurologist then a referral should have been made. During an interview on 1/6/25 at 8:24 p.m., ADON F and ADON G said they reviewed Resident #3's chart and did not see where a referral for cardiologist and neurologist was set up. ADON F said normally whenever they received residents from the hospital and the hospital put the word ambulatory before a word, such as ambulatory referral to cardiology and ambulatory referral to neurology, then the hospital discharged resident to facility and the hospital would still set up referral and then contact the facility with the appointment information. ADON F and ADON G stated as the nursing managers, they should be responsible for making sure referrals were made whenever a resident was admitted , and they could not explain why referrals were not made for Resident #3 whenever she admitted from the hospital.