STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675444	A. Building B. Wing	08/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Reunion Plaza Senior Care and Rehabilitation Cente	1401 Hampton Rd Texarkana, TX 75503

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44596 Based on record review, and interview, the facility failed to treat each resident with respect and dignity and provide care in a manner that promoted maintenance or enhancement of his or her quality of life for 1 of 12 residents reviewed for resident rights. (Resident #32) The facility failed to promote self-determination for Resident #32 by not allowing her to make healthcare decisions for herself when on 06/16/2024, LVN M, who was an agency nurse, refused to call an ambulance for Resident #32 because she felt Resident #32 was medically stable at the facility. This failure could place residents at risk for decreased quality of life, decreased self-esteem and increase anxiety. Findings included: Record review of an undated face sheet reflected Resident #32 was a [AGE] year-old female admitted to the facility on [DATE] with the diagnoses of PVD (peripheral vascular disease- poor circulation), sepsis (severe infection), and diabetes mellitus type II. She was discharged [DATE]. Record review of Resident #32's 5-day MDS assessment dated [DATE] indicated she had a BIMS of 15 which reflected Resident #15 had no cognitive impairment and required substantial to maximum assistance for toileting, transfer, and hygiene. The MDS indicated Resident #32 received dialysis during her stay. No behaviors were noted on the MDS. Record review of Resident #32's EHR revealed no care plans for behaviors. (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 08/14/2024 at 10:00 a.m., Resident #32 stated that her only issue when she was a resident was, she was not allowed to go the hospital when she requested on 06/16/2024. She stated she called her sister one evening stating she was not feeling right. She stated after speaking with her sister she was going to ask the nurse to call an ambulance and go to the ER to be checked out. The resident stated she could feel herself becoming more confused and caught herself having a hallucination of a snake coming out of the wall. She stated being on dialysis she knew this meant something in her body chemistry was not right. She stated the nurse came down to her room and checked her vital signs and told her there was nothing wrong with her and she would not be calling an ambulance because it would be against medical advice for her to leave when nothing was wrong with her. Resident #32 stated she told LVN M that she had the right to go to the hospital. She stated LVN M told her that she (LVN M) understood that, but she (LVN M) would not be calling the ambulance. She stated her family member called the nurse and the nurse hung up on Resident #32's family several times. She stated she then called her another family who came to the facility later in the day and called the ambulance himself. During an interview on 08/15/2024 at 2:22 p.m., LVN M stated she worked agency for the facility on 06/16/2024. She stated she remembered Resident #32's family member calling the facility about a dozen times that day. She stated after the 1st time Resident #32's family member called, and she went and checked on Resident #32. She stated her vital signs were normal and she was able to answer all my questions. She stated she was not familiar with Resident #32 but found out that she was medically complex when reading her chart. She stated Resident #32 had cancer, was on dialysis, and had gangrene in a wound. LVN M stated she called the MD on call and reported her vital signs and he (MD) stated there was no reason to send her out. LVN M was unable to remember the name of the MD or the vital signs and none were documented in the chart. LVN M stated she told the family member it was against medical advice for Resident #32 to be sent to the hospital and she would not be calling an ambulance for her. During an interview on 08/15/2024 at 2:45 p.m., the DON stated she remembered very well the issues Resident #32 had with LVN M. She stated after Resident #32's family member called and reported LVN M, LVN M was taken off the schedule to work at the facility. The DON stated that all residents have the right to self-determination. They should have the same abilities in the facility that they have a home. She stated it was her responsibility to ensure all staff understood resident rights. She stated she immediately did an Inservice and LVN M never worked in the facility again. During an interview on 08/15/2024 at 3:16 p.m., the ADM stated she was aware that LVN M, who was an agency nurse refused to call an ambulance for Resident #32 because she felt Resident #32 was medically stable at the facility. The ADM stated a facility wide in-service on Resident Rights and self-determination was done to educate all staff and LVN M was no longer used in the facility. Review of an undated Resident Rights facility policy indicated, .Federal and state laws guarantee certain basic right to all resident in this facility. These rights include the resident's right to .a dignified existence .be treated with respect, kindness dignity . and self-determination.

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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	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** 46062 Based on observation, interview, and record review the facility failed to ensure residents were free from abuse for 2 of 27 residents (Resident #1 and Resident #3) reviewed for resident abuse. 1.The facility failed to ensure Resident #1 was free from abuse when on 11/02/2023 CNA H shook Resident #1's wheelchair when pushing into the bathroom for incontinent care. 2.The facility failed to ensure Resident #3 was free from abuse when on 6/20/24 CNA J forcefully pushed Resident #3's wheelchair with her in it, from the doorway of her room to the doorway of another room across the hallway (approximately 13 foot). These failures could place residents at risk of physical harm, mental anguish, and/or emotional distress. The findings included: 1.Record review of Resident #1's face sheet, dated 8/13/24, revealed she was [AGE] years old and initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident #1 had diagnoses of dementia (progressive loss of intellectual functioning, especially with impaired memory), weakness, abnormality of gait and mobility, lack of coordination, and hypertension (high blood pressure). Record review of Resident #1's quarterly MDS assessment, dated 10/17/23, revealed she sometimes understood others and was sometimes understood by others. The MDS revealed Resident #1 had a BIMS score of 2, which indicated severe cognitive impairment. The MDS revealed Resident #1 used a wheelchair for mobility. The MDS revealed Resident #1 required maximal to moderate assistance for most ADLs. The MDS revealed Resident #1 was always incontinent of bowel and bladder. Record review of Resident #1's comprehensive care plan dated 8/13/24, revealed Resident #1 had cognitive deficit related to dementia; she had impaired physical mobility; she had self-care deficit; and she was at risk for problems with elimination. Record review of the facility's PIR dated 11/02/23 with an incident category of abuse was signed by the ADM on 11/09/23. The PIR revealed CNA L had reported CNA H had become agitated during Resident #1's incontinent care of bowel movement and shook Resident #1's wheelchair while she was sitting in it. The PIR included a form titled Interview Statement Employee completed on 11/2/23 at 10:50 AM for CNA L who stated CNA H was agitated and shook Resident #1's wheelchair. CNA L said the other aide (CNA H) did not help CNA L provide incontinent care after shaking Resident #1's wheelchair. CNA L stated, I realize CNA H was old, but that was not an excuse to have an attitude. The ADM signed The Interview Statement Employee form on 11/2/23 as being the one who conducted the interview. The PIR revealed CNA H was suspended during the investigation and then was not allowed to return. The PIR revealed staff was to be in-serviced promptly on abuse. During an observation on 8/14/24 at 11:54 AM, Resident #1 was self-propelling herself in her wheelchair around the nurse's station and hallway. Resident #1 was clean and well groomed. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 8/14/24 at 3:08 PM, Resident #1 said she was doing fine and self-propelled herself away and went down the hallway. During an interview on 8/15/24 at 8:20 AM, Resident #1's RP said Resident #1 was a difficult patient at times and she was incontinent of bowel and bladder. Resident #1's RP said she did not remember being notified about the incident from 11/02/23 but it was back in November of last year. Resident #1's RP said the facility normally notified her when anything happened. During an interview on 8/15/24 at 8:32 AM, CNA H said another staff member said she shook Resident #1's wheelchair during incontinent care, but CNA H said she did not shake Resident #1's wheelchair. CNA H said she was suspended during the investigation, and she decided to not return to the facility because she was getting too old to do the amount of work that was required when there was frequent call-ins. Attempted to call CNA L on 8/15/24 at 12:31 PM and at 4:02 PM, but there was no answer and was unable to leave a message. CNA L did not return call prior to exit. 2. Record review of Resident #3's face sheet, dated 8/13/24, revealed she was [AGE] years old and admitted to the facility on [DATE]. Resident #3 had diagnoses of cerebral palsy (lifelong condition affecting movement, coordination, and muscle tone), intellectual disabilities (below average intelligence and set of life skills present before age 18), scoliosis (sideways curvature of the spine), and bladder disorder. Record review of Resident #3's quarterly MDS assessment, dated 7/3/24, revealed she had unclear speech and rarely understood others and was rarely understood by others. The MDS revealed Resident #3 was unable to complete the BIMS, which indicated she had severe cognitive impairment. The MDS revealed Resident #3 had severely impaired cognitive skills for daily decision making. The MDS revealed Resident #3 used a wheelchair for mobility. The MDS revealed Resident #3 required maximal to dependent assistance for most ADLs. Record review of Resident #3's comprehensive care plan dated 8/13/24, revealed Resident #3 had cognitive deficit related to intellectual disability; she had speech deficit expressive related to developmental disabilities; she was a fall risk; impaired physical mobility with an intervention to provide appropriate level of assistance to promote safety of resident; she was physically aggressive and had interventions of all staff educated about triggers, what de-escalates, what signals onset of agitation, guide away from source of distress, intervene before resident agitation escalates. Record review of the facility's PIR dated 6/20/24 with an incident category of abuse was signed by the ADM on 6/26/24. The PIR revealed LVN K had reported CNA J had pushed Resident #3's wheelchair while she was sitting in it from one side of the hallway to the other quickly. The PIR revealed CNA J responded inappropriately to Resident #3's behaviors. The PIR revealed CNA J was interviewed and did not deny the actions, but stated she was being hit and she pushed the wheelchair and not the resident. CNA J was suspended during the investigation and ultimately was not allowed to return. The PIR revealed staff was in-serviced on abuse. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During on observation on 8/14/24 at 11:43 AM, Resident #3 was observed sitting in a specialized wheelchair in dining room, feeding herself. Resident #3 had difficulties with feeding self. Resident #3 had abnormal spastic jerking type arm movements. Resident #3 had a divided plate and large handle spoon. Resident #3 had unrecognizable mumbles, loud noises, and un-understandable speech. Resident #3 was clean, well groomed, and was wearing a helmet. Attempted to call Resident #3's RP on 8/15/24 at 8:43 AM and at 2:48 PM, but there was no answer, a voice mail was left requesting a return call. Resident #3's RP did not return call prior to exit. Attempted to call CNA J on 8/15/24 at 9:17 AM and at 4:58 PM, but there was no answer and was unable to leave a message. CNA J did not return call prior to exit. During an interview on 8/15/24 at 12:36 PM, LVN K said she recalled the incident with CNA J and Resident #3. LVN K said she was standing by her medication cart facing hall 100 and saw Resident #3 being combative, flailing her arms backwards, and agitated while CNA J was pushing Resident #3's wheelchair out of the doorway of her room. LVN K said she then saw CNA J forcefully shove Resident #3's wheelchair across the hallway. LVN K said Resident #3 went from her doorway to the doorway of the room on the other side of the hall. LVN K said she immediately told CNA J that she could not do that under no circumstance due to Resident #3 could have fallen out of her chair or hit the wall and been injured. LVN K said CNA J said she was not going to get whooped by her. LVN K said she told CNA J that she should have walked away or gotten someone else to help and not have shoved Resident #3's wheelchair across the hallway. LVN K said Resident #3 had difficulty making her needs known and continued to be agitated after the incident, but she was able to take over Resident #3's care and was able to determine Resident #3 wanted her glasses from out of her room. LVN K said Resident #3 was assessed to have no injuries and was given her glasses. Resident #3 calmed down and she did not have any other issues. LVN K said she wrote CNA J up and contacted the ADM and CNA K was suspended during the investigation. LVN K said that was the first time she had ever witnessed a staff member being abusive toward a resident in her nursing career and she would not tolerate it. During an interview on 8/15/24 beginning at 5:15 PM, the DON said she had been the DON since 1/29/24 and would not have knowledge of incidents occurring before then. The DON said the nurse said CNA J was frustrated with Resident #3 and had pushed Resident #3 out of the doorway and across the hallway and did not go with her. The DON said the nurse told CNA J it was not okay to push Resident #3 across the hallway and sent CNA J home. The DON said there was potential for harm to Resident #3 when CNA J pushed her and did not go with her. The DON said CNA J could have walked away and gotten assistance of another staff member and not have pushed Resident #3 across the hallway. The DON said if CNA J had done that to her mom, it would not have been okay. The DON said CNA J was suspended during the investigation and she had been counseled previously related customer service and she felt there was potential for harm and CNA J was terminated. The DON said it would never be appropriate to shake a resident's wheelchair and it would be an act of abuse and it could intimidate the resident. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 8/15/24 beginning at 5:45 PM, the ADM said she was the Abuse Coordinator. The ADM said CNA L was training with CNA H during the time of the incident on 11/2/23 with Resident #1. The ADM said CNA L came to her office with tears in her eyes and said she had witnessed CNA H visibly upset when Resident #1 had an episode of diarrhea and shook Resident #1's wheelchair by the handles while pushing it. The ADM said CNA L completed the incontinent care and Resident #1 was unharmed and unable to recall the event due to confusion. The ADM said CNA H denied the allegation. The ADM said CNA H was suspended during the investigation and was terminated due to that was not the customer service she wanted portrayed in her facility. The ADM said on 6/20/24 LVN K reported CNA J had pushed Resident #3's wheelchair from one side of the hall to the other quickly and said she was not going to be whooped by her. The ADM said Resident #3 had cerebral palsy and had spastic arm movements and could become agitated and combative at times. The ADM said Resident #3 was assessed by LVN K and was found to be agitated but was not harmed. The ADM said LVN K was able to calm Resident #3. The ADM said CNA J could have dealt with the situation differently, such as walking away or calling for assistance. The ADM said CNA J did not deny the actions, but stated she was being hit and she pushed the wheelchair and not the resident. The ADM said CNA J was suspended during the investigation and was terminated for poor customer service. Record review of the facility's abuse policy, titled Abuse, Neglect and Exploitation and Misappropriation of Resident Property, dated revised 6/23/17 revealed . this policy was to ensure that all healthcare facilities comply with federal and state regulations regarding protecting facility patients and residents from abuse . each resident had the right to be free from abuse . by anyone, including but not limited to facility staff . 44596

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44596 Based on observation, interview and record review, the facility failed to ensure each resident's person-centered comprehensive care plan was reviewed and revised by the interdisciplinary team after each assessment for 4 of 12 residents (Residents #18, #6, #8, and #10), reviewed for care plans. 1.The facility failed to revise and update Resident #18's care plan following physically aggressive behaviors against another resident. No interventions for aggressive behavior were listed on the behavior care plan. 2.The facility failed to revise and update Resident #6's care plan with interventions following a fall with major injury. The care plan did not include Resident #6's hip fracture or interventions for the care of the hip fracture. 3.The facility failed to revise and update Resident #8 and add interventions of a scoop mattress, move bedroom closer to nurses' station, and applying a fall mat beside bed after fall on 04/10/2024. 4. The facility failed to include added interventions of a fall mat and pommel cushion for #10's care plan following 04/24/2024 fall with fall interventions following falls with injury. These failures could affect residents of the facility by not addressing their physical, mental, and psychosocial needs for each to attain or maintain their highest practicable physical, mental, and psychosocial outcome. Findings included: 1. Record review of an undated face sheet indicated Resident #18 was an [AGE] year-old male admitted to the facility on [DATE] with the diagnose of hemiplegia (one-sided paralysis), cerebral infarction (stroke), and dysphagia (difficulty swallowing). Record review of the annual MDS dated [DATE] indicated Resident #18 had a BIMS of 09, which indicated moderate cognitive impairment. The MDS indicated physical behavior towards others. The MDS indicated Resident #18 required set up assistance only for eating and oral hygiene. The MDS indicated Resident #18 required substantial assistance for toileting and transfer. Record review of the care plan titled 'Behavioral Changes' dated 07/07/2023 indicated Resident #18 was a moderate risk for elopement. No other behaviors were addressed in the care plan. No interventions for behaviors were listed in the care plan. Record review of nurses note for Resident #18 dated 11/28/2023 written by LVN A revealed: The CNA called out to this Nurse that resident [#18] is kicking his roommate, (Resident #19). When resident [#18] was asked why he was doing this resident refused to answer. Left note to Administrator also text her. Will monitor resident [#18's] behavior, roommate (Resident #19) was placed in bed and resident (#18) was talked to and told to stay on his side of room. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 08/14/2024 at 2:30 p.m., the MDS Coordinator stated all behaviors that are considered verbal or physical behaviors should be care planned no later than 7 days following the completion of the MDS. The MDS Coordinator stated she was not aware that Resident #18 had any further behavior of physical aggressiveness, but it should be care planned with interventions, so that if it occurred again the staff would know how to address the issue. 2. Record review of an undated face sheet indicated Resident #6 was a [AGE] year-old male admitted to the facility on [DATE] with dementia, hypertension (high blood pressure), repeated falls, and a right hip fracture. Record review of a significant change MDS dated [DATE] indicated Resident #6 had a short- and long-term memory problem. It indicated he required partial to moderate assistance with oral care, toileting, dressing and hygiene. It also indicated he had a hip fracture and one major fall with injury since the last assessment. Record review of the care plan titled Fall Risk indicated Resident #6 had a fall on 03/23/2024 less than 24 hours after admitting. Record review of the care plan for Resident #6 dated 04/04/2024 indicated no care plan for his hip fracture care plan with interventions for the care of his hip fracture. During an interview on 08/14/2024 at 2:30 p.m., the MDS Coordinator stated interventions for falls and any injury related to the fall should be updated on the care plan as the falls happen. She stated the falls were reviewed in the clinical stand up meeting each morning and the care plans are to be updated with interventions as they were discussed in the meeting. The MDS Coordinator stated she was not aware that Resident #6 was not care planned for his hip fracture and interventions for care. 3. Record review of an undated face sheet indicated Resident #8 was a [AGE] year-old male admitted to the facility on [DATE] with the diagnoses of depression, atrial fibrillation (irregular heartbeat), and left femur (long bone in leg) fracture. Record review of the admission MDS dated [DATE] indicated Resident #8 had a BIMS of 14 which indicated no cognitive impairment. Resident #8 required total dependency for toileting, hygiene, dressing and supervision for eating. Record review of the care plan dated 04/10/2024 titled Fall Risk indicated Resident # 8 had a fall on 04/10/2024. The intervention was listed as keeping call light within reach. No other interventions were listed for 04/10/2024 fall. Record review of the incident report for 04/10/2024 for Resident #8's fall, indicated he fell and suffered a fractured nose and received staples to his head. The interventions for the fall on the incident report read: add a scoop mattress, move bedroom closer to nurses' station, and apply a fall mat beside bed. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 08/14/2024 at 2:30 p.m., the MDS Coordinator stated interventions for falls and any injury related from the fall should be updated on the care plan as the falls happen. She stated the falls were reviewed in the clinical stand up meeting each morning and the care plans are to be updated with interventions as they are discussed in the meeting. The MDS Coordinator stated she was unaware why all the interventions were not listed on Resident #8's care plan. She stated it was important to have all interventions listed because the care plan was the blueprint of the specific resident's care instructions. 4. Record review of an undated face sheet revealed Resident #10 was an [AGE] year-old male admitted to the facility on [DATE] with the diagnoses of cerebral infarction (stroke), diabetes mellitus type II, and hemiplegia (paralysis to one side). Record review of the annual MDS dated [DATE] indicated Resident #10 had a BIMS of 04 which indicated severe cognitive impairment. The MDS indicated Resident #10 was dependent for ADLs. The MDS indicated Resident #10 had a fall with injury since the last assessment. Record review of the care plan dated 05/30/2024 for Resident #10 titled Fall Risk had the intervention for the resident to maintain safety over next 90 days and have frequent checks. No interventions for Resident #10 to have a fall mat or pommel cushion were listed on the care plan. Record review of the incident report dated 04/24/2024 indicated Resident #10 had a fall with a closed head injury. Interventions listed were fall mat at bedside and pommel cushion in chair. During an observation on 08/14/2024 at 2:25 p.m., Resident #10 had a fall mat beside his bed and a pommel cushion in his wheelchair. During an interview on 08/14/2024 at 2:30 p.m., the MDS Coordinator stated interventions for falls and any injury related from the fall should be updated on the care plan as the falls happen. She stated the falls were reviewed in the clinical stand up meeting each morning and the care plans are to be updated with interventions as they are discussed in the meeting. The MDS Coordinator stated she was unaware why all the interventions were not listed on Resident #10's care plan. She stated it was important to have all interventions listed because the care plan was the blueprint of the specific resident's care instruction. She stated Resident #10 had to have the fall mat and pommel cushion because he was impulsive and would attempt to transfer himself unsafely. During an interview on 08/15/2024 at 2:20 p.m., the DON stated that all care plans should be reviewed and revised quarterly, but acute items such as behaviors and falls should be updated with intervention as they happen and are discussed in morning meeting. She stated it was important for all staff to be able to quickly access the care plan and know the up-to-date interventions in place for the residents. She stated this information was critical to assist with prevention of further behavioral issues and falls with injury. During an interview on 08/15/2024 at 3:30 p.m., the ADM stated it was the responsibility of nurse management, mainly the DON to follow up and ensure the care plans were being updated both quarterly and acutely. She stated not having up to date care plans could result in staff not knowing how to treat different situations with different residents. (continued on next page)

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Reunion Plaza Senior Care and Rehabilitation Cente	1401 Hampton Rd Texarkana, TX 75503

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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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of a Care Plans, Comprehensive Person-Centered facility policy dated December 2016 reflected, .A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident .the care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment .The comprehensive, person-centered care plan will .Describe the services that are to be furnished to attain and maintain the resident's highest practicable physical, mental, and psychosocial well-being .Incorporate identified problem areas .Assessments of residents are on-going and care plans are revised as information about the residents and the resident's condition change .

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Plan the resident's discharge to meet the resident's goals and needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44596 Based on interview and record review, the facility failed to develop and implement an effective discharge planning process for 1 of 15 residents (Resident #32) reviewed for care plans. The facility failed to prepare Resident #32 to effectively transition to post-discharge care and the reduction of factors leading to preventable readmissions. These negative findings could cause a resident to have an unsafe living environment upon discharge. Findings included: Record review of an undated face sheet indicated Resident #32 was a [AGE] year-old female admitted to the facility on [DATE] with the diagnoses of PVD (peripheral vascular disease- poor circulation), sepsis (severe infection), and diabetes mellitus type II. Record review of Resident #32's 5-day MDS assessment dated [DATE] indicated she had a BIMS of 15 and required substantial to maximum assistance for toileting, transfer and hygiene. The MDS indicated Resident #32 received dialysis during her stay. No behaviors were noted on the MDS. The MDS indicated Resident #32 planned to go back to her home upon discharge. Record review of Resident #32's EHR revealed no care plans for discharge. Record review of Resident #32's EHR revealed a blank discharge instruction care sheet dated 07/16/2024 and a blank recapitulation summary sheet dated 07/17/2024. During an interview on 08/14/2024 at 10:00 a.m., Resident #32 stated she discharged on [DATE] from the facility. She stated prior to discharge she was given no written or oral instruction on her medication or treatment regimen. She stated when she arrived at home, she had no DME. She stated the SSD told her she would have a hospital bed, mechanical lift, bedside commode, and home health services the day after she discharged . She stated she had to sleep on her loveseat because that was the only surface, she could transfer to being a double amputee. She stated she had no idea what medication changes had been made or when the medications should have been taken because she got no education or instruction on her medication. Resident #32 stated she returned to the hospital on 07/20/2024 and no home health or DME arrived prior to her admission to the hospital. She stated she was admitted to the hospital for hypokalemia (low potassium) related to her dialysis. She stated her family was able to take her to and from dialysis. During an interview on 08/14/2024 at 10:30 p.m., Resident #32's family member stated they were able to take the resident to and from dialysis and they were able to adminster all her medications to her. Resident #32's family member stated the only medication that changed for her while in the nursing home was the MD added a multivitamin with iron. He stated no other changes were made in her medications. He said the resident did not have an order for Potassium and she did not receive Potassium at the facility. (continued on next page)

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 08/15/2024 at 9:45 a.m., the SSD remembered that Resident #32 was supposed to have discharged on [DATE] and decided to leave 2 days early. She stated she had already turned her information in for her DME and home health to start after 07/17/2024. She stated she had not called the home health or DME company to inform them Resident #32 had gone home early. She stated not having home health or DME at home could cause a decreased quality of life or injury. During an interview on 08/15/2024 at 2:15 p.m., the DON stated she remembered Resident #32 discharging early. She stated Resident #32 had cancer and wanted to seek treatment for the cancer and because she wanted to go to the oncologist and that interfered with her insurance she decided to discharge early. The DON stated Resident #32 was not ready to go home without support. The DON stated Resident #32's family member could help her with most tasks but not all of them. The DON stated Resident #32 needed the hospital bed, the mechanical lift and the bedside commode. The DON stated since failure to ensure discharge plans were carried out for Resident #32, the discharge process had been revamped to avoid missing important information such as that. She stated it was the social service department that was responsible for all aspects of discharge planning before. She stated now there are 5-6 people responsible for different parts of the discharge process and it was working much better. During an interview on 08/15/2024 at 3:00 p.m., the ADM stated she recalled Resident #32 leaving the facility earlier than expected. She stated she was unaware Resident #32 had not received her medication instructions or any of her DME. She stated not having the DME needed when you discharge can lead to accidents such as falls. She stated not knowing how to take you medications correctly could lead to hospitalization s. She stated at the time it would have been the SSD's sole responsibility to ensure all those things were completed. She stated now there were 5 people involved in the discharge process and it had helped keep everyone safe and happy. Record review of the facility discharge /Transfer Policy dated December 2018 reflected a facility must establish, maintain and implement identical policies and practices regarding transfer and discharge provision of services for all individuals regardless of payor source. The provisions included home health and durable medical equipment needed for a safe living environment post discharge.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44596 Based on interview and record review, the facility failed to ensure that residents received adequate supervision and assistance devices to prevent accidents for 1 (Resident #14) of 6 residents reviewed for quality of care. The facility failed to ensure Resident #14 had supervision that prevented him from going outside and falling causing a hematoma and abrasion to his head. This failure could result in residents experiencing accident, injuries, and diminished quality of life. Findings included: 1. Record review of an undated face sheet reflected Resident #14 was a [AGE] year-old male that admitted to the facility on [DATE] with the diagnosis of dementia, atrial fibrillation (irregular heartbeat), and diabetes mellitus type II and discharged [DATE]. Record review of Resident #14's admission MDS dated [DATE] reflected he had a BIMS of 01 which indicated severe cognitive impairment. The MDS also indicated Resident #14 had some physically aggressive behavior and he required partial to moderate assistance with ADLs. Record review of Resident #14's care plan dated 05/07/2024 reflected a care plan titled Behavioral Changes with the problem of high elopement risk. The goal was to keep the resident safe within the facility. Record review of Admission assessment dated [DATE] indicated Resident #14 was a high elopement risk scoring a 22 out of 25 points scored for elopement. Record review of an incident report dated 06/22/2024 revealed Resident #14 exited the front of the building and fell from his wheelchair onto the ground outside the front entrance of the building. Resident #14 sustained an abrasion to his forehead and a hematoma. During an interview on 08/14/2024 at 10:02 a.m., RN P stated Resident #14 attempted to find an exit all day every day since the day he was admitted . She stated he was hard to redirect about 50% of the time. She stated she learned to redirect him with food and sitting in the dining room and that worked most of the time. She stated he would push right past you if you were standing in the way of him and where he was attempting to go. She stated she had not felt he was being mean, she stated he just had not registered that someone was in front of him. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 08/14/2024 at 2:20 p.m., LVN Q stated on 06/22/2024 at lunch time Resident #14 went outside the front door of the facility and fell from his wheelchair onto his right side striking his head on the ground causing a hematoma and abrasion to his right forehead. She stated she was alerted by a family member of his presence outside because the staff was busy serving lunch, and no one saw him go outside. She stated she was aware he was an elopement risk, and they were doing frequent checks on him every 15-20 minutes and keeping him in eyesight if he were out of this room. LVN Q stated all the staff pitched in and tried to keep an eye on Resident #14, but it was not always possible to watch him. She stated he just slipped out because all hands are on deck when it was meal service time. She stated he was exit seeking every day because of his dementia. She stated he had gotten outside once before but the staff saw him before the door even closed behind him and redirected him back into the facility. LVN Q stated she had not believed he would have fallen that time if he had not been outside because it appeared to her the wheel on his wheelchair went off the sidewalk and dumped him out onto the ground. She stated the next day he discharged to a secured unit on 06/23/2024. During an interview on 08/15/2024 at 2:00 p.m., the DON stated she was aware Resident #14 was an elopement risk and she understood there were other facilities that could take better care of his needs, but his family insisted he stay at the facility. She stated the family was devastated when we informed them that he could no longer stay at our facility, and we needed to find him a safe place to live immediately. The DON stated Resident #14 had 4-5 falls while he was here from the wandering up and down the hall all day and night. She stated the fall he had on 06/22/2024 could have been prevented had Resident #14 not been exit seeking and found his way outside, where the sidewalk caused him to be dumped from his wheelchair. During an interview on 08/15/2024 at 3:15 p.m., the ADM stated she was aware Resident #14 was an elopement risk and the facility was trying different things to see if an adjustment period might calm that behavior down. She stated unfortunately it was not a successful match for him to remain in the facility because all the resident's must be safe that stay at the facility. Review of facility's fall prevention policy titled Fall Evaluation and Prevention, dated revised August 2020, reflected The facility will evaluate residents for their fall risk and develop interventions for prevention . Upon Admission, the nursing staff/interdisciplinary care team should determine if a resident is at risk for falls and develop appropriate interventions based on the evaluation. The goal is to prevent falls if possible and avoid any injury related to falls.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44596 Based on interview and record review the facility failed to ensure residents were free of any significant medication errors for 1 of 12 residents reviewed for medications. (Resident #32) The facility failed to ensure Resident #32's IV antibiotic (meropenem) was initiated per MD orders to begin on 06/07/2024. These failures could cause prolonged illness and increased recovery time for residents. Findings included: Record review of an undated face sheet indicated Resident #32 was a [AGE] year-old female admitted to the facility on [DATE] with the diagnoses of PVD (peripheral vascular disease- poor circulation), sepsis (severe infection), and diabetes mellitus type II. Record review of Resident #32's 5-day MDS 06/12/2024 assessment indicated she had a BIMS of 15 and required substantial to maximum assistance for toileting, transfer and hygiene. The MDS indicated Resident #32 received dialysis during her stay. No behaviors were noted on the MDS. Record review of Resident #32's EHR revealed no care plans for IV antibiotics. Record review of Resident #32's discharge orders from the acute hospital on 06/06/2024 revealed the following discharge instructions: Additional instructions- She will need to continue vancomycin and meropenem until 06/18/2024. Record review of Resident #32's dialysis MAR dated 06/07/2024 indicated Vancomycin 750 mg IV once daily on Monday- Wednesday and Friday were administered every Monday, Wednesday and Friday from 06/07/2024 to 06/18/2024. Record review of Resident #32's facility MAR dated June 2024 indicated meropenem 1 gram daily was not started until 06/10/2024. During an interview on 08/14/2024 at 7:00 p.m., LVN N stated she was the nurse that admitted Resident #32 on 06/06/2024. LVN N stated she saw on the discharge order sheet that the resident was to continue her vancomycin that she was receiving at dialysis and meropenem until 06/18/2024. The meropenem had no dose or frequency so I put on the 24-hour report that clarification was needed on her [Resident #32's] antibiotic. She stated she was off the next couple of days and never thought about it after that. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 08/15/2024 at 2:15 p.m., the DON stated Resident #32's meropenem was not started on 06/07/2024 because it was overlooked on the discharge orders, and it was not until a chart audit was done on 06/10/2024 that a clarification order was received that it was okay to start the meropenem 1 gram on 06/10/2024 and continue it for 14 days. The resident and her family were informed, as well as the wound care specialist that ordered the antibiotic. No increased white blood cells, no change in the wound drainage was noted. The DON stated Resident #32 was still getting the vancomycin with her dialysis treatment three times per week. She stated she assessed Resident #32, and no acute issues were found. During an interview on 08/15/2024 at 2:30 p.m., NP O stated he was called and was informed the facility missed 3 doses of IV meropenem for Resident #32. NP O stated in his medical opinion that since the resident was receiving the other antibiotics, it was only 3 missed doses, and there were no physical signs of decline, and no harm was done to the resident by postponing the treatment. He stated if Resident #32 had developed a temperature or pain to the affected area he would have had cause for concern, but she had not so he just began the IV and continued it for the same duration originally ordered. He stated he gave a clarification order to start the meropenem when it was available from the pharmacy and continue it for the original 14 days ordered. During an interview on 08/15/2024 at 3:20 p.m., the ADM stated she was made aware of the 3 missed doses of meropenem by the DON on 06/10/2024 when it was noticed and a staff in-service on clarification of medication orders was conducted. The ADM stated it was the DON's responsibility to check behind the nurses and make sure all medications were ordered per the discharge instructions. The mistake was noticed during that reconciliation. The ADM stated not receiving ordered antibiotics could lead to prolonged infections, recurrent infections, or sepsis. Record review of policy dated April 2019 was documented Administering Medications, Medications are administered in a safe and timely manner, and as prescribed. Only persons licensed or permitted by this state to prepare, administer, and document the administration of medications may do so. The director of nursing services supervises and directs all personnel who administer medications and/or have related functions. Medications are administered in accordance with prescriber orders, including any required time frame.