STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675458	A. Building B. Wing	03/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Parkview Nursing and Rehabilitation Center	1501 S Main St Lockhart, TX 78644

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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 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42600 Based on interviews and record review, the facility failed to permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless the discharge was necessary for the resident's welfare and the resident's needs could not be met in the facility for 1 of 3 residents (Resident #1) reviewed for discharge requirements. 1. The facility failed to provide Resident #1's guardian a written discharge notice with appeal information. 2. The facility failed to document interventions attempted to meet Resident #1's needs prior to discharging the resident on 02/23/2025. This failure could place discharged residents and residents residing in the facility at risk of being discharged and not allowed to return to the facility causing a disruption in their care and/or services. Findings included: Review of Resident #1's face sheet reflected a [AGE] year-old-man admitted on [DATE] with diagnoses of spastic quadriplegic cerebral palsy (severe disorder that affects movement balance and posture, where all four limbs are abnormally stiff and tight), anxiety disorder (group of mental health conditions characterized excessive and persistent worry, fear and nervousness that significantly interfere with daily life), profound intellectual disabilities (condition that involves limitations on intelligence (limitations on intelligence, learning and everyday abilities), unspecified behavioral and emotional disorders, and deaf-nonspeaking. Review of Resident #1's admission MDS dated [DATE] reflected the BIMS assessment was not completed because Resident #1 was not understood. Review reflected Resident #1's cognitive skills for daily decision making was severely impaired. Further review reflected physical behavioral symptoms directed towards others, verbal behavioral symptoms directed at other were not exhibited. Resident #1 had a functional limitation in range of motion on one side for both upper and lower extremities. Resident #1 was total dependence for transfers and required substantial or maximum assistance for most ADLs. (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 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #1's care plan date 02/13/2025 reflected Resident #1 was PASRR positive with interventions to encourage and support advocacy efforts to ensure the resident had necessary services provided to promote wellness and functional abilities. Interventions also included to hold scheduled care plan meetings that included resident, family, licensed RN, and LIDDA to discuss changes in condition and resident needs. Care plan dated 02/14/2025 reflected Resident #1 was at risk for impaired psychosocial well-being related to dependent behavior and ineffective coping skills., with interventions that included assess social support systems and community resources and to assist, encourage, and support realistic goals. Review of Resident #1's progress note dated 02/16/2025 reflected Resident #1 was sitting at the dining room table and motioned with his hand for another resident to go by when another resident got next to Resident #1 and was hit in the face as she was passing by. Review of Resident #1's event follow up progress note dated 2/17/2025 by LVN B reflected Resident #1 had compliance with redirection to reduce risk of recurrence of event. Review of Resident #1's event follow up note dated 02/18/2025 reflected the resident to staff event with Resident #1. Resident #1 was compliant with interventions and was removed from situation and environment. Resident #1 was in room after event. Resident #1 became upset and was offered PRN anxiety medication with snack and tolerated medication and snack and was transferred back into bed and slept for remainder of shift. Review of Resident #1's progress note dated 02/18/2025 by the DON reflected Resident was 1:1 for breakfast and swung arms in air at staff. The DON was able to de-escalate the situation and sat with Resident #1 while he ate breakfast. Review of Resident #1's progress notes from 01/31/2025 through 02/23/2025 reflected no additional incidents with staff or residents. The progress notes reflected no documented interventions trialed with Resident #1. Review of Resident #1's physician orders reflected order dated 02/03/2025 for psych consult. Review of Resident #1's medical chart reflected no written discharge notice to guardian/representative. Review also reflected there were no psychiatric/psychological notes or services started for Resident #1. Review of medical chart reflected no documentation from physician regarding facility's inability to meet Resident #1's needs. Review of Resident #1's care conference note dated 01/31/2025 reflected Resident #1 was cooperative and smiled a lot. Resident was able to use left hand to feed himself but did not understand what was being said due to cognition and was deaf in both ears. Review reflected the SW looked for communication pictures to help with communication. Review reflected Resident #1 could be hostile when frustrated and to use patience. Review of hospital referral for Resident #1 dated 01/29/2025 reflected Resident #1 was deaf and did not need ASL, only knew basic signs, and communicated by pointing. The referral reflected facial expressions were important to Resident #1 and if he was not smiled at it may have been perceived as threatening and act out by trying to swing left arm or kick legs. Review reflected Resident did not have strength to cause harm. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of discharge planning dated 02/05/2025 completed by the SW reflected Resident #1's current admission was anticipated to be long term and the discharge goal was long-term care. The resident/family/guardian concerns regarding discharge plans reflected there was no discharge planned. Review of the discharge planning and summary dated 02/23/2025 reflected resident/representative initiated discharge with reason as necessary for the Resident's welfare and the resident's needs cannot be met in the facility- explain below. Explanation was not included. Discharge summary reflected that Resident #1 was orientated to person and unable to communicate needs. discharged summary reflected yes was selected under resident/representative find current discharge plan acceptable. Discharge summary reflected resident was discharged to another facility. During an interview on 03/03/2025 at 9:36 AM, Resident #1's RP stated that she received a voicemail on 02/21/2025 that Resident #1 was going to be discharged from the facility. The RP stated that she also received a voicemail on 02/23/2025 that Resident #1 had discharged to a sister facility. The RP stated that the facility notified her earlier in the week of an incident but did not mention that Resident #1 was going to be discharged . The RP stated that the facility did not provide any concerns that Resident #1 needed to be discharged . The RP stated that she did not receive a written discharge notice or information about an appeal process. The RP stated that the SW stated that she was not sure why Resident #1 was discharged but stated that he was aggressive. The RP stated she felt blind-sided by the way the discharge was done. She stated that Resident #1 had been at the facility for almost a month, and he was eating and drinking again, and felt that he was starting to adjust. The RP stated Resident #1 has IDD and was deaf and difficult to communicate with. The RP stated that she did not feel the facility tried to work with her or Resident #1 prior to the discharge and if any interventions were put in place due to his behaviors, she was unaware. During an interview on 03/03/2025 at 11:15 AM, CNA C stated when Resident #1 was upset he would throw tantrums and would start to swing his arms. She stated he would sign after and apologize. She stated that he had an impairment on one of his sides and could swing with one arm. She stated that his trigger was his diet, and he did not like a pureed diet. She stated that he would become upset if his food was not sweet. CNA C stated that she felt Resident #1 became overstimulated when there were too many people around. CNA C stated that when he was in the dining room and was upset 3-4 staff would try to intervene and then he would start to swing. CNA C stated she did not recall if there was a specific in-service completed about working with Resident #1 and his needs. During an interview on 03/03/2025 at 11:24 AM, COTA D, she stated Resident #1 was very sweet and that his chart said to smile at him. COTA D stated that he would point, and wave and he was able to point at what he wanted. COTA D stated that he got upset when people were not able to understand what he wanted. COTA D stated that she did not ever see him swinging at people. She said once in the therapy gym he started mumbling because he did not want to participate but was redirected easily. COTA D stated that he was wheelchair bound, deaf, and IDD. She stated that Resident #1 was able to bring his hand to his mouth and feed himself. COTA D stated that Resident #1 knew a bit of sign language and was able to point and grunt to indicate what he wanted. COTA D stated he had an impairment on one side. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 03/03/2025 at 12:13 PM SW stated that Resident #1's discharge was not initiated by him because he was not able to communicate. She stated that his communication ability was limited, and his sign language was limited. She stated that staff were unable to talk to him other than shaking their head no when he hit staff. The SW stated it was a facility-initiated discharge for Resident #1. The SW stated that the facility reached out to the RP on several occasions and did not hear back from her. The SW stated that messages were left that he was hitting other residents and staff members. The SW stated that Resident #1 was discharged to a sister facility. The SW stated the sister facility was better equipped and more experienced in dealing with residents with these types of behavior. The SW stated the facility thought it would be a better fit for Resident #1. The SW stated she did not document when she spoke with Resident #1's RP or attempted phone calls because nothing was being challenged or disputed and she had nothing to document except that the SW had called the RP. The SW stated that the RP was notified of the discharge the Thursday (02/20/2025) or Friday (02/21/2025) prior to the Sunday (02/23/2025) discharge and was provided the location via voicemail. The SW stated Resident #1's RP was not involved in selecting the location of the discharge because the RP did not call back. The SW stated the most appropriate setting to meet Resident #1's care needs was a facility that was able to find some type of way of communication. The SW stated Resident #1 did not have any way to communicate and would get frustrated. The SW stated that she was whacked by Resident #1 and that there was no warning. The SW stated that a facility that had experience in dealing with residents that had physical violence was the best option for Resident #1. The SW stated that as a team (therapy and SW) Resident #1 was evaluated, and it was determined that he would have benefited from picture cards for the bathroom, food, and medicine. The SW stated that this was communicated with the RP, but the picture cards were not purchased or provided by the RP. The SW stated that this was approximately two weeks prior to Resident #1's discharge. The SW stated that she did not document when she was hit by Resident #1 because she did not log it because she was not injured, and that Resident #1 had challenges. The SW stated she was told he hit other residents and stated it was logged by nursing. The SW stated she felt Resident #1 was more than the facility could handle because he lacked communication abilities. The SW stated that the new facility had experience in dealing with residents with physical aggression issues. She stated that she had not been to the sister facility and the DON would know better. The SW stated that the RP was not provided a written discharge notice but was called. The SW stated she was not aware the RP was provided appeal information. The SW stated nursing also called the RP about Resident #1's discharge. The SW stated interventions for Resident #1 included attempts to communicate with him with hands, such as putting hands up and saying stop, shaking head and saying no. She stated the facility got him in his chair and he was taken outside, and he was involved in activities and a basketball hoop was put on his wall. The SW stated that the facility tried everything they could do. The SW stated that she tried redirecting him and spending time with him and hoped he would adjust better. The SW stated that he was used to being around people and who used sign language. The SW stated she would smile at Resident #1 a lot. The SW stated Resident #1 knew a few signs. The SW stated that number one barrier was communication. The SW stated she did not think Resident #1 was able to comprehend pictures. The SW stated she was not sure if the facility Resident #1 discharged to had the capability to teach him ASL. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 03/03/2025 at 12:41 PM, SLP E stated that Resident #1 knew very few signs. SLP E stated that Resident #1 would put his open hand to his mouth and decided he wanted to eat this way. SLP E stated Resident #1 became agitated because he had a puree diet and would fight anyone who tried to feed him as he wanted to feed himself. SLP E stated Resident #1 never became aggressive with her and if he became agitated, she would sit across from him and back away and he was okay. SLP E stated he understood expression language but receptive he did not understand. SLP E stated she showed Resident #1 a picture of sandwich and he expressed an overexaggerated yes. SLP E stated Resident #1 understood what was being asked, but he was unable to get his point across. SLP E stated Resident #1 was not able to read. SLP E stated she used basic picture cards, and he was able to respond by shaking he head, no. SLP E stated the best way to communicate with Resident #1 was by utilizing basic one work or two-word prompts such as go eat or let's go. SLP E stated she told the therapy team to speak with three words max, and very slowly. SLP E believed Resident #1 could read lips. SLP E stated she did not provide any in-servicing to care staff on how to communicate with Resident #1. During an interview on 03/03/2025 at 1:00 PM, an anonymous staff member stated that there was too much commotion going on for Resident #1 and stated CNAs would not slow down to work with him. Anonymous staff member stated that CNAs would take him too quickly out of the dining room and did not explain what they were going to do and were too fast paced. During an interview on 03/03/2025 at 1:05 PM, the AD, stated that clinicals were received prior to resident's admission. He stated the DON reviewed all clinicals and told him yes or no to a resident admitting to the facility. The AD stated that clinicals were received prior to Resident #1's admission. The AD stated that he has not been told physical aggression was a barrier to admission and there was nothing that stood out that the facility was unable to accept. The AD stated he remembered he saw the referral for Resident #1 and that he had behaviors at a previous SNF but Resident #1 did not have behaviors in the hospital. The AD stated that the facility was aware of behaviors Resident #1 had at his previous SNF. During an interview on 03/03/2025 at 1:12 PM, CNA F stated that she did not provide care for Resident #1 but saw him in the dining room. She stated that he would wave his arms but did not think he was trying to hit anyone just get someone's attention. During an interview on 03/03/2025 at 1:27 PM, the DOR stated that she tried to use pictures online to communicate with Resident #1. The DOR stated that staff talked with Resident #1's RP and suggested specific picture cards but they were not provided. The DOR stated when Resident #1 first admitted she was told to approach him by smiling and then attempt to provide care or work with him. The DOR stated the most important thing was to go in with a smile. The DOR stated that she, the SW, and the MDS met in general and discussed other ideas on how to communicate with Resident #1. The DOR stated that she verbally told CNAs who provided care to smile and try to simulate the activity they were going to do prior to providing the care to Resident #1, but it was not a formal in-service. During an interview on 03/03/2025 at 1:50 PM, LVN G stated that she saw Resident #1 in the dining room and that he would get frustrated because no one understood him, and he could not verbalize. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 03/03/2025 at 3:28 PM, LVN B stated that he was familiar with Resident #1. LVN B stated that he tried to find ways to help Resident #1. LVN B stated there was not specific intervention put in place when care was provided for Resident #1. LVN B stated he tried to communicate with Resident #1 with sign and expressions. LVN B stated he felt Resident #1 understood the signs and expressions. LVN B stated Resident #1 could expression when he wanted more food, was thirsty, wanted to watch basketball, and wanted to go to bed. LVN B stated he did not see Resident #1 become aggressive with residents but saw Resident #1 throw his hands at staff. LVN B stated aggressive behaviors should have been documented in the resident's chart. LVN B stated it was important to document behaviors so any interventions that were put in place so other staff would be aware and there would be trail of what was done to help the resident. LVN B stated that it was also important to document conversations or attempted conversations with guardian's or residents' responsible parties so there is a trail and to ensure that staff spoke with the correct individual and other staff were aware of what happened with the resident. During an interview on 03/03/2025 at 4:13 PM, RN H stated she was familiar with Resident #1. She stated that some days he was calm and some days too much noise would upset him. She stated he would squeal, and he knew basic or simple signs like hungry or tired. RN H stated Resident #1 got frustrated if he was not understood right away. RN H stated that when Resident #1 was mad he would swing his arm in a getaway motion. RN H stated when that happened, they would trade off staff and get someone else to care for him. RN H stated as she continued to work with him, she figured out what worked for him and what did not. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 03/03/2025 at 4:50 PM, the DON stated that she felt the facility could have offered more services for Resident #1's hearing impairment and he could have gotten behavioral support involved. The DON stated that Resident #1 needed extended services that the facility could not do because staff were not trained on PASRR positive aggressive residents. The DON stated prior to Resident #1's admission she did not know if his behaviors were truly aggressive and knew he flailed his arms around. The DON stated he may have had behaviors from being hungry. The DON stated that Resident #1's RP instructed the facility to send him to the ER if his behaviors escalated. The DON stated interventions for Resident #1 were 1:1 care, frequent rounding, removed from dining room as much as possible, and have him eat at a table alone or at nurses' station. The DON stated when Resident #1 finished eating, his behaviors became aggressive as staff tried to remove him from the dining room. The DON stated that she did not believe Resident #1 tried to hit another resident. The DON stated prior to admission they received a report from his RP that his behaviors were good, and he was being discharged from the hospital. The DON stated she reviewed his referral and clinical information and felt it was necessary to give people second changes and she was unsure what caused his behavior in the past. The DON stated there was verbal training provided to keep a positive expression. The DON stated that Resident #1 always moved his arms but did not hit anyone initially. The DON stated she felt that the facility Resident #1 discharged to had a smaller staff to resident ratio and could sit down and meet his needs. The DON stated she believed the facility had a locked unit but was not sure. The DON stated that Resident #1 was referred to psychiatric services, but they come out once or twice a month and he had not been seen. She stated that the NP provided mediation management and PASRR services had not started. The DON stated that staff reached out and left message about the discharge to Resident #1's RP and that the SW also reached out, but the DON did not know if a written discharge notice was provided. She stated that a care plan meeting was not provided with Resident #1's RP prior to discharge because she did not believe it was in the facility's policy to have an emergency care plan meeting prior to discharge. The DON stated she was not sure if interventions were documented anywhere, and it was more verbally communicated. The DON stated that Resident #1 had an immediate discharge when a facility was found that was willing to take him. The DON stated she was unsure if the RP was provided options. The DON stated that she would expect any attempts or conversations with RP to be documented. During an interview on 03/03/2025 at 5:15 PM, the ADM stated that Resident #1's discharge was facility initiated. The ADM stated that Resident #1 hitting staff was what caused his need to discharge. The ADM stated the RP was not involved in picking the facility and stated that staff could not get ahold of the RP. The ADM stated he reached out to the other facility. The ADM stated that the facility was unable to control Resident #1's violent outbursts or anticipate when the next one would be. The ADM could not recall interventions put in place to assist Resident #1 prior to discharge. The ADM stated that DON reviewed clinical information prior to residents' admission to determine capability to care for residents. The ADM stated that he felt like most admissions looked worse on paper and they usually had good outcomes. The ADM stated he did not ask the receiving administrator what the accepting facility could do to meet the needs of Resident #1 and took the administrator's word that the facility was better equipped for handling behavioral needs. The ADM stated he was unsure if PASRR services or behavioral health services had started. The ADM stated the RP was not provided a 30-day discharge notice and he was unsure if the RP was provided a written notice. The ADM stated he expected any interventions that were done to be documented and expected any attempts made to reach out to guardian to be documented. The ADM stated it was important to document so that everyone was on the same page as to what was happening. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of facility policy titled Transfer or Discharge, Facility-Initiated with revision date of October 2022 reflected once admitted to the facility, residents have the right to remain in the facility. Facility-initiated transfers and discharges, when necessary, must meet specific criteria and requires resident/representative notification and orientation, and documentation as to specified in this policy. Further review reflected documentation of facility-initiated transfer or discharge must include basis for transfer or discharge, specific needs that cannot be met, facility's attempt to meet those needs and the receiving facility's services that are available to meet those needs. Review reflected upon notice of transfer or discharge, the resident will be provided with a statement of his or her right to appeal the transfer, or discharge, including: a. the name, address, email and telephone number of the entity which receives such requests; b. information about how to obtain, complete and submit an appeal form; c. how to get assistance completing the appeal process; and d. the facility bed-hold policy. Review of policy reflected than an appropriate notice was provided to the resident and/or legal representative. Should the resident be transferred or discharged for any of the following reasons, the basis for the transfer or discharge will be documented in the resident's clinical record by a physician: a. The safety of the individuals in the facility is endangered due to the clinical or behavioral status of the resident; or b. The health of the individuals in the facility would otherwise be endangered.