STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675468	A. Building B. Wing	02/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hico Nursing and Rehabilitation	712 Railroad Ave Hico, TX 76457

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49099 Based on interviews and record review, the facility failed to consult with the resident's physician when there is a significant change in the resident's physical, mental, or psychosocial status, for 1 of 7 residents (Resident #1) reviewed for changes in condition. The facility failed to notify Resident #1's mental health primary care provider (MHNP) when there was a change of condition in behaviors after an incident with Resident #1 having unsolicited sexual advances/behaviors toward another resident on 01/08/25. This failure could place residents at risk of not having their physicians notified of changes resulting in a delay in decision making for medical interventions. Findings: Review of Resident #1's face sheet dated 02/18/25 reflected a [AGE] year-old male admitted to the facility on [DATE] with diagnoses that included adrenocortical insufficiency (a condition in which the adrenal glands do not produce enough hormones such as cortisol and aldosterone), unspecified psychosis (mental health condition characterized by a loss of contact with reality) not due to a substance or known physiological condition, generalized anxiety disorder (a group of mental health conditions characterized by excessive worry, fear, and nervousness that can interfere with daily life), onychogryphosis (a condition characterized by abnormal thickening, curvature, and discoloration of the nails), and autistic disorder (a neurological and developmental disorder that affects how people interact with others, communicate, learn, and behave). Review of Resident #1's quarterly MDS assessment dated [DATE] reflected a BIMS score of 6 indicating severe cognitive impairment. The behavior section of the MDS indicated physical behavioral symptoms directed towards others was marked behavior of this type occurred 1 to 3 days. Verbal behavioral symptoms directed towards others was marked behavior of this type occurred 4 to 6 days. Other behavioral symptoms not directed towards others was marked behavior of this type occurred 1 to 3 days. Active diagnosis for psychiatric and mood disorders was marked for psychotic disorder (other than schizophrenia). (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: 675468	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/18/2025
NAME OF PROVIDER OR SUPPLIER: Hico Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE: 712 Railroad Ave Hico, TX 76457	

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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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #1's care plan revised 12/03/24 indicated Resident #1 has been identified as having PASRR positive status related to an intellectual disability. A focus reflected Resident #1 has a diagnosis of unspecified psychosis with interventions that included Resident #1 is receiving supportive care psychiatric services. A focus reflected Resident #1 has potential to be verbally and physically aggressive toward staff or others related to diagnosis of severe intellectual disabilities and vascular dementia with behavioral disturbances. Resident #1 does not like loud auditory sounds such as noise, talking laughing, or entering personal space. Resident #1 will yell out or attempt to physically remove unwanted triggers. Interventions included monitor/document/report/ as needed any signs or symptoms of resident posing danger to self and others and Resident #1 is receiving counseling from supportive care counseling with an LPC. The care plan did not indicate sexual behaviors with relevant interventions in place. Review of Resident #1's mental health provider notes reflected a visit on 01/02/25 and then again on 01/16/25 with the visit notes for 01/16/25 reflecting no new behaviors reported. Review of Resident #1's incident reports revealed report dated 01/08/25 RN A was monitoring the activity area and observed Resident #1 with his hands under another residents' shirt. RN A stopped the incident and separated the residents. RN A performed a skin assessment, and no injuries were noted. In an interview on 02/18/25 at 11:15 AM with RN A she stated she was the one who witnessed the incident with Resident #1 putting his hand under another female resident's shirt and on her chest/breast. She stated she immediately intervened to separate the residents. She stated she notified Resident #1's doctor and family but not MHNP. She stated Resident #1 was already on psych services and was being seen by MHNP for both verbal and physical behaviors towards staff. RN A stated Resident #1 has never had behaviors towards another resident and that this was the first incident where behaviors were directed at another resident and the first time he has had sexual behaviors. In an interview on 02/18/25 at 02:58 PM with MHNP she stated she is the primary care psychiatric services provider for Resident #1 and managing his behaviors due to diagnosis of autism with psychosis. She stated that she is aware of Resident #1's verbal and physical behaviors towards staff members, but stated she was not aware of any behaviors directed at other residents. MHNP stated that she was not notified of an incident occurring on 01/08/25 and said she would consider new sexual behaviors directed at other residents a change of condition for Resident #1 and it was her expectation that behavioral changes of condition were reported to her. MHNP stated that she relies on the facility to inform her of any changes because the resident is not in his right mind. She stated a negative outcome of the facility not notifying her of changes has the potential to result in other residents becoming fearful of Resident #1 due to not having behaviors managed. She stated it could also result in new/agency/PRN staff not knowing how to care for Resident #1 or what behaviors to look for if it was not addressed appropriately or care planned. In an interview on 02/18/25 at 04:20 PM with the DON, she stated it was her expectation that primary care providers were notified of changes in condition regarding Resident #1 and was not sure why the NP was not notified. The DON stated that she believes newly identified sexual behaviors are significant and need to be reported. She stated a negative outcome of providers not being notified of changes in condition was the potential for cognitive or physical decline. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Hico Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 712 Railroad Ave Hico, TX 76457	

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 02/18/25 at 05:15 PM with the ADM, he stated it was his expectation that nursing staff notify and update primary care providers with any changes in condition. He stated newly identified sexual or inappropriate behaviors are significant and should be reported which is why he also promptly made the report to state agencies. The ADM stated a negative outcome of primary care providers not being notified is the potential for psychiatric or therapy issues, nothing happens to improve the resident's quality of life. Review of the facility Notification of Changes policy last revised on 01/01/25 reflected: The purpose of this policy is to ensure the facility promptly informs the resident, consults the residents physician; and notifies, consistent with her or her authority, the residents representative when there is a change requiring notification. Compliance Guidelines: The facility must inform the resident, consult with the resident's physician and or notify the residents family member or legal representative when there is a change requiring such notification. Circumstances requiring notification include: - Accidents: potentially requiring physician intervention. - Significant change in the resident's physical, mental, psychosocial condition such as deterioration in health, mental, or psychosocial status; this may include clinical complications. - Circumstances that require a need to alter treatment. Review of the undated Statement of Resident Rights reflected: You have the right to all care necessary for you to have the highest possible level of care.

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NAME OF PROVIDER OR SUPPLIER: Hico Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE: 712 Railroad Ave Hico, TX 76457	

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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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42949 Based on interview and record review the facility failed to develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care within 48 hours of the resident's admission for 1 of 7 residents (Resident #2) reviewed for baseline care plans. The facility failed to include Resident #2's fall history/fall risks in her baseline care plan. This failure could result in residents not receiving needed care and treatment. Findings Included: Review of Resident #2's face sheet dated 02/18/25 reflected an [AGE] year-old female admitted to the facility on [DATE] with diagnoses that included senile degeneration of the brain (progressive decline in cognitive function that occurs with aging), anxiety disorder (mental health condition characterized by repeated episodes of sudden feelings of intense anxiety, fear, or terror), restlessness (feeling of unease, agitation, or inability to sit still), and agitation, and essential (primary) hypertension (high blood pressure). Review of Resident #2's admission MDS assessment dated [DATE] reflected a BIMS score was not indicated. Review of Resident #2's baseline care plan dated 02/11/25 reflected initial admission/ discharge goals stated resident is here for respite care only; she will return home where she lives with her [family member]. Initial discharge goals also were marked for return to community, receive hospice care/ coordination, and receive respite care. The section for functional abilities related to walking was marked independent and mobility devices were marked none. Level of consciousness was marked cognitively impaired due to dementia status. The safety risks section does resident have a history of falls was marked no and the comment section was left blank and did not indicate any fall risks or interventions. The baseline care plan was signed as being completed by DON. Review of Resident #2's comprehensive care plan revised 02/17/25 indicated a focus area initiated 02/13/25 of resident is high risk for falls related to confusion, gait/balance problems, incontinence, poor communication/ comprehension, unaware of safety needs with interventions that included anticipate and meet resident needs, be sure call light is in reach and prompt response is needed to all requests for assistance, follow facility fall protocol . The care plan was also revised 02/17/25 and indicated the resident had 2 falls on 02/12/25 one witnessed and one unwitnessed, an unwitnessed fall on 02/13/25, and a witnessed fall 02/15/25 with interventions continue interventions on the at-risk plan, fall mat placed at bedside, for no apparent acute injury determine and address causative factors of the fall, monitor/document/report as needed to MD signs and symptoms of pain, bruises, change in mental status, and new or onset confusion, sleepiness, inability to maintain posture or agitation, and provide activities that promote exercise and strength building where possible. (continued on next page)

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Hico Nursing and Rehabilitation	712 Railroad Ave Hico, TX 76457

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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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #2's BIMS assessment completed 02/13/25 reflected a BIMS score of 0 indicating severe cognitive impairment. Review of Resident #2's Hospice Respite Admission documents dated 02/11/25 indicated patient on hospice prior to facility admit on 02/11/25. In an interview on 02/18/25 at 12:25 PM with HRN she stated she was the hospice nurse for Resident #2 and has provided care to the resident prior to being admitted to the facility as well as while at the facility. HRN stated that information was provided to the facility on the care Resident #2 required prior to admission. She stated that in the hospice process they will meet with the facility prior to the resident's admission and give a background to ensure they can accept the resident for respite care, then prior to admission a comfort kit packet is sent to them that contains medical history (which includes falls), allergies, and primary diagnosis (which was senile degeneration of the brain). HRN stated that she also was at the facility on 02/11/25 on the day Resident #2 was admitted and did a verbal hand off going over care, history, orders etc. HRN stated even without the verbal handoff that occurred on 02/11/25, the comfort kit which contains the medical history, diagnosis, allergies etc. would have had more than enough information to deem Resident #2 a high fall risk. HRN stated Resident #2 was ambulatory and could walk but would become unstable and disoriented and would fall. She stated the facility did notify hospice each time the resident fell and hospice did complete their own assessments as well, with no major injuries ever noted. She stated it was not unusual for the resident to have so many falls and that she did see fall preventive measures in place when she would visit the resident which included the bed in the lowest position and fall mat at bedside. In an interview on 02/18/25 at 04:20 PM with the DON, she stated she completed Resident #2's baseline care plan and stated she missed her fall risks. She stated that it is her expectation that baseline care plans are completed within 48 hours of admission when they are due and should reflect the minimum requirements to care for the resident. She stated fall history and risks should be marked (if applicable). The DON stated she was made aware of Resident #2's high fall risks by hospice and there was documentation of previous falls at home. The DON stated not having the falls addressed on the baseline care plan was her error because she did have the documentation. She stated Resident #2's first fall was at the nurses station and it was witnessed. She was with nursing staff and when the resident turned around as she was walking she got tangled in her legs and fell . The resident was assessed and no major injuries were noted. She stated there were fall precautions that were in place for the resident such as bed in the lowest position and fall mat at bedside; and that the comprehensive care plan was updated quickly to address fall risks. She stated that when completing the fall risk assessment that should have reminded her to go back and update the baseline care plan. In an interview on 02/18/25 at 05:15 PM with the ADM he stated it was his expectation that care plans are individualized and updated as needed. He stated changes and updates to care plans are made based on any changes with the Residents. He stated if items don't reflect current care needs or are not updated there is the potential for nothing to help improve the resident's quality of life. Review of the undated facility Care Plans- Baseline policy reflected: A baseline plan of care to meet the resident's immediate health and safety needs is developed for each resident within 48 hours of admission. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Hico Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 712 Railroad Ave Hico, TX 76457	

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The baseline care plan includes instructions needed to provide effective, person-centered care of the resident that meet professional standards of quality of care and must include the minimum healthcare information necessary to properly care for the resident. The baseline care plan is used until the staff can conduct the comprehensive assessment and develop an interdisciplinary person-centered comprehensive care plan (no later than 21 days after admission). The baseline care plan is updated as needed to meet the residents needs until the comprehensive care plan is developed. Review of the undated Statement of Resident Rights reflected: You have the right to all care necessary for you to have the highest possible level of care.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675468	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/18/2025
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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49099 Based on interviews and record review the facility failed to develop and implement a comprehensive person-centered care plan consistent with the resident rights that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs and describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being for 1 of 7 residents (Resident #1) reviewed for care plans in that: The facility failed to ensure that Resident #1's newly identified sexual behaviors were documented in his care plan with interventions after an incident with Resident #1 having unsolicited sexual advances/behaviors toward another resident on 01/08/25. The facility's failure placed residents requiring care at risk of not having their individual needs met, not receiving necessary care and services, and not having continuity of care. Findings included: Review of Resident #1's face sheet dated 02/18/25 reflected a [AGE] year-old male admitted to the facility on [DATE] with diagnoses that included adrenocortical insufficiency (a condition in which the adrenal glands do not produce enough hormones such as cortisol and aldosterone), unspecified psychosis (mental health condition characterized by a loss of contact with reality) not due to a substance or known physiological condition, generalized anxiety disorder (a group of mental health conditions characterized by excessive worry, fear, and nervousness that can interfere with daily life), onychogryphosis (a condition characterized by abnormal thickening, curvature, and discoloration of the nails), and autistic disorder (a neurological and developmental disorder that affects how people interact with others, communicate, learn, and behave). Review of Resident #1's quarterly MDS assessment dated [DATE] reflected a BIMS score of 6 indicating severe cognitive impairment. The behavior section of the MDS indicated physical behavioral symptoms directed towards others was marked behavior of this type occurred 1 to 3 days. Verbal behavioral symptoms directed towards others was marked behavior of this type occurred 4 to 6 days. Other behavioral symptoms not directed towards others was marked behavior of this type occurred 1 to 3 days. Active diagnosis for psychiatric and mood disorders was marked for psychotic disorder (other than schizophrenia). (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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #1's care plan revised 12/03/24 indicated Resident #1 has been identified as having PASRR positive status related to an intellectual disability. A focus reflected Resident #1 has a diagnosis of unspecified psychosis with interventions that included Resident #1 is receiving supportive care psychiatric services. A focus reflected Resident #1 has potential to be verbally and physically aggressive toward staff or others related to diagnosis of severe intellectual disabilities and vascular dementia with behavioral disturbances. Resident #1 does not like loud auditory sounds such as noise, talking laughing, or entering personal space. Resident #1 will yell out or attempt to physically remove unwanted triggers. Interventions included monitor/document/report/ as needed any signs or symptoms of resident posing danger to self and others and Resident #1 is receiving counseling from supportive care counseling with an LPC. The care plan did not indicate sexual behaviors with relevant interventions in place. Review of Resident #1's incident reports revealed report dated 01/08/25 RN A was monitoring the activity area and observed Resident #1 with his hands under another residents' shirt. RN A stopped the incident and separated the residents. RN A performed a skin assessment, and no injuries were noted. In an interview on 02/18/25 at 11:15 AM with RN A she stated she was the one who witnessed the incident with Resident #1 putting his hand under another female resident's shirt and on her chest/breast. She stated she immediately intervened to separate the residents. She stated she notified Resident #1's doctor and family but not MHNP. She stated Resident #1 was already on psych services and was being seen by MHNP for both verbal and physical behaviors towards staff. RN A stated Resident #1 has never had behaviors towards another resident and that this was the first incident where behaviors were directed at another resident and the first time he has had sexual behaviors. In an interview on 02/18/25 at 02:58 PM with MHNP she stated she is the primary care psychiatric services provider for Resident #1 and managing his behaviors due to diagnosis of autism with psychosis. She stated that she is aware of Resident #1's verbal and physical behaviors towards staff members, but stated she was not aware of any behaviors directed at other residents. MHNP stated that she was not notified of an incident occurring on 01/08/25 and said she would consider new sexual behaviors directed at other residents a change of condition for Resident #1 and it was her expectation that behavioral changes of condition were reported to her. MHNP stated that she relies on the facility to inform her of any changes because the resident is not in his right mind. She stated a negative outcome of the facility not notifying her of changes has the potential to result in other residents becoming fearful of Resident #1 due to not having behaviors managed. She stated it could also result in new/agency/PRN staff not knowing how to care for Resident #1 or what behaviors to look for if it was not addressed appropriately or care planned. In an interview on 02/18/25 at 04:20 PM with the DON, she stated it was her expectation that care plans are patient centered; they should reflect specialties, diagnosis and all centered around the patient. She stated they should be updated as needed with any incident or accident and items that are no longer needed should also be resolved on the care plan. The DON stated it was her responsibility to update the medical/nursing parts of the care plan. She stated the care plans keep everyone on the same page on how they care for the resident and if they are not updated and nobody is on the same page then it sets up the residents for worsening condition or declined level of care. (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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 02/18/25 at 05:15 PM with the ADM, he stated it was his expectation that care plans are individualized to the person and updated as needed. He stated updates are made based on any care changes. He stated newly identified inappropriate sexual behaviors are significant and should be care planned along with being shared through report from one nurse to another. Review of the facility Care Plans, Comprehensive Person Centered policy revised March 2022 reflected: A comprehensive person-centered care plan that includes measurable objectives and timetables to meet the residents physical, psychosocial and functional needs is developed and implemented for each resident. The comprehensive person centered care plan: - Includes measurable objectives and timeframes. - Describes the services that are to be furnished to attain or maintain the residents highest practicable physical, mental, and psychosocial well being including: 1. Services that would otherwise be provided for the above but are not provided due to the resident exercising his or her rights including right to refuse treatment, 2. Any specialized services to be provided as a result of PASRR recommendations, 3. Which professional services are responsible for each element of care. - Includes the residents' stated goals upon admission and desired outcomes. - Builds on the residents' strengths. - Reflects currently recognized standards of practice for problem areas and conditions. When possible, interventions address the underlying source(s) of the problem area(s) not just symptoms or triggers. The interdisciplinary team reviews and updates the care plan: - When there has been a significant change in the residents condition. - When the desired outcome is not met. - When the resident has been readmitted to the facility following a hospital stay. - At least quarterly in conjunction with the required quarterly MDS assessment. Review of the undated Statement of Resident Rights reflected: You have the right to all care necessary for you to have the highest possible level of care.