STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675842	A. Building B. Wing	07/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MI Casita Nursing and Rehabilitation Center	2400 Quaker Ave Lubbock, TX 79410

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 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** 04033 Based on interview, and record review, the facility failed to implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at S483.10(c)(2) and S483.10(c)(3), that including measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment for 1 of 5 residents (Resident #1) reviewed for care plans. The facility failed to ensure staff implemented Resident #1's comprehensive care plan for the behavior of becoming combative during incontinent care. This failure placed residents at risk of not having their individual care needs met. Findings included: Record review of Resident #1's Admission Record dated 07/22/24, indicated he was a [AGE] year-old male admitted to the facility 02/03/23. Resident #1's diagnosis included unspecified dementia with other behavioral disturbance (impaired concentration, apathy, anxiety, and agitation), other cerebral infarction (also known as ischemic stroke, is the pathological process that results in an area of necrotic tissue in the brain), psychotic disorder with delusions due to known physiological features (false beliefs, abnormal thinking, and perceptions), major depressive disorder, recurrent severe without psychotic features), other reduce mobility, difficulty in walking, unspecified lack of coordination, delusional disorder (a belief or altered reality that is persistently held despite evidence or agreement to the contrary, generally in reference to a mental disorder), anxiety disorder (a mental disorder characterized by feelings of worry, anxiety, or fear that are strong enough to interfere with one's daily activities) , narcissistic personality disorder (a person has an inflated sense of self-importance), intermittent explosive disorder (a behavioral disorder characterized by the explosive outbursts of anger and/or violence, often to the point of rage, that are disproportionated to the situation at hand), Hemiplegia and Hemiparesis (muscle weakness or partial paralysis on one side of the body that can affect the arms, legs, and facial muscles), age-related cognitive decline, cognitive communication deficit, and slurred speech. (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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #1's Minimum Data Set (MDS) dated [DATE] indicated he had a Brief Interview for Mental Status score of 3, that revealed he had severe cognitive impairment. MDS's Section E-Rejection of Care-Presence and Frequency indicated Resident #1 had not displayed rejection of care behaviors. MDS's Section GG-Functional Limitation in Range of Motion indicated Resident #1 had limitation to one side of his upper extremity (shoulder, elbow, wrist, and hand), and limitation to both side of his lower extremities (hip, knee, ankle, foot). MDS's Section GG-Self-Care indicated he was dependent for toileting hygiene. MDS's section GG-Mobility indicated he needed partial/moderate assistance when rolling left and right: The ability to roll from lying on back to left and right side and return to lying on back on the bed. Resident #1 required substantial/maximal assistance to sit to lying, lying to sitting on side of bed, sit to stand, chair/bed-to-transfer, and toilet transfer. Record review of Resident #1s Emotional Distress/Psychosocial Monitoring Post Incident dated 06/19/24 indicated he revealed a change in nervous energy, anxiousness, or movements. This report indicated the psychiatrist was notified on 06/19/24 and this led to Resident #1's Seroquel being increased to 75 milligrams (mg) twice a day. Record review of Nursing Progress Note dated 06/19/24 indicated the CNA (Certified Nurse Aide A) notified (Licensed Vocational Nurse (LVN-B) that patient (Resident #1) kicked her in the face. Record Review of Resident #1's Care Plan dated 06/11/25 indicated he required one staff for extensive assistance to use the toilet. He required 1 to 2 staff for transfers depending on activity tolerance for the day. And he had the behavior of resisting care due to his Dementia. He will refuse showers and Activities of Daily Living (ADLs) care and can get aggressive with staff. When Resident #1 displays the behavior of aggression staff should allow the resident to make decisions about treatment regime, and to provide sense of control. Encourage as much participation/interaction by the resident as possible during care activities. Give clear explanation of all care activities prior to and as they occur during each contact. If possible, negotiate a time for ADLs so that the resident participates in the decision-making process, and return at the agreed upon time. If resident resists with ADLs, reassure resident, leave, and return 5-10 minutes later and try again. Notify immediate supervisor and administration of all behaviors. Praise the resident when the behavior is appropriate. And provide consistency in care to promote comfort with ADLs, maintain consistency in timing of ADLs, caregiver, and routine as much as possible. Record Review of Resident #1's Kardex Report dated 06/01/24 indicated when Resident #1 displays the behavior of aggression staff should allow the resident to make decisions about treatment regime, and to provide sense of control, anticipate and meet needs, and ensure call light is within reach and respond promptly to Encourage as much participation/interaction by the resident as possible during care activities. Encourage the resident to participate to the fullest extent possible with each interaction. Give clear explanation of all care activities prior to and as they occur during each contact. Give the resident choices about care and activities. If possible, negotiate a time for ADLs so that the resident participates in the decision-making process, and return at the agreed upon time. If resident resists with ADLs, reassure resident, leave, and return 5-10 minutes later and try again. Keep the resident's routine consistent and try to provide consistent care givers to decrease confusion. Monitor for fatigue. Plan activities during optimal times when pain and stiffness are abated. Notify nurse of any new areas of skin breakdown: redness, blisters, bruises, discoloration noted during bath or daily care. Initiate a Stop and Watch alert of change in skin, Praise all efforts at self-care. Praise the resident when behavior is appropriate. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of CNA's Relias Transcript dated 06/19/24 indicated on 07/24/24 she scored 80 percent on Behavioral Health for Older Adults. On 06/19/24 she trained on Resident Combativeness. 04/03/24 she scored 88 percent on Preventing, Recognizing, and Reporting Abuse. On 04/04/24 she completed the training for Safeguarding Resident Rights in Nursing Facilities. During an interview with CNA D on 07/18/24 at 2:52 p.m., indicated on 06/19/24 at before 5 p.m., she was at the nurses' station with LVN B, when CNA A exited Resident #1's room and said I can't do this anymore, while covering her mouth with her hand. CNA D said she entered Resident #1's room and saw him lying on his right side facing the wall, with his sweatpants pulled down to his knees, and a brief tucked under his buttocks. CNA D said in the past she had changed Resident #1's brief and he had been compliant. CNA D said if a resident is noncompliant, she should inform the resident she will return later to complete his care. During an interview with DON on 07/18/24 at 3:25 p.m. indicated on 06/19/24 at approximately 5 p.m. CNA A said Resident #1 was facing the wall on his right side, which is his nonparalyzed side, as she changed his soiled brief. That was when Resident #1 became upset and tried to hit her with his non paralyzed arm by swinging it over his head, and then he kicked her on her mouth causing it to bleed. DON said the police met with Resident #1 who did not fill out a report, because he said nothing happened. The DON said CNA should have immediately stopped the care if Resident #1 was combative, reported to the charge nurse, returned a minutes later to continue the care, or ask for a different staff to care for him. During an interview with the administrator on 07/18/24 at 3:31 p.m. Indicated on 06/19/24 at approximately 5 p.m. the DON informed her CNA A was bleeding form her mouth because Resident #1 kicked her while she was changing his brief. The Administrator said she asked Resident #1 what happened to his face, and he replied he was not telling her and picked up his arm as if he was going to hit her. The Administrator said the police tried to interview Resident #1, but he told the officer nothing happened and to leave his room. The Administrator said if Resident #1 was refusing care and combative, CNA A should have stopped immediately, left the room, returned a few minutes later to continue his care, or asked for a different staff to care for him. During an interview with ADON E on 07/18/24 at 3:56 p.m. indicated on/06/19/24 Resident #1 was refusing care and was combative, CNA A should have left the room to give him time to calm down, reported this to LVN B, returned a few minutes later to continue care, or ask for a different staff to care for him. During an interview with CNA A on 07/18/24 at 9:01 p.m. said on 06/19/24 at approximately 4:30 p.m. she entered Resident #1's room and informed him she was changing his brief, then take him to the dining area. CNA A said she directed Resident #1, who was very confused, to turn towards the wall so she could wipe him, and she used the draw sheet to turn him. Resident #1 was lying on his nonparalyzed side, when he became combative by swinging his non paralyzed right arm at her. CNA A said Resident #1, who had his sweatpants around his knees, kept pushing his knees into the wall as she tried to wipe him. CNA A said Resident #1 was lying on his nonparalyzed side, swinging his arm over his head towards her. CNA A said she released Resident #1 and proceeded to strap his brief, but he kicked her on the mouth. CNA A said she continued with the care because she was short staffed, and she wanted to complete his care. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with LVN B on 07/19/24 at 9:49 pm indicated on 06/16/24 at approximately 4:30 p.m., she was sitting at the nurses' station, which is directly across the hallway from Resident #1's room, when CNA A exit his room and said, he just kicked me on the mouth. LVN B said she directed CNA A to report to administration. LVN A said she directed CNA D to help Resident #1 up from his bed and take him to the dining room. LVN B said she had been in and around the nurses' station and did not hear any noise coming from Resident #1's room, because the door to his room was closed. LVN B said if a resident becomes combative during care, staff should leave them alone if their safe, report to the charge nurse, return later, or pass the care to a staff. During an interview with LVN F on 07/22/24 at 10:38 a.m. indicated Resident #1's Care Plan dated 06/11/24 addressed Resident #1's behaviors of becoming combative when provided care. The staff should have stopped the care, walked away, reported this to the nurse, and returned 5-10 minutes later to attempt the care. LVN F indicated Resident #1's Care Plan carries over to the Kardex report that CNAs use to implement when caring for residents. Record review of the facilities' Policy and Procedure Comprehensive Care Planning that was undated, indicated its purpose was to Ensure every resident has a comprehensive complete, accurate, and all-inclusive specific care plan written timely to meet all requirement of the RAI (Residential Assessment Instrument) and regulatory process to include input from all the IDT (Interdisciplinary team) members. Every resident will have a specific care plan written for all ADL (activities of daily living) needs. And Care Plan will be revised as needed weekly. Record review of the facilities policy and procedure for Behavioral Assessment, Intervention, and Monitoring dated 2002 included The facility will provide, and resident will receive behavioral health services as needed to attain or maintain the highest practicable physical, mental, and psychosocial well-being in accordance with the comprehensive assessment and plan of care.