

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675970	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/22/2024
NAME OF PROVIDER OR SUPPLIER Memphis Convalescent Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1415 N 18th St Memphis, TX 79245	

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)
<p>F 0623</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48491</p> <p>Based on Interview and Record Review, the facility failed to send a copy of the discharge notice to the Office of the State Long-Term Care Ombudsman for 1 (Resident #1) of six residents reviewed for transfer/discharge.</p> <p>The facility failed to send a discharge notice in writing to the facility's ombudsman as soon as practicable after Resident #1's discharge to home due to the facility not being able to meet Resident #1's needs.</p> <p>This failure could place residents at risk of being discharged and not having access to available advocacy services, discharge/transfer options, and appeal processes.</p> <p>Findings included:</p> <p>Record review of Resident #1's face sheet reflected the resident was a [AGE] year-old male, with initial admitted [DATE], readmitted [DATE] and then discharged to home on 04/23/2024. The resident had diagnoses which included: dementia (cognitive loss), schizoaffective disorder, bipolar type (mood disorder that varies by person but has mania and depression and causes distorted reality), and cocaine dependence, low back pain, muscle wasting and atrophy (breakdown of muscles), and unsteadiness on feet.</p> <p>Record review of Resident #1's progress notes dated 04/05/2024 revealed that resident was being readmitted to the facility from a behavioral hospital after he assaulted another resident on 03/24/24. Resident #1's family member was told by facility staff that they would not be able to keep resident in facility if another incident occurs and Resident #1's family member stated she would move him home with her if that happened.</p> <p>Record review of Resident #1's quarterly MDS assessment dated [DATE] revealed Resident #1 had a BIMS score of a three out of 15 which indicates that the resident had severe cognitive impairment. Discharge MDS dated [DATE] revealed it was an unplanned discharge with date of discharge recorded as 04/23/2024.</p> <p>(continued on next page)</p>

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: 675970	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/22/2024
NAME OF PROVIDER OR SUPPLIER Memphis Convalescent Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1415 N 18th St Memphis, TX 79245	
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)		
<p>F 0623</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 05/22/2024 at 3:08 PM, the DON stated that she remembers Resident #1 coming back from a 72-hour pass with his family member on 04/23/24 and she remembers he was angry and cussing and saying he wanted to go home. DON and ADM had a meeting with Resident #1 and the family member agreed to discharge him and take him home with her. DON stated that the Ombudsman was not notified, and she did not know that the Ombudsman needed to be notified.</p> <p>During an interview on 05/22/2024 at 3:24 PM, ADM stated that she did not contact the Ombudsman when the discharge for Resident #1 happened. She stated that she did not think of it because Resident #1 was demanding to go home and because it was not against his will, she did not think she needed to contact the Ombudsman. ADM went on to state a possible negative outcome for not contacting the Ombudsman would be that Resident #1 would not have his rights or his appeal rights met.</p> <p>Record review of the facility's policy dated 11/28/2016, provided by the ADM, titled Discharge Planning Process Policy,</p> <p>.The final discharge summary will be available for release to authorized individuals and agencies, with the consent of the resident or the resident's legal representative.</p> <p>There was no mention in the policy about contacting the State Ombudsman's office.</p>		