STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675978	A. Building B. Wing	06/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arbor Grace Wellness Center	1241 W Marshall Howard Blvd Littlefield, TX 79339

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 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** 46534 Based on observation, 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 for 1 (Resident #1) of 5 residents reviewed for baseline care plans. The facility failed to ensure CNA D used the necessary mechanical lift to transfer Resident #1 as documented in the baseline care plan. This failure could place residents at risk of accidents and/or injury. Findings Included: Record review of Resident #1's admission record dated 06/04/24 revealed a [AGE] year-old male admitted to the facility on [DATE] with diagnoses that included, but were not limited to, quadriplegia (paralysis that affects all limbs and body from the neck down), muscle wasting and atrophy, reduced mobility, generalized anxiety disorder (inability to control constant worrying), and panic disorder (anxiety disorder that causes sudden and intense fear). Record review of Resident #1's Admission MDS completed on 05/26/24 revealed a BIMS of 15 which indicated intact cognition. Section GG of the MDS indicated Resident #1 had impairment to both sides of his upper and lower extremities and utilized a wheelchair. Section GG indicated Resident #1 was dependent across all ADLs with Sit to stand, Toilet transfer, Car transfer, and Walk 10 feet coded as Not applicable - Not attempted and the resident did not perform this activity prior to the current illness, exacerbation, or injury. Section K revealed Resident #1 was 72 inches tall and weighed 235 pounds. Record review of Resident #1's Care Plan face sheet in his EHR, dated 06/04/24 revealed no completed care plan. There was a care plan in progress with a start date of 05/21/24 and a completion target date of 06/04/24. The care plan only had three focus areas listed. They were diet, advance directive, and activities. Of the three, only activities had accompanying goals and interventions. Record review of Resident #1's baseline care plan, dated 05/14/24, revealed he was TOTAL ASSIST-HOYER for transfers and Total assist for all ADLs. The baseline care plan was completed and signed by MDS LVN. (continued on next page)

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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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	During an observation and interview on 06/04/24 at 08:25 AM Resident #1 was lying in his bed on his back under a blanket with HOB raised watching television. He stated he was unable to get out of bed by himself. He stated staff used the Hoyer lift to transfer him except for CNA D. Resident #1 stated CNA D was in the Army or Marines and thought he was strong enough to just lift Resident #1. Resident #1 stated he did not feel safe when CNA D lifted him. He stated he did not tell CNA D or any other staff member that he did not feel safe when CNA D lifted him for transfers. During an interview on 06/04/24 at 12:50 PM CNA D stated he did transfer Resident #1 without a Hoyer lift. He stated he picked Resident #1 up out of his bed by placing his arms beneath Resident #1's arms and around Resident #1's back so they two of them were chest-to-chest. He stated he was an agency CNA and had worked in the facility 5-6 times prior to this incident. During an interview on 06/04/24 at 01:16 PM CNA F stated she had been a CNA at the facility for [AGE] years. She stated she knew if a resident needed a two-person transfer or Hoyer lift transfer by looking at their POC on the tablet the CNAs used. She stated Resident #1 was a Hoyer transfer. During an interview on 06/04/24 at 01:22 PM CNA E stated the nurses typically told the CNA's which resident's needed Hoyer lifts and which one's needed 2-person transfers. She stated Resident #1 was a 2-person transfer. During an interview on 06/04/24 at 01:24 PM when asked how direct care staff knew how to transfer a resident, DON stated she would ask employees who had been in the facility a long time how a certain resident should be transferred. During an interview on 06/04/24 at 01:25 PM ADM stated a resident's baseline care plan would indicate how they were to be transferred. During an interview on 06/04/24 at 02:14 PM MDS LVN stated Resident #1 was to be transferred with a Hoyer lift as his baseline care plan indicated. She stated a CNA transferring Resident #1 alone could result in injury to Resident #1 or to the CNA. During an interview on 06/04/24 at 07:19 PM CNA I stated she had worked for the facility for [AGE] years. She stated she knew a resident needed a Hoyer lift if the resident was unable to stand. CNA I stated Resident #1 needed a Hoyer lift. During an interview on 06/05/24 at 09:11 AM CNA D stated he knew Resident #1 was to be transferred with a Hoyer lift. He stated he knew because he asked Resident #1 how staff transferred him. CNA D stated Resident #1 told him if he could transfer him without the Hoyer lift it was fine. CNA D stated he could not think of any negative outcome of transferring Resident #1 on his own without using the Hoyer lift. During an interview on 06/05/24 at 09:27 AM CNA G stated she was an agency CNA. She stated she knew if a resident needed a Hoyer lift or two-person transfer by finding out in report from the off-going CNA. She stated it was important to ask the CNA's who were used to working with the residents especially if it is your first time in the facility. (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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 06/05/24 at 09:37 AM Resident #1's family member stated she was told by Resident #1 that CNA D transferred him alone without using the Hoyer lift. She stated she was worried that Resident #1 might get hurt. During an interview on 06/05/24 at 09:40 AM LVN C stated there was always the possibility of injury if a resident was not transferred as indicated in the care plan. During an interview on 06/05/24 at 09:43 AM ADM stated, A lot can happen; accidents can happen if a resident was not transferred as indicated in the care plan. During an interview on 06/05/24 at 09:49 AM DON stated if residents were not transferred as indicated in their care plans staff or the resident is gonna get hurt. Record review of facility policy dated December 2016 and titled Care Plans-Baseline revealed the following: . A baseline plan of care to meet the resident's immediate needs shall be developed for each resident . 1. To assure that the resident's immediate care needs are met and maintained, a baseline care plan will be developed within forty-eight (48) hours of the resident's admission. Record review of facility policy dated April 2006 and titled Departmental Supervision revealed the following: . 4. The Director of Nursing Services and/or the Nurse Supervisor/Charge Nurse, as a minimum, is responsible for: c. Reviewing individual resident care plans for appropriate goals, problems, approaches, and revisions based on nursing needs; d. Assuring that the resident's plan of care is being followed; .

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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** 46534 Based on observation, interview, and record review the facility failed to develop and implement a comprehensive person-centered care plan for each resident consistent with the resident rights that included measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that were identified in the comprehensive assessment for 1 (Resident #2) of 5 residents reviewed for care plans. The facility failed to ensure CNA D followed Resident #2's care plan by transferring the resident as a 2-person assist. This failure could place residents at risk of accidents and/or injuries. Findings Included: Record review of Resident #2's admission record dated 06/05/24 revealed a [AGE] year-old male admitted to the facility on [DATE] with diagnoses that included, but were not limited to, primary lateral sclerosis (a neuron disease that affects the nerve cells in the brain that control movement resulting in weakness in the muscles that control the legs, arms and tongue), muscle weakness, muscle wasting and atrophy, reduced mobility, Parkinson's disease (chronic and progressive movement disorder that initially causes tremors in one hand and stiffness or slowing of movement) with dyskinesia (abnormality or impairment of voluntary movement), and muscle spasm. Record review of Resident #2's Quarterly MDS completed on 03/17/24 revealed a BIMS of 00 which indicated severely impaired cognition. Section GG indicated Resident #2 had impairment in his upper and lower extremities on both sides and was dependent across all ADLs. Section I indicated Resident #2's primary medical condition was Progressive Neurological Conditions. Section K indicated Resident #2 was 67 inches tall and weighed 159 pounds. Record review of Resident #2's baseline care plan, dated 12/03/20 indicated he was TOTAL ASSIST for transfers. Record review of Resident #2's main care plan revealed he had limited mobility due to his diagnoses. It was further noted, Requires assistance for all transfers and ADLs. This focus area was initiated on 07/05/2022. Record review of Resident #2's care plan completed on 03/18/24 revealed an intervention that noted Resident #2 was (X)dependent for transfers. This intervention was initiated on 07/05/2022. Record review of Resident #2's progress notes revealed a note written by LVN H on 06/02/24 at 07:56 PM. LVN H noted that LVN C told her about an incident from earlier that day where Resident #2 was lowered to the ground by CNA D and CNA D called for assistance. According to LVN H's note, LVN C assessed Resident #2 at the time and no injuries were noted. Then LVN C, a housekeeping staff member, and CNA D transferred Resident #3 from the floor into the shower chair. (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	During an observation and interview on 06/04/24 at 08:57 AM Resident #2 was seated in his w/c in the common area near the nurses' station watching TV. When he was asked if anyone had dropped him in the shower, he shook his head side to side, which indicated 'no'. During an interview on 06/04/24 at 12:50 PM CNA D stated he was attempting to transfer Resident #2 on 06/02/24 into the shower chair and when he got Resident #2 to the shower chair, he began to slip so CNA D lowered Resident #2 to the ground gently. He stated he thought Resident #2 got mad and jerked in his arms and that is why Resident #2 began to slip. CNA D stated he was holding Resident #2 under his arms and they were chest-to-chest. CNA D stated LVN C looked at Resident #2 after he was lowered to the ground and Resident #2 had no injuries, no nothing. He stated he and LVN C and another staff member picked Resident #2 up off the floor and placed him in the shower chair. During an interview on 06/04/24 at 01:16 PM CNA F stated she had been a CNA at the facility for [AGE] years. She stated she knew if a resident needed a two-person transfer or Hoyer lift transfer by looking at their POC on the tablet the CNAs used. She stated Resident #2 was a two-person transfer. During an interview on 06/04/24 at 01:22 PM CNA E stated the nurses typically told the CNA's which resident's needed Hoyer lifts and which one's needed 2-person transfers. She stated Resident #2 was a 2-person transfer. During an interview on 06/04/24 at 01:24 PM when asked how direct care staff knew how to transfer a resident, DON stated she would ask employees who had been in the facility a long time how a certain resident should be transferred. During an interview on 06/04/24 at 01:25 PM ADM stated a resident's baseline care plan would indicate how they were to be transferred During an interview on 06/04/24 at 01:44 PM LVN C stated she assessed Resident #2 after CNA D lowered him to the ground in the shower room. She stated they had to have a third staff member help them lift Resident #2 off the ground because he got real stiff .and he wouldn't bend his knees. She stated Resident #2 did not fall and was not in any distress. During an interview on 06/04/24 at 07:19 PM CNA I stated she had worked for the facility for [AGE] years. She stated she knew a resident needed a Hoyer lift if the resident was unable to stand. CNA I stated Resident #2 needed a two-person transfer. During an interview on 06/05/24 at 09:11 AM CNA D stated he did transfer Resident #2 on his own. He stated he knew Resident #2 was a two-person transfer but unfortunately the rest of the staff was beyond busy so that was not able to happen. CNA D stated after the incident where he had to lower Resident #2 to the floor and get help from two staff members to transfer Resident #2 from the floor to the shower chair the nurse told him Resident #2 was a two-person transfer. During an interview on 06/05/24 at 09:27 AM CNA G stated she was an agency CNA. She stated she knew if a resident needed a Hoyer lift or two-person transfer by finding out in report from the off-going CNA. She stated it was important to ask the CNA's who were used to working with the residents especially if it is your first time in the facility. (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 on 06/05/24 at 09:30 AM MDS LVN stated total assist in a baseline or regular care plan meant two-person assist. She stated Resident #2 required a two-person assist with transfer. She stated the (X)dependent in Resident #2's care plan meant he needed a two-person transfer. During an interview on 06/05/24 at 09:40 AM LVN C stated there was always the possibility of injury if a resident was not transferred as indicated in the care plan. During an interview on 06/05/24 at 09:43 AM ADM stated, A lot can happen; accidents can happen if a resident was not transferred as indicated in the care plan. During an interview on 06/05/24 at 09:49 AM DON stated if residents were not transferred as indicated in their care plans staff or the resident is gonna get hurt. Record review of facility policy dated December 2016 and titled Care Plans, Comprehensive Person-Centered revealed the following: . A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs in developed and implemented for each resident. The comprehensive, person-centered care plan will . b. Describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being; . Record review of facility policy dated April 2006 and titled Departmental Supervision revealed the following: . 4. The Director of Nursing Services and/or the Nurse Supervisor/Charge Nurse, as a minimum, is responsible for: c. Reviewing individual resident care plans for appropriate goals, problems, approaches, and revisions based on nursing needs; d. Assuring that the resident's plan of care is being followed; .

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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** 46534 Based on observation, interview, and record review the facility failed to ensure the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents for 2 (Resident #1 and Resident #2) of 5 residents reviewed for accidents. 1. The facility failed to ensure CNA D used the necessary mechanical lift to transfer Resident #1 as documented in the baseline care plan. 2. The facility failed to ensure CNA D followed Resident #2's care plan by transferring the resident as a 2-person assist. These failures could place residents at risk of accidents and/or injury. Findings Included: 1. Record review of Resident #1's admission record dated 06/04/24 revealed a [AGE] year-old male admitted to the facility on [DATE] with diagnoses that included, but were not limited to, quadriplegia (paralysis that affects all limbs and body from the neck down), muscle wasting and atrophy, reduced mobility, generalized anxiety disorder (inability to control constant worrying), and panic disorder (anxiety disorder that causes sudden and intense fear). Record review of Resident #1's Admission MDS completed on 05/26/24 revealed a BIMS of 15 which indicated intact cognition. Section GG of the MDS indicated Resident #1 had impairment to both sides of his upper and lower extremities and utilized a wheelchair. Section GG indicated Resident #1 was dependent across all ADLs with Sit to stand, Toilet transfer, Car transfer, and Walk 10 feet coded as Not applicable - Not attempted and the resident did not perform this activity prior to the current illness, exacerbation, or injury. Section K revealed Resident #1 was 72 inches tall and weighed 235 pounds. Record review of Resident #1's Care Plan face sheet in his EHR, dated 06/04/24 revealed no completed care plan. There was a care plan in progress with a start date of 05/21/24 and a completion target date of 06/04/24. The care plan only had three focus areas listed. They were diet, advance directive, and activities. Of the three, only activities had accompanying goals and interventions. Record review of Resident #1's baseline care plan, dated 05/14/24, revealed he was TOTAL ASSIST-HOYER for transfers and Total assist for all ADLs. The baseline care plan was completed and signed by MDS LVN. (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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and interview on 06/04/24 at 08:25 AM Resident #1 was lying in his bed on his back under a blanket with HOB raised watching television. He stated he was unable to get out of bed by himself. He stated staff used the Hoyer lift to transfer him except for CNA D. Resident #1 stated CNA D was in the Army or Marines and thought he was strong enough to just lift Resident #1. Resident #1 stated he did not feel safe when CNA D lifted him. He stated he did not tell CNA D or any other staff member that he did not feel safe when CNA D lifted him for transfers. During an interview on 06/04/24 at 12:50 PM CNA D stated he did transfer Resident #1 without a Hoyer lift. He stated he picked Resident #1 up out of his bed by placing his arms beneath Resident #1's arms and around Resident #1's back so they two of them were chest-to-chest. He stated he was an agency CNA and had worked in the facility 5-6 times prior to this incident. During an interview on 06/04/24 at 02:14 PM MDS LVN stated Resident #1 was to be transferred with a Hoyer lift as his baseline care plan indicated. She stated a CNA transferring Resident #1 alone could result in injury to Resident #1 or to the CNA. During an interview on 06/05/24 at 09:37 AM Resident #1's family member stated she was told by Resident #1 that CNA D transferred him alone without using the Hoyer lift. She stated she was worried that Resident #1 might get hurt. 2. Record review of Resident #2's admission record dated 06/05/24 revealed a [AGE] year-old male admitted to the facility on [DATE] with diagnoses that included, but were not limited to, primary lateral sclerosis (a neuron disease that affects the nerve cells in the brain that control movement resulting in weakness in the muscles that control the legs, arms and tongue), muscle weakness, muscle wasting and atrophy, reduced mobility, Parkinson's disease (chronic and progressive movement disorder that initially causes tremors in one hand and stiffness or slowing of movement) with dyskinesia (abnormality or impairment of voluntary movement), and muscle spasm. Record review of Resident #2's Quarterly MDS completed on 03/17/24 revealed a BIMS of 00 which indicated severely impaired cognition. Section GG indicated Resident #2 had impairment in his upper and lower extremities on both sides and was dependent across all ADLs. Section I indicated Resident #2's primary medical condition was Progressive Neurological Conditions. Section K indicated Resident #2 was 67 inches tall and weighed 159 pounds. Record review of Resident #2's baseline care plan, dated 12/03/20 indicated he was TOTAL ASSIST for transfers. Record review of Resident #2's main care plan revealed he had limited mobility due to his diagnoses. It was further noted, Requires assistance for all transfers and ADLs. This focus area was initiated on 07/05/2022. Record review of Resident #2's care plan completed on 03/18/24 revealed an intervention that noted Resident #2 was (X)dependent for transfers. This intervention was initiated on 07/05/2022. (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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #2's progress notes revealed a note written by LVN H on 06/02/24 at 07:56 PM. LVN H noted that LVN C told her about an incident from earlier that day where Resident #2 was lowered to the ground by CNA D and CNA D called for assistance. According to LVN H's note, LVN C assessed Resident #2 at the time and no injuries were noted. Then LVN C, a housekeeping staff member, and CNA D transferred Resident #3 from the floor into the shower chair. During an observation and interview on 06/04/24 at 08:57 AM Resident #2 was seated in his w/c in the common area near the nurses' station watching TV. When he was asked if anyone had dropped him in the shower, he shook his head side to side, which indicated 'no'. During an interview on 06/04/24 at 12:50 PM CNA D stated he was attempting to transfer Resident #2 on 06/02/24 into the shower chair and when he got Resident #2 to the shower chair, he began to slip so CNA D lowered Resident #2 to the ground gently. He stated he thought Resident #2 got mad and jerked in his arms and that is why Resident #2 began to slip. CNA D stated he was holding Resident #2 under his arms and they were chest-to-chest. CNA D stated LVN C looked at Resident #2 after he was lowered to the ground and Resident #2 had no injuries, no nothing. He stated he and LVN C and another staff member picked Resident #2 up off the floor and placed him in the shower chair. During an interview on 06/04/24 at 01:44 PM LVN C stated she assessed Resident #2 after CNA D lowered him to the ground in the shower room. She stated they had to have a third staff member help them lift Resident #2 off the ground because he got real stiff .and he wouldn't bend his knees. She stated Resident #2 did not fall and was not in any distress. During an interview on 06/05/24 at 09:11 AM CNA D stated he did transfer Resident #2 on his own. He stated he knew Resident #2 was a two-person transfer but unfortunately the rest of the staff was beyond busy so that was not able to happen. CNA D stated after the incident where he had to lower Resident #2 to the floor and get help from two staff members to transfer Resident #2 from the floor to the shower chair the nurse told him Resident #2 was a two-person transfer. During an interview on 06/04/24 at 01:16 PM CNA F stated she had been a CNA at the facility for [AGE] years. She stated she knew if a resident needed a two-person transfer or Hoyer lift transfer by looking at their POC on the tablet the CNAs used. She stated Resident #1 was a Hoyer transfer and Resident #2 was a 2-person transfer. During an interview on 06/04/24 at 01:22 PM CNA E stated the nurses typically told the CNA's which resident's needed Hoyer lifts and which one's needed 2-person transfers. She stated Resident #1 and Resident #2 were 2-person transfers. During an interview on 06/04/24 at 01:24 PM when asked how direct care staff knew how to transfer a resident, DON stated she would ask employees who had been in the facility a long time how a certain resident should be transferred. During an interview on 06/04/24 at 01:25 PM ADM stated a resident's baseline care plan would indicate how they were to be transferred. During an interview on 06/04/24 at 07:19 PM CNA I stated she had worked for the facility for [AGE] years. She stated she knew a resident needed a Hoyer lift if the resident was unable to stand. CNA I stated Resident #1 needed a Hoyer lift and Resident #2 needed a 2-person transfer. (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 06/05/24 at 09:11 AM CNA D stated he knew Resident #1 was to be transferred with a Hoyer lift. He stated he knew because he asked Resident #1 how staff transferred him. CNA D stated Resident #1 told him if he could transfer him without the Hoyer lift it was fine. CNA D stated he could not think of any negative outcome of transferring Resident #1 on his own without using the Hoyer lift. CNA D stated he did transfer Resident #2 on his own. He stated he knew Resident #2 was a two-person transfer but unfortunately the rest of the staff was beyond busy so that was not able to happen. CNA D stated after the incident where he had to lower Resident #2 to the floor and get help from two staff members to transfer Resident #2 from the floor to the shower chair the nurse told him Resident #2 was a two-person transfer. CNA D stated he was an agency staff and had worked in the facility 5-6 times before he transferred Resident #1 without the Hoyer lift. During an interview on 06/05/24 at 09:27 AM CNA G stated she was an agency CNA. She stated she knew if a resident needed a Hoyer lift or two-person transfer by finding out in report from the off-going CNA. She stated it was important to ask the CNA's who were used to working with the residents especially if it is your first time in the facility. During an interview on 06/05/24 at 09:30 AM MDS LVN stated total assist in a baseline or regular care plan meant two-person assist. She stated Resident #2 required a two-person assist with transfer. She stated the (X)dependent in Resident #2's care plan meant he needed a two-person transfer. During an interview on 06/05/24 at 09:40 AM LVN C stated there was always the possibility of injury if a resident was not transferred as indicated in the care plan. During an interview on 06/05/24 at 09:43 AM ADM stated, A lot can happen; accidents can happen if a resident was not transferred as indicated in the care plan. During an interview on 06/05/24 at 09:49 AM DON stated if residents were not transferred as indicated in their care plans staff or the resident is gonna get hurt. Record review of facility policy dated December 2016 and titled Care Plans-Baseline revealed the following: . A baseline plan of care to meet the resident's immediate needs shall be developed for each resident . 1. To assure that the resident's immediate care needs are met and maintained, a baseline care plan will be developed within forty-eight (48) hours of the resident's admission. Record review of facility policy dated December 2016 and titled Care Plans, Comprehensive Person-Centered revealed the following: . A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs in developed and implemented for each resident. The comprehensive, person-centered care plan will . b. Describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being; . Record review of facility policy dated April 2006 and titled Departmental Supervision revealed the following: . 4. The Director of Nursing Services and/or the Nurse Supervisor/Charge Nurse, as a minimum, is responsible for: c. Reviewing individual resident care plans for appropriate goals, problems, approaches, and revisions based on nursing needs; d. Assuring that the resident's plan of care is being followed; .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675978	A. Building B. Wing	06/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arbor Grace Wellness Center	1241 W Marshall Howard Blvd Littlefield, TX 79339

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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 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. 46534 Based on observation, interview, and record review the facility failed to use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week for 1 (06/01/24-06/02/24) of 5 weekends reviewed for RN services. The facility failed to have an RN working on 06/01/24 and 06/02/24. This failure could place residents at risk of not having supervisory coverage for coordination of events such as emergency care and disasters. Findings Included: Record review of complaint intake #508323 alleged facility did not have RN coverage on 06/01/24 and 06/02/24. During an observation and interview on 06/04/24 at 01:36 PM BOM was asked who the RN on duty was for 06/01/24 and 06/02/24. She searched her computer for time sheets from an RN on those days and stated the facility did not have an RN working either of those days. She printed off a report titled, Time and Attendance Detail Report by Employee Period From 06/01/24 to 06/02/24. The paper was blank except for the title. She stated it did not show the filters she used in her search criteria but she searched for DON and RN hours, and nothing showed up which meant the facility did not have RN coverage on those dates. During an interview on 06/04/24 at 01:52 PM LVN A stated he could not think of a negative outcome for residents of not having RN coverage in the facility. He stated if something came up that the LVN on duty could not handle the resident would usually go to the hospital anyway even if an RN was here. During an interview on 06/04/24 at 01:54 PM DON stated not having an RN in the building could negatively impact residents because, They [RNs] supervise the staff and if any issues the LVNs can't take care of. During an interview on 06/04/24 at 01:55 PM ADON was asked if she could think of a negative outcome of not having an RN in the building over the weekend. She replied, I personally don't think so because usually they just stay locked up for 8 hours. Occasionally they will come out and ask us if we need anything. During an interview on 06/05/24 at 09:45 AM ADM stated she was responsible for staff scheduling and ensuring an RN was in the building 8 hours a day 7 days a week. She stated on 06/01/24 and 06/02/24 she was unable to find an RN who could work. She said the only negative outcome she could think of regarding not having an RN in the building was that RNs could delegate to LVNs in the case of an emergency. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675978	A. Building B. Wing	06/05/2024

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of facility report titled, Time and Attendance Detail Report by Employee Period From 06/01/2024 To 06/02/2024 revealed no RN hours.