STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675995	A. Building B. Wing	12/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
University Rehabilitation Center	2244 Brinker Rd Denton, TX 76208

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 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** 50222 Based on observation, interview, and record review the facility failed to ensure residents received adequate supervision to prevent incidents and accidents for one resident (Resident #13) of four residents reviewed for possible accident hazards and incidents. The facility failed to provide adequate supervision for Resident #13 on 10/31/2024 after she was placed on one-to-one monitoring. The noncompliance was identified as past noncompliance (PNC) on 10/31/2024 at 7:05 p.m. The facility had corrected the noncompliance on 10/31/2024 immediately following the incident before the state's investigation began. This failure could place residents at risk for possible resident-to-resident altercations and injuries due to lack of supervision. Findings included: Record review of Resident #13's Quarterly MDS assessment dated [DATE] revealed Resident #13 was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses of Alzheimer's disease, depression, muscle wasting and atrophy (loss of muscle mass), and a cognitive communication deficit. The MDS also revealed a BIMS score of 07 (suggested moderately impaired cognition). Record review of Resident #13's care plan revised on 11/06/2024 revealed on 10/26/2024 Resident #13 was placed on one-on-one supervision as an intervention for behaviors. On 10/31/2024 an intervention was added to the care plan that stated nurses were talked to about monitoring and the expectation of one-on-one supervision. Record review of Resident #15's Quarterly MDS assessment dated [DATE] revealed Resident #15 was aan [AGE] year-old female admitted to the facility on [DATE] with diagnoses of Alzheimer's disease and stroke. Record review of nursing progress note dated 10/26/2024 at 7:15 p.m., revealed Resident #13 was placed on one-on-one supervision due to unpredictable behaviors and aggression. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of nursing progress note dated 10/27/2024 at 3:21 p.m., revealed Resident #13 remained on one-on-one supervision. Record review of nursing progress note dated 10/28/2024 at 10:58 a.m., revealed Resident #13 remained on one-on-one supervision and required redirection due to multiple attempts to wander into other residents' rooms. Record review of nursing progress note dated 10/29/2024 at 2:00 p.m., revealed Resident #13 remained on one-on-one supervision. Record review of nursing progress note dated 10/30/2024 at 2:00 p.m., revealed Resident #13 remained on one-on-one supervision. Record review of nursing progress note dated 10/31/2024 at 9:36 p.m. by LVN A, revealed LVN A was notified by another nurse that Resident #13 had an altercation with Resident #15 on the 500 hall that did not result in any injuries. Record review of nursing progress note dated 10/31/2024 at 11:03 p.m. by LVN A, revealed Resident #13 was placed on one-on-one supervision. In an interview on 12/02/2024 at 1:51 p.m., LVN A reported Resident #13 was brought back to the nurse's station from the 500 hall on 10/31/2024 after an altercation with another resident. LVN A stated he assessed Resident #13 and there were no injuries. LVN A stated Resident #13 was then placed on one-on-one supervision. In an interview on 12/02/2024 at 2:40 p.m., the former DON stated Resident #13 was supposed to be one-on-one supervision on 10/31/2024 at the time of the incident, but there was a miscommunication. The former DON stated Resident #13 had been at a Halloween party, and the former DON was not sure who was assigned to Resident #13 after that. The former DON reported there was always a dedicated staff member assigned to watch Resident #13, but she did not remember who was assigned to the resident at that time. Record review of resident one-on-one observation assignment sheet was dated from 10/26/2024 to 11/01/2024 and revealed LVN A and LVN B were assigned to Resident #13 from 4:00 p.m. to 10:00 p.m. on 10/31/2024. Signatures were missing on 10/31/2024 for LVN A and LVN B for 4:00 p.m. to 10:00 p.m. In an interview on 12/02/2024 at 2:56 p.m., LVN A reported that Resident #13 was not on one-on-one supervision at the time of the incident on 10/31/2024. LVN A reported that Resident #13 was usually on one-on-one supervision in the mornings, and a dedicated staff member for one-on-one supervision could have prevented the incident. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 12/02/2024 at 3:27 p.m., LVN C stated on 10/31/2024 Resident #13 had Resident #15's doll and became aggressive when the Resident #15 attempted to retrieve the doll. LVN C stated Resident #13 hit Resident #15 on the shoulder and face with the soft doll. LVN C reported that she immediately intervened, and no injuries had occurred. LVN C stated that there was no bruising or redness, and that Resident #13 was supposed to have a dedicated staff member assigned to provide one-to-one supervision. LVN C reported she did not see LVN A or LVN B with Resident #13 but thought that she had a one-to-one person assigned with her. LVN C stated she did not remember who was with her and that she immediately took Resident #13 back to her nurse's station. LVN C stated the purpose of the one-to-one supervision was to prevent Resident #13 from getting into trouble and to follow Resident #13 around. Record review of the PIR dated 11/06/2024 revealed residents were assessed, and no injuries or pain were noted, and both residents were at their baseline. In an observation on 12/02/2024 at 2:10 p.m., three soft cotton filled baby dolls were in the bed next to Resident #15. The dolls were around one foot long and approximately six inches wide. They were covered in a thick, soft, furry material resembling animal-like doll clothes. In an interview on 12/02/2024 at 4:19 p.m., the ADM reported that Resident #13 was on one-to-one supervision at the time of the incident on 10/31/2024. The ADM stated LVN B was assigned to Resident #13, and Resident #13 got away from LVN B at the time of the incident. The ADM stated Resident #13 was visible by LVN B but not within physical reach. The ADM did not specify how far away from Resident #13 LVN B was, but that it would take a few seconds for LVN B to intervene. The ADM reported that the risk of inadequate supervision was that residents could have been hurt. The ADM reported after this incident that one-on-one training was completed with LVN A and LVN B concerning one-on-one supervision, one-on-one supervision training was also completed with all staff members, and a notification was added to the dashboard of their EMR that notified all staff of any resident that was on one-on-one supervision. The ADM reported that one-to-one supervision meant that the staff member would have no other duties and keep the resident within arm's reach at all times. The ADM also reported that Resident #13 was discharged on [DATE]. In an attempted interview on 12/02/24 at 3:18 p.m., a telephone call was made to LVN B and voicemail left. No return call received. In an interview and observation on 12/02/2024 at 5:22 p.m., the ADM reported that the DON and ADM were responsible for monitoring one-to-one supervision assignments and ensuring the one-on-one observation assignment sheets were completed. The ADM stated after the incident she checked the observation assignment sheets daily (even on the weekends) and would continue to monitor this way in the future. The ADM reported the nurses were responsible for monitoring the one-on-one staff. The ADM stated the notification that was added to the dashboard of their EMR after the incident notified all staff if a resident was placed on one-to-one monitoring. The ADM stated it displayed on the screen and could not be removed. Observed the ADM pull up the EMR dashboard and observed the notifications displayed at the top of the screen. The ADM reported that Resident #13 was discharged to a higher level of care. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the PIR dated 11/06/2024 listed Resident #13's level of supervision was within arm's length. PIR also revealed interventions taken immediately after the incident were that the EMR dashboard was updated to include notification of who was on one-to-one supervision, re-education on the one-to-one process was initiated with staff, and Resident #13 was discharged to a higher level of care. Record review of facility in-service dated 10/31/2024 revealed education titled One on One Education on 1 to 1 policy and procedure was attached to a sheet signed by staff members. In an interview on 12/02/2024 at 11:44 a.m., CNA F stated he received one-to-one training and would know if someone was on one-to-one supervision. CNA F stated he would know because staff would be with the resident and have a sign off sheet. CNA F stated there would also be a notification on PCC. In an interview on 12/02/2024 at 12:02 p.m., LVN E reported she had received training for one-to-one supervision and would know if a resident was on one-to-one supervision because it would say on PCC. LVN E stated a staff member would be assigned to them at all times and a sign off sheet must be completed. In an interview on 12/02/2024 at 1:30 p.m., LVN D reported he received training for one-to-one supervision that consisted of the notification on PCC, staying within arm's reach of the resident at all times, and signing an observation sheet. In an interview on 12/02/2024 at 3:27 p.m., LVN C stated that she had received lots of training for one-to-one supervision. LVN C stated that staff had to always remain next to the resident and sign the sign off sheet. LVN C stated PCC would also tell them if a resident was assigned to one-to-one training. In an interview on 12/02/2024 at 5:34 p.m., LVN G stated if a resident was on one-to-one supervision, then he would be told in report, and it should also tell you on PCC. LVN G stated he would monitor the resident even if another staff member was assigned to them, and the person assigned to the resident must stay next to them until relieved by another staff member. LVN G stated staff could not let the resident wander off, and an in-service for one-to-one monitoring had been completed. Review of facility education titled One on One Education on 1 to 1 policy and Procedure, undated, reflected 2. Staff member must transfer sign in sheet with resident and have that assignment only during the observation. 3. Staff member must transfer sign in sheet to their relief and not leave their post until that member has taken over the patient assignment. 4. Daily review of the sign in sheet to be completed by the DON or designee or administrator or designee.