STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676046	A. Building B. Wing	01/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Care Nursing & Rehabilitation	200 County Rd 616 Brownwood, TX 76802

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** 45458 Based on interview and record reviews, the facility failed to immediately consult with the resident's physician when there was a need to alter treatment significantly and a decision to discharge the resident from the facility to the hospital for 1 (Resident #1) of 3 residents reviewed for notification of changes. The facility failed to notify Resident #1's physician when Resident #1 was transferred and discharged to the hospital on 12/25/2024. This failure could place residents at risk of not having their change of condition communicated to their physician, delay of treatment, and a decline in the residents' health and well-being. The findings included: Record review of Resident #1's Facesheet, dated 01/01/2025, revealed Resident #1 was an [AGE] year-old female, with an admitted into the facility of 12/10/2024. Diagnoses included Unspecified systolic (congestive) heart failure (refers to a diagnosis of heart failure where the problem lies with the heart's ability to contract and pump blood effectively), Type II diabetes mellitus without complications (disease that occurs when the body does not use insulin properly, resulting in high blood sugar levels), Anemia with chronic kidney disease (occurs when the kidneys cannot produce enough erythropoietin (EPO), a hormone that signals the body to make red blood cells), and Essential (primary) hypertension (type of high blood pressure that develops gradually over time and no clear cause). Record review of Resident #1's Admission Minimum Data Set (MDS), dated [DATE], revealed Resident #1's BIMS score was 14, which indicated intact cognitive response. Record review of Resident #1's Progress Notes, dated 12/25/2024 at 10:44 p.m., documented by LVN B, revealed Resident #1, was sent to ER per resident request and family member request. Resident B/P continues to be high 199/80 with wrist cuff. Resident's B/P was 186/112 at 8:00 p.m., resident did not want to go to the ER at that time because she had been up and moving around, after the recheck, she called her family member and family member called the nurse home and told the nurse to send the resident to the ER, so the nurse went to the resident's room and told the resident her family member wanted her to go to the ER. (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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676046	A. Building B. Wing	01/08/2025

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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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 01/01/2025 at 12:20 p.m., Resident #1's family member said Resident #1 called her and reported her blood pressure was high and Resident #1 needed to go to the emergency room . Resident #1's family member said she called the facility and spoke with LVN B and requested Resident #1 be sent to the ER. During an interview on 01/07/2025 at 11:11 a.m., the Administrator said when a resident was sent out by ambulance to the emergency room , her expectation was for the nurse to notify the physician and follow the facility policy. The Administrator said the physician should have been notified when Resident #1's blood pressure was elevated and when Resident #1 was transported to theER on [DATE]. The Administrator said lack communication could delay medical treatment. During an interview on 01/07/2025 at 11:31 a.m., Physician E said he was not notified when Resident #1 was transported to the emergency room due to high blood pressure on 12/25/2024. Physician E said he learned of the transfer and hospital admission on 12/31/2024 when he was notified by the facility after the fact. Physician E said it was his expectation for the facility to call him when a resident had elevated blood pressure. During an interview on 01/07/2025 at 1:05 p.m., LVN B said she was on duty 12/25/2024 when Resident #1's blood pressure was elevated, and Resident #1 was sent out the ER. LVN B said she took Resident #1's blood pressure at approximately 8:30 p.m., and recorded Resident #1's blood pressure reading at 186/112. LVN B said Resident #1 told LVN B that she did not want to go to the emergency room at that time because Resident #1 said she had been up moving around in her room. LVN B said she informed Resident #1 she would return and recheck her blood pressure in a few minutes. LVN B said she left Resident #1's room then received a call from Resident #1's family member who demanded Resident #1 be sent to the ER. LVN B said she immediately called 911. LVN B said Resident #1's family member arrived at the facility prior to the ambulance and Resident #1 was transported to the ER. LVN B said she had determined prior to Resident #1's family member phone call and arrival that she was going to transfer Resident #1 out by ambulance. LVN B said at the time of the incident, Resident #1 had received medical treatment and she was not sure why she failed to contact the physician and report Resident #1 was sent to the ER. During an interview on 01/07/2025 at 3:47 p.m., the DON said she was aware the physician for Resident #1 was not notified when Resident #1 was sent to theER on [DATE] due to high blood pressure. The DON said the nurse on duty was responsible to contact the physician, but she should also follow-up to ensure all notifications were made. The DON said by not contacting the physician, a delay in treatment could occur. Record review of the facility's policy, Notifying the Physician of Change in Status, dated 03/11/2013, revealed, the nurse should not hesitate to contact the physician at any time when an assessment and their professional judgement deem it necessary for immediate medical attention. The nurse will notify the physician immediately with significant change in status. The will nurse will document signs and symptoms of significant change, time/date of call to physician, and interventions that were implemented in the resident's clinical record.