

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676100	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/03/2024
NAME OF PROVIDER OR SUPPLIER San Angelo Nursing and Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 5455 Knickerbocker Rd San Angelo, TX 76904	

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 0559</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to share a room with spouse or roommate of choice and receive written notice before a change is made.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41944</p> <p>Based on Observation, interview and record review the facility failed to ensure the resident the right to receive written notice, including the reason for the change, before the resident's room or roommate in the facility is changed for 1 Of 4 residents (Resident #1) reviewed for resident rights. Transfer and the reason for the transfer before the roommate was changed.</p> <p>Based on interview and record review the facility failed to ensure residents legal guardian had the right to be informed in advance, by the physician or other practitioner or professional, of the risks and benefits of proposed care, of treatment and treatment alternatives or treatment options and to choose the alternative or option he or she preferred for 1 of 1 resident (Resident #60) reviewed for resident rights.</p> <p>The facility failed to ensure the Social Worker told Resident #1's representative the reason for his room change following an incident with his roommate on 9/17/24.</p> <p>This failure could place resident's roommate at risk for not being aware of the reason for the change in rooms.</p> <p>Findings included:</p> <p>Record review of Resident #1's Face Sheet (Admission Record) dated 10/03/24 indicated a [AGE] year-old male admitted to the facility on [DATE]. Resident #1's medical history included muscle wasting, dementia, schizoaffective disorder (a mental health condition that includes schizophrenia symptoms, such as hallucinations and delusions, and mood disorder symptoms such as depression and mania), anxiety disorder, and major depressive disorder (depressed mood all or most of the time).</p> <p>Record review of Resident #1's Quarterly MDS assessment dated [DATE] indicated Resident #1 could usually be understood and could usually understand others. The MDS indicated the resident had a BIMS score of 00 which indicated severe cognitive impairment. The assessment indicated Resident #1 displayed physical behaviors directed toward others and did not reject care. The assessment also indicated Resident #1 was dependent on one to two people for moving to and from lying position, turning side to side, and body positioning. Resident #1 was dependent on one to two people for toileting and bathing and was always incontinent of urine and bowel.</p> <p>Record review of Social Worker progress notes indicated the following:</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
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<p>F 0559</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-9/17/24 at 5:03 PM Social Worker documented Resident #1's guardian was notified of resident room move. He will be in</p> <p>-9/20/24 the Social Worker documented Resident #1 moved to another room due to current roommate sprinkling him with water due to him making a sucking noise. CNA A reported to the DON and administrator. All parties notified; resident moved to another room.</p> <p>Record review of the provider 5-day investigation report dated 9/18/24 revealed the incident occurred on 9/18/24.</p> <p>Record review of Nursing Progress notes indicated the following:</p> <p>-10/3/24 at 11:40 AM documented notified the guardian of Resident #1 and apologized. The nurse spoke with the guardian to explain what the initial reason for the move of the resident was. Resident #1's roommate stated to a CNA A he throws water on Resident # 1's face to train him like a dog.</p> <p>In an observation on 10/1/24 at 11:00 AM revealed Resident #1 was Sitting in the hallway in his wheelchair with his head bent forward. He did not respond to the surveyor. He did not seem shy away from staff or the surveyor.</p> <p>During an interview with Resident #1's Guardian on 10/3/24 at 9:06 AM she stated she had not been notified of the incident of alleged abuse as the reason for the room change for Resident #1. The Guardian stated she was notified by the Social Worker on 9/17/24, that they wanted to try Resident #1 in another room but was not given the specifics as to why. The Guardian was aware that several facilities are moving patients for a variety of reasons and advised that the guardian did not feel the move would work out but that they could try it and see how it went. The guardian was not told this was due to the present roommate bullying Resident #1.</p> <p>During an interview with the Social Worker on 10/3/24 at 9:30 AM she said she was informed by the DON that she should call the guardian of Resident # 1 to get permission for a room change, but the DON did not say why they were doing the room change until later in the afternoon. She stated she did not notify the Guardian of the alleged incident between Resident # 1 and his roommate. She stated she would have told the Guardian if she had been informed of the situation. She stated a negative outcome for the resident would be that he would remain in that situation if the Guardian did not give permission for the move.</p> <p>During an interview with the DON on 10/03/24 at 10:00 AM she said the guardian should be notified per facility policy for changes of condition, or a change in the president's plan of care. She stated she thought the Social Worker had notified the guardian of the situation because she thought she was aware of the reason for the move. She stated she should have monitored to ensure that the guardian was informed of the reason for the move.</p> <p>Review of Texas Human Resources Code Section 102.003</p> <p>Sec. 102.003. RIGHTS OF THE ELDERLY. (a) An elderly individual has all the rights, benefits, responsibilities, and privileges granted by the constitution and laws of this state and the United States, except where lawfully restricted. The elderly individual has the right to be free of interference, coercion, discrimination, and reprisal in exercising these civil rights.</p> <p>(continued on next page)</p>		

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<p>F 0559</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>(b) An elderly individual has the right to be treated with dignity and respect for the personal integrity of the individual, without regard to race, religion, national origin, sex, age, disability, marital status, or source of payment. This means that the elderly individual:</p> <p>(1) has the right to make the individual's own choices regarding the individual's personal affairs, care, benefits, and services.</p> <p>(2) has the right to be free from abuse, neglect, and exploitation; and</p> <p>(3) if protective measures are required, has the right to designate a guardian or representative to ensure the right to quality stewardship of the individual's affairs.</p> <p>Review of the policy titled Notification of changes, not dated, stated the following in part:</p> <p>The facility will immediately inform the resident and consult with the resident's physician, if appropriate, when changes occur. If known, the facility shall also notify the resident's physician if appropriate and the legal guardian or an interested family member.</p> <p>Notification of change shall include an accident involving the resident A significant change in the resident's mental or psychosocial status such as a deterioration in health mental or psychosocial status, a decision to transfer or discharge a resident, or a change in roommate assignment</p>

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41944</p> <p>Based on interview, and record review the facility failed to ensure Residents were free from abuse a 1 of 6 residents (Resident #1) reviewed for abuse.</p> <p>1. The facility to protect Resident #1 from Resident #2 pouring water on Resident #1 when he annoyed him.</p> <p>The deficient practices could affect any resident and contribute to further abuse or neglect.</p> <p>Findings included:</p> <p>Record review of Resident #1's Face Sheet (Admission Record) dated 10/03/24 indicated a [AGE] year-old male admitted to the facility on [DATE]. Resident #1's medical history included muscle wasting, dementia, schizoaffective disorder (a mental health condition that includes schizophrenia symptoms, such as hallucinations and delusions, and mood disorder symptoms such as depression and mania), anxiety disorder, and major depressive disorder (depressed mood all or most of the time).</p> <p>Record review of Resident #1's Quarterly MDS assessment dated [DATE] indicated Resident #1 could usually be understood and could usually understand others. The MDS indicated the resident had a BIMS score of 00 which indicated severe cognitive impairment. The assessment indicated Resident #1 displayed physical behaviors directed toward others and did not reject care. The assessment also indicated Resident #1 was dependent on one to two people for moving to and from lying position, turning side to side, and body positioning. Resident #1 was dependent on one to two people for toileting and bathing and was always incontinent of urine and bowel.</p> <p>Record review of the facility reported investigation worksheet and the provider 5-day investigation report dated 9/18/24 revealed the incident occurred on 9/17/24 and that Resident #1 was moved to another room on another hall. The incident was reported by CNA A.</p> <p>Record review of Resident 2's Face Sheet (Admission Record) dated 10/02/24 indicated a [AGE] year-old male admitted to the facility on [DATE]. Resident #2's medical history included dementia with agitation depression and mania, anxiety disorder, diabetes (condition causing increased levels of glucose in the blood which can affect multiple body systems) and high blood pressure.</p> <p>Record review of Resident #2's Quarterly MDS assessment dated [DATE] indicated Resident #2 could be understood and could understand others. The MDS indicated the resident had a BIMS score of 15 which indicated he was cognitively intact. The assessment indicated Resident #2 displayed no behaviors directed toward others and did not reject care. The assessment also indicated Resident #2 used a wheelchair and required maximum assistance to walk ten feet. Resident #2 was independent moving to and from lying position, turning side to side, and body positioning. Resident #2 required minimal or touch assistance of one person for toileting and bathing and was always incontinent of bowel and had a urinary catheter.</p> <p>Record review of Social Worker progress notes indicated the following:</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-9/20/24 the Social Worker documented Resident #1 moved to another room due to current roommate Resident #2 sprinkling him with water due to him making a sucking noise. CNA A reported to the DON and administrator. All parties notified; resident moved to another room.</p> <p>Observation on 10/1/24 at 11:00 AM revealed Resident #1 was Sitting in the hallway in his wheelchair with his headbent forward. He did not respond to the surveyor.</p> <p>In an interview with CNA A on 9/26/24 at 1:50 PM he stated he reported to the LVN C that Resident #2 told him he sprinkled water in the face of Resident #1 to train him like a dog immediately after it was told to him by Resident #2.</p> <p>In an interview with CNA B on 9/26/24 at 1:40 PM and on 10/1/24 at 3:00 PM, she stated she suspected Resident #2 had poured water on Resident #1 multiple times and she stated she reported her concerns when Administrator called her to investigate the incident. She stated she has never seen him treat anyone else in an abusive manner. CNA B stated she told LVN C about it when she found Resident #1 wet one time. She stated she could not remember when that was and could not give a date or how many times.</p> <p>In an interview with LVN C at 3:00 PM he stated he had not been told of an allegation of abuse to Resident #1 by CNA B. He stated CNA A told him, and he reported it to the administrator who is also the abuse coordinator.</p> <p>In an interview with the Administrator on 10/01/24 3:45 PM. The administrator stated CNA B did not report to him she witnessed abuse or had suspicions of abuse toward Resident #1 by his roommate. He stated his expectation was that suspicion of abuse or allegations of abuse be reported to him immediately. He stated she had been reprimanded and terminated for not reporting immediately. He stated that Resident #2 had been issued a 30-day discharge notice earlier in the month and after talking with CNA B regarding her allegations of abuse Resident #2 was discharged today (10/1/24) with medications and home health and APS was notified. He stated an Inservice had been started on immediate reporting of allegations of suspected abuse or neglect. He stated it was his responsibility to monitor and ensure the facility is doing all that is within control to prevent occurrences of abuse and neglect.</p> <p>Review of the facility's policy Abuse and Neglect Policy and Procedure, not dated stated in part:</p> <p>The Administrator and designee is responsible for maintaining all facility policies that prohibit abuse and neglect to include the following: training of employees, investigation of allegations , and prevention of occurrences.</p>		

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<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement policies and procedures to prevent abuse, neglect, and theft.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41944</p> <p>Based on observation, interview, and record review the facility failed to ensure all alleged violations involving abuse are reported immediately to the Administrator of the facility for 1 of 6 residents (Resident #1) reviewed for abuse.</p> <p>1. CNA B failed to immediately report her suspicions of abuse when she found Resident #1 Wet .</p> <p>The deficient practices could affect any resident and contribute to further abuse or neglect.</p> <p>Findings included:</p> <p>Record review of Resident #1's Face Sheet (Admission Record) dated 10/03/24 indicated a [AGE] year-old male admitted to the facility on [DATE]. Resident #1's medical history included muscle wasting, dementia, schizoaffective disorder (a mental health condition that includes schizophrenia symptoms, such as hallucinations and delusions, and mood disorder symptoms such as depression and mania), anxiety disorder, and major depressive disorder (depressed mood all or most of the time).</p> <p>Record review of Resident #1's Quarterly MDS assessment dated [DATE] indicated Resident #1 could usually be understood and could usually understand others. The MDS indicated the resident had a BIMS score of 00 which indicated severe cognitive impairment. The assessment indicated Resident #1 displayed physical behaviors directed toward others and did not reject care. The assessment also indicated Resident #1 was dependent on one to two people for moving to and from lying position, turning side to side, and body positioning. Resident #1 was dependent on one to two people for toileting and bathing and was always incontinent of urine and bowel.</p> <p>Record review of the facility reported investigation worksheet and the provider 5-day investigation report dated 9/18/24 revealed the incident occurred on 9/17/24 and that Resident #1 was moved to another room on another hall. The incident was reported by CNA A.</p> <p>Record review of Resident 2's Face Sheet (Admission Record) dated 10/02/24 indicated a [AGE] year-old male admitted to the facility on [DATE]. Resident #2's medical history included dementia with agitation depression and mania, anxiety disorder, diabetes (condition causing increased levels of glucose in the blood which can affect multiple body systems) and high blood pressure.</p> <p>Record review of Resident #2's Quarterly MDS assessment dated [DATE] indicated Resident #2 could be understood and could understand others. The MDS indicated the resident had a BIMS score of 15 which indicated he was cognitively intact. The assessment indicated Resident #2 displayed no behaviors directed toward others and did not reject care. The assessment also indicated Resident #2 used a wheelchair and required maximum assistance to walk ten feet. Resident #2 was independent moving to and from lying position, turning side to side, and body positioning. Resident #2 required minimal or touch assistance of one person for toileting and bathing and was always incontinent of bowel and had a urinary catheter.</p> <p>Record review of Social Worker progress notes indicated the following:</p> <p>(continued on next page)</p>		

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<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-9/20/24 the Social Worker documented Resident #1 moved to another room due to current roommate Resident #2 sprinkling him with water due to him making a sucking noise. CNA A reported to the DON and administrator. All parties notified; resident moved to another room.</p> <p>Observation on 10/1/24 at 11:00 AM revealed Resident #1 was Sitting in the hallway in his wheelchair with his headbent forward. He didnot respond to the</p> <p>In an interview with CNA A on 9/26/24 at 1:50 PM he stated he reported to the LVN C that Resident #2 told him he sprinkled water in the face of Resident #1 to train him like a dog immediately after it was told to him by Resident #2.</p> <p>In an interview with CNA B on 9/26/24 at 1:40 PM and on 10/1/24 at 3:00 PM, she stated she suspected Resident #2 had poured water on Resident #1 multiple times and she stated she reported her concerns when Administrator called her to investigate the incident. She stated she has never seen him treat anyone else in an abusive manner. CNA B stated she told LVN C about it when she found Resident #1 wet one time. She stated she could not remember when that was and could not give a date or how many times.</p> <p>In an interview with LVN C at 3:00 PM he stated he had not been told of an allegation of abuse to Resident #1 by CNA B. He stated CNA A told him, and he reported it to the administrator who is also the abuse coordinator.</p> <p>In an interview with the Administrator on 10/01/24 3:45 PM. The administrator stated CNA B did not report to him she witnessed abuse or had suspicions of abuse toward Resident #1 by his roommate. He stated his expectation was that suspicion of abuse or allegations of abuse be reported to him immediately. He stated she had been reprimanded and terminated for not reporting immediately. He stated that Resident #2 had been issued a 30-day discharge notice earlier in the month and after talking with CNA B regarding her allegations of abuse Resident #2 was discharged today (10/1/24) with medications and home health and APS was notified. He stated an Inservice had been started on immediate reporting of allegations of suspected abuse or neglect. He stated it was his responsibility to monitor and ensure the facility is doing all that is within control to prevent occurrences of abuse and neglect.</p> <p>Review of the facility's policy Abuse and Neglect Policy and Procedure, not dated stated in part:</p> <p>The Administrator and designee is responsible for maintaining all facility policies that prohibit abuse and neglect to include the following: training of employees, investigation of allegations , and prevention of occurrences.</p>		