STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676133	A. Building B. Wing	04/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Maverick Nursing and Rehabilitation Center	3106 Bob Rogers Dr Eagle Pass, TX 78852

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48753 Based on record review and interview, the facility failed to ensure residents have the right to formulate an advance directive and determine the choice to receive or not receive CPR (cardiopulmonary resuscitation) for 1 of 6 residents (Resident #6) reviewed for advanced directives in that: Resident #6 did not have advance directives documented in the admission agreement or electronic medical record from the date of admission, [DATE], to discharge date , [DATE]. This deficient practice could affect residents admit to the facility and place them at risk of not having their wishes known, which could delay emergency treatment. Findings included: Review of Resident #6's face sheet dated revealed he was a [AGE] year-old male was admitted into the facility on [DATE] with diagnoses including Alzheimer's Disease. Review of Resident #6's consolidated orders for [DATE] revealed resident had an order for Full Code status, initiated [DATE]. Review of Resident #6's admission care plan, initiated [DATE], revealed the resident had no advanced directives and no advanced directive care planning had been scheduled with the resident's representative. Review of Resident #6's record revealed the resident's representative did not sign the facility admission agreement that discusses advanced directives prior to admission or after the resident's admission to the facility. (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

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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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on [DATE] at 10:22 a.m. with the Admissions Director revealed she met with the resident representative prior to admission and told the representative the admissions packet needed to be completed. She said she did not get the admission agreement signed prior to or during the residents stay at the facility. She said she tries to complete admissions packets with residents or their representatives prior to admission or the day they admit. She said the importance of doing this is so the facility has consent to treat and to establish advanced directives. She stated the company policy is to have admission agreement completed within 24 to 48 hours of admission. She further stated the advanced directive declination page of the admissions agreement is provided to nursing and the facility Social Worker once completed. Interview on [DATE] at 10:40 am with the facility Social Worker revealed an advanced directive discussion was not completed with the resident representative. The Social Worker stated he was on vacation the week the resident admitted , and the resident was discharged prior to his return from vacation. The Social Worker stated the MDS Nurse may be responsible for his duties when he was not at the facility. The Social Worker stated the importance of discussing advanced directives with the resident or their representative was to respect each resident's rights. Furthermore, he stated he has received training on advanced directives from his corporate Social Worker. Interview on [DATE] at 3:00 pm with the facility DON revealed the facility Social Worker and Admissions Director are responsible for discussing advanced directives with the resident or the representative prior to or at the time of admission. He stated the nursing department was notified about a resident's advanced directive preferences from the Admission Director or Social Worker. He stated if the Social Worker was not at the facility, one of the nurse managers should address advanced directives. He stated the MDS Nurse just started the week before and acknowledged none of the nurse managers discussed advanced directives with the resident or his representative. Review of the facility's admission policy, revised [DATE], revealed a document titled Facility Internal Patient Self-Determination Checklist Texas . The checklist reflects a list of advanced directive types along with checkboxes for resident has, provided a copy to the facility and would like to obtain. Review of the facility advanced directives care planning policy, revised ,d+[DATE], stated, this facility respects the rights of individuals to make their own end-of-life treatment decisions regarding health care and this facility will document in the resident's clinical record whether the resident has executed an Advance Directive. Copies of executed directives shall be maintained in the resident's clinical record.