STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676176	A. Building B. Wing	08/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Crowley Nursing and Rehabilitation	920 E Fm 1187 Crowley, TX 76036

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 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48236 Based on interview and record review the facility failed to permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless the discharge was necessary for the resident's welfare and the resident's needs could not be met in the facility for two of nine residents (Residents #1 and #2) reviewed for discharge requirements. The facility failed to ensure documentation was made by the physician for the basis of Resident #1's discharge and/or the specific resident needs that could not be met by the facility. These failures could place residents at risk of being discharged without a safe and effective transition of care, an accurate reason for discharge and inaccurate information communicated to the receiving health care institution or provider. Findings included: 1. Record review of Resident #1's Admission Record dated 08/15/24 reflected Resident #1 was an [AGE] year-old female with an original admitted [DATE]. Record review of Resident #1's MDS assessment dated [DATE] reflected the resident had the following diagnoses non-Alzheimer's dementia, hypertension, renal insufficiency, hyperlipidemia, anxiety, and depression. The MDs assessment reflected the resident had severe cognitive impairment with a BIMS score of 5, and the resident had verbal behavioral symptoms directed toward others 1-3 days per week. Record review of Resident #1's undated care plan reflected: Goal . Resident will not verbally abuse others. The care plan did not reflect a date or incident of physical aggression. The care plan only reflected information about verbal aggression. Record review of Resident #1's care plan conference summary dated 05/01/24 revealed, Mood/Behavior-Pleasant and appropriate/easily agitated. (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
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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 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident # 1's Progress Note dated 07/10/24 at 12:34 PM by ADON A revealed, Resident was in WC on 100 hall wheeling from dining room to her room and saw another resident sitting in her WC in her door way. Resident #1 took her shoe off and hit the other resident on both arms. The other resident started yelling. The other resident [sic] to BOM office and reported incident. Resident #1 placed on one on one with staff. MD, ADMIN, DON, RP notified. Record review of Resident #1's Progress Note dated 07/10/24 at 9:07 PM by LVN C revealed, Resident discharged to home this evening. Picked up by her [family member] Resident discharged with her medications and took with all her belongings. Record review of the Incident Report dated 07/10/24 at 12:30 PM by ADON A revealed, Head to toe assessment done and no marks of any kind noted on this resident as of yet No injuries post incident. Further review of Resident #1' clinical records revealed there was no physician's documentation related to the basis for the discharge, specific resident needs that could not be met by the facility, attempts to meet the resident's needs and/or services that would be available at the receiving facility to meet the resident's needs. Interview on 08/14/24 at 1:10 PM with Resident #1's POA and husband revealed they received a phone message voicemail from the BOM on 07/10/24 in the afternoon. When the POA and her husband returned the phone call later that afternoon, they were told the facility had faxed out referrals to other nursing facilities because Resident #1 was a danger to others. They were also informed another facility accepted her, and they would be transferring her later that day. The POA stated they would not allow the facility to transfer their mother without visiting the facility first. The POA and her husband went to the facility and picked up Resident #1 that evening and took her home with them. Interview on 08/15/24 at 12:58 PM with LVN E revealed she had worked at the facility four years. LVN E also revealed she had been Resident's #1's nurse previously when she worked the secured unit. LVN E stated that Resident #1 was verbally aggressive. LVN E said that the incident that occurred on 07/10/24 was the only incident involved Resident #1 hitting another resident. LVN E also revealed Resident #1 had improved and was transferred from the secured unit to Hall 100. Resident #1 had been on her hall about 3-4 months. LVN E stated she did not believe they would transfer Resident #1 off the secured unit if she had physical aggression toward other residents. Interview on 08/15/24 at 1:20 PM with CNA D revealed she had provided care to Resident #1. CNA D stated the resident was verbally aggressive with residents and staff, but she had not known Resident #1 to hit a resident before this incident. Interview on 08/15/24 at 2:20 PM with the BOM revealed she was the highest level of management in the building when the incident occurred with Resident #1. The BOM stated she contacted the Administrator about the incident when it occurred. The BOM also said that to her knowledge, no injury occurred to the resident that Resident #1 struck with her shoe. The BOM also revealed after informing the Administrator of the incident involving Resident #1, the Administrator stated to discharge the resident. The BOM stated he called and left a message for the POA. The BOM said the POA returned the call and said she would come and pick up the resident because she did not want Resident #1 discharged to a facility that day that she had no knowledge about and had not seen. The BOM said that Resident #1 had not been physically aggressive to other residents to her knowledge. (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 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 08/15/24 at 3:54 PM with ADON B revealed she provided care to Resident #1. ADON B stated Resident #1 was verbally aggressive when she was on the unit, but Resident #1 was not physically aggressive toward other residents. ADON B concluded by stating that she had seen other residents hit other residents with no resulting injury, but they were not discharged . Those residents had care planned interventions, such as separating the residents before there was a discharge discussed. Interview on 08/15/24 at 5:30 PM with the DON revealed she did not work at the facility at the time of the incident. There was another DON at the time of the incident. However, the DON was not in the building and was away on vacation at the time. The DON stated there should have been a care plan meeting to reduce future incidents involving psych, medical, and any testing that could rule out any behavioral issues and possibly moving her to a different hall before enforcing an immediate discharge. The DON also stated that if these measures did not help the resident, then the facility could examine possibly moving her to a different hall. Then the DON said that if this did not help, then the facility could look at moving Resident #1 back to the secured unit. The DON could not locate the 48-hour discharge notice that she acknowledged should be in the EHR. The DON also could not locate a physician's note stating Resident #1 was a harm to herself or others. The DON stated the risk to the resident of an unsafe discharge was the resident does not have proper resources set up. Interview on 08/15/24 at 6:04 PM with the Administrator revealed he was on vacation when Resident # 1 was discharged . The Administrator stated that he was not aware that the resident was discharged so quickly, meaning the same day as the incident occurred. The Administrator also stated they typically issue a formal discharge and do not discharge a resident the same day as the incident occurs. The Administrator said that recently there was past physical aggression on the secured unit, so he reacted too quickly to discharge Resident #1. The Administrator also revealed that they did not have a letter from the Medical Director stating that Resident #1 was a threat to herself or others and was unaware that was needed. The Administrator stated because their policy was not followed, there were not resources set up for the resident prior to discharge, therefore creating a risk to the resident's physical and mental health. 2. Record review of Resident #2's Admission Record dated 08/15/24 reflected Resident #2 was an [AGE] year-old male with an original admitted [DATE]. Record review of Resident #2's MDS assessment dated [DATE] revealed the resident had diagnoses of Alzheimer's disease, muscle weakness, cognitive communication deficit, difficulty in walking, and repeated falls. The MDS reflected the resident had moderate cognitive impairment with a BIMS score of 11 and had no behavioral symptoms. Record review of Resident #2's undated care plan revealed no focus, goals, or interventions related to physical aggression or sexual inappropriateness. Record review of Resident #2's Notice of Proposed Transfer w Discharge (Texas) dated 06/03/24 revealed that the transfer/discharge to home with [family member] Effective: 6/5/24. The document also revealed Reason for proposed Transfer/discharge Safety of individuals in the facility is endangered. This was issued as a 48-hour emergency discharge on 06/03/24. (continued on next page)

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Crowley Nursing and Rehabilitation	920 E Fm 1187 Crowley, TX 76036

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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 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #2's Progress Notes dated 05/31/24 at 3:20 PM written by ADON A reflected: Staff member reported to this staff member [sic] reported to this nurse that she observed resident touching another resident's breast. When asked this resident stated that he doesn't remember if he touched her breast or not. He then stated that his memory isn't that good. The residents were separated. Admin, DON, MD, RP for both residents notified. This resident placed on one on one with staff. Record review of Resident #2's Progress notes dated 05/31/24 at 10:32 PM written by the Social Worker reflected: .POA .was open to alternative placement but did not want to take the resident home. SW sent out residents clinicals to multiple different facilities and awaits answer. Resident remains on one on one. Record review of Resident #2's Progress Notes dated 06/04/24 at 9:09 AM written by LVN F reflected: Resident continues on 1:1 for behaviors. Some tearfulness noted this morning R/T upcoming discharge home. Resident says, 'I will miss everyone.' Resident verbally consoled by staff. Record review of Resident #2's Progress Notes dated 06/05/24 at 11:00 PM written by LVN D reflected: Resident discharged home with [family member] with meds and all personal belongings in good condition Further review of Resident #2's clinical records reflected there was no physician's documentation related to the basis for the discharge, specific resident needs that could not be met by the facility, attempts to meet the resident's needs and/or services that would be available at the receiving facility to meet the resident's needs. Interview on 08/15/24 at 12:53 PM with LVN G revealed she never saw Resident #2 touch a resident inappropriately, and she did not believe that he did. LVN G said she never heard Resident #2 talk inappropriately to a resident either. Interview on 08/15/24 at 1:27 PM with CNA D revealed she never saw Resident #2 sexually aggressive or inappropriate with a resident. CNA D also said she never saw Resident #2 be physically aggressive toward residents either. Interview on 08/15/24 at 1:31 PM with Laundry Aide H revealed she observed Resident #2 with his hand on a female's breast on the outside of her shirt. Laundry Aide H stated Resident #2 dropped his hand when he was observed by her. She stated she had never seen Resident #2 touch another resident inappropriately prior to this incident. She said she reported the incident immediately to administration. Interview on 08/15/24 at 4:03 PM with ADON B revealed she was Resident #2's nurse previously. ADON B stated she had not heard of Resident #2 touching a resident inappropriately prior to this incident. ADON B also said residents in the past would have interventions put in place before discharge, such as being placed on a secured unit. (continued on next page)

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 08/15/24 at 5:02 PM with the DON revealed she did not work at the facility at the time of the incident. There was another DON at the time of the incident. The DON stated she had never seen the resident be physically or sexually aggressive toward other residents. The DON also stated that before you discharge a resident, you should attempt interventions. The DON said that possible interventions that could have been attempted were separating and relocating the residents involved in an incident. The DON said one on one was a possible intervention. The DON was unable to locate a note from the physician stating that the resident was a harm to himself or others. The DON revealed that she was unaware of the discharge policy. The DON concluded by stating that there was risk of harm to the resident when there is an unsafe discharge. Interview on 08/15/24 at 6:19 PM with the Administrator revealed there was not a letter from the physician or medical director stating that Resident #2 was a harm to himself or others The Administrator revealed that he determined when a resident should be discharged without consulting the medical director or the resident's physician. The administrator stated that if he deemed a resident a threat to themselves or others, he issued a discharge notice. The Administrator also revealed that no one oversaw this process or monitored the process. The Administrator stated because their policy was not followed, there was a possibility of risk to the resident's physical and mental health. Review of the facility's Transfer or Discharge Documentation policy and procedure, dated December 2016, reflected: When a resident is transferred or discharged , details of the transfer or discharge will be documented in the medical record and appropriate information will be communicated to the receiving health care facility or provider .the following information will be documented in the medical record .If the resident is being transferred or discharged because his or her needs cannot be met at the facility, documentation will include . the specific resident needs that cannot be met; the facility attempt to meet those needs; and the receiving facility services(s) that are available to meet those needs .A summary of the resident's overall medical, physical and mental condition .Should the resident be transferred or discharged for any of the following reason, the basis for the transfer or discharge will be documented in the resident's clinical record by the resident's Attending Physician: The transfer or discharge is necessary for the resident's welfare, and resident's needs cannot be met in the facility .The safety of individuals in the facility is endangered due to the clinical or behaviors status of the resident; or the health of individuals in the facility would otherwise be endangered .Information will be communicated to the receiving facility or provider .The basis for the transfer or discharge .The specific resident needs that cannot be met; the facility's attempt to meet those needs; and the receiving facility's services that are available to meet those needs .Contact information of the practitioner responsible for the care of the resident .Comprehensive care plan goals; and all other necessary information, including a copy of the resident's discharge summary, and any other documentation, as applicable, to ensure a safe and effective transition of care.

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48236 Based on interview and record review, the facility failed to notify the resident, resident representative and send a copy to the Office of the State Long-Term Care Ombudsman, of the transfer or discharge and the reasons for the move in writing and in a language and manner they understood for one of nine residents (Resident #1) reviewed for discharge rights. 1. The facility initiated an emergency discharge for Resident #1 due to safety concerns by notifying the resident's RP by phone only and not in writing. The facility failed to provide Resident #1 an emergency discharge letter with the required information and resources, including discharge instructions with plan of care. 2. The facility failed to notify the State Long-Term Care Ombudsman by phone or in writing of Resident #1's discharge. These failures could place residents at risk of not receiving preparation and knowing their rights related to discharge, as well as necessary services to meet their needs upon discharge, which could exacerbate their medical condition and a diminished quality of life. Findings included: Record review of Resident #1's Admission Record dated 08/15/24 reflected Resident #1 was an [AGE] year-old female with an original admitted [DATE]. Record review of Resident #1's MDS assessment dated [DATE] revealed the resident had the following diagnoses: non-Alzheimer's dementia, hypertension, renal insufficiency, hyperlipidemia, anxiety, and depression. The MDS reflected the resident had severe cognitive impairment with a BIMS score of 5 and had verbal behavioral symptoms directed toward other 1-3 days per week. Record review of Resident #1's EHR on 08/15/24 revealed no Notice of Proposed Transfer Discharge (Texas). Record review of Resident #1's EHR on 08/15/24 also reflected no documentation indicating notifications was made to the State Long-Term Care Ombudsman either by phone or in writing of Resident #1's emergency discharge. Record review of Resident #1's undated care plan reflected: Goal . Resident will not verbally abuse others. Care plan did not reflect a date or incident of physical aggression. The care plan only reflected information about verbal aggression. Record review of Resident #1's care plan conference summary dated 05/01/24 reflected: Mood/Behavior-Pleasant and appropriate/easily agitated. Record review of Resident # 1's Progress Note dated 07/10/24 at 12:34 PM by ADON A reflected: (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 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident was in WC on 100-hall wheeling from dining room to her room and saw another resident sitting in her WC in her doorway. Resident #1 took her shoe off and hit the other resident on both arms. The other resident started yelling. The other resident[sic] to BOM office and reported incident. Resident #1 placed on one on one with staff. MD, ADMIN, DON, RP notified. Record review of Resident #1's Progress note dated 07/10/24 at 9:07 PM by LVN C reflected: Resident discharged to home this evening. Picked up by her [family member] Resident discharged with her medications and took with all her belongings. Record review of the Incident Report dated 07/10/24 at 12:30 PM by ADON A reflected: Head to toe assessment done and no marks of any kind noted on this resident as of yet No injuries post incident. Further review of Resident #1' clinical records reflected there was no physician's documentation related to the basis for the discharge, specific resident needs that could not be met by the facility, attempts to meet the resident's needs and/or services that would be available at the receiving facility to meet the resident's needs. Interview on 08/14/24 at 1:10 PM with Resident #1's POA revealed they received a phone message from the BOM. When she and her husband returned the phone call, they were told the facility was faxing out referrals to other nursing facilities because Resident #1 was a danger to others. They were also informed that another facility accepted her, and they would be transferring her immediately that day. The POA stated they would not allow the facility to transfer their mother without visiting the facility. The POA and her husband went to the facility and picked up Resident #1 that evening. Interview on 08/15/24 at 12:58 PM with LVN E revealed she had worked at the facility four years. LVN E also revealed she had been Resident's #1's nurse previously when she worked the secured unit. LVN E stated Resident #1 was verbally aggressive. LVN E said the incident that occurred on 07/10/24 was the only incident that involved Resident #1 hitting another resident. LVN E also revealed Resident #1 had improved and was transferred from the secured unit to Hall 100. Resident #1 had been on her hall about 3-4 months. LVN E stated she did not believe that they would transfer Resident #1 off the secured unit if she had physical aggression toward other residents. Interview on 08/15/24 at 1:20 PM with CNA D revealed she had provided care to Resident #1. CNA D stated the resident was verbally aggressive with residents and staff, but she had not known Resident #1 to hit a resident before this incident. Interview on 08/15/24 at 2:20 PM with the BOM revealed she was the highest level of management in the building when the incident occurred with Resident #1. The BOM stated she contacted the Administrator about the incident when it occurred. The BOM also said to her knowledge, no injury occurred to the resident that Resident #1 struck with her shoe. The BOM also revealed after informing the Administrator of the incident involving Resident #1, the Administrator stated to discharge the resident. The BOM stated she called and left a message for the POA. The BOM said the POA returned the call and said she would come and pick up the resident because she did not want Resident #1 discharged to a facility that day that she had no knowledge about and had not seen. The BOM said Resident #1 had not been physically aggressive to other residents to her knowledge. (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 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 08/15/24 at 3:54 PM with ADON B revealed she provided care to Resident #1. ADON B stated Resident #1 was verbally aggressive when she was on the unit. ADON B said that Resident #1 was not physically aggressive toward other residents. ADON B concluded by stating that she had seen other residents hit other residents with no resulting injury, but they were not discharged . Those residents had care planned interventions such as separating the residents before there was a discharge discussed. Interview on 08/15/24 at 5:30 with the DON revealed she did not work at the facility at the time of the incident. There was another DON at the time of the incident. However, the DON was not in the building and was away on vacation at the time. The DON stated there should have been a care plan meeting to reduce future incidents involving psych, medical, and any testing that could rule out any behavioral issues and possibly moving her to a different hall before enforcing an immediate discharge. The DON also stated if these measures did not help the resident, then the facility could examine possibly moving her to a different hall. Then the DON said that if this did not help, then the facility could look at moving Resident #1 back to the secured unit. The DON could not locate the 48-hour discharge notice that she acknowledged should be in the EHR. The DON also could not locate a physician's note stating Resident #1 was a harm to herself or others. The DON stated the risk to the resident of an unsafe discharge was the resident does not have proper resources set up. Interview on 08/15/24 at 6:04 PM with the Administrator revealed he was on vacation when Resident #1 was discharged . The Administrator stated he was not aware that the resident was discharged so quickly, meaning the same day as the incident occurred. The Administrator also stated they typically issue a formal discharge and do not discharge a resident the same day as the incident occurs. The Administrator said recently there was past physical aggression on the secured unit, so he reacted too quickly to discharge Resident #1. The Administrator also revealed they did not have a letter from the Medical Director stating that Resident #1 was a threat to herself or others and was unaware that was needed. The Administrator stated because their policy was not followed, there were not resources set up for the resident prior to discharge, therefore creating a risk to the resident's physical and mental health. Review of the facility's current, undated Transfer and Discharge policy and procedure reflected: (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Purpose: To ensure that residents are transferred and discharged from the facility in compliance with state and federal laws and to provide complete, safe, and appropriate discharge planning and necessary information to the continuing care provider .Policy: 1. The facility may transfer or discharge a resident for the following reasons: .C. The safety of the individuals in the Facility is endangered by the resident's presence; . IV .Situations that may prevent 30 days' notice include: A. The resident poses a threat to the health or safety of other individuals at the Facility; V. Cases in which 30 days' notice is not possible, notice of transfer or discharge should be provided to the resident of his/her responsible party as soon as practicable; .Procedure: . IV. The Facility may use Notice of Transfer/Discharge or another comparable form to provide the resident or his/her personal representative with advanced notice of the transfer or discharge. The notice will include the following information: A. The reason the resident is being transferred/discharged , B. The effective date of the transfer/discharge; C. The name, complete address and telephone number to which the resident is being transferred, D. A statement that the resident has the right to appeal the action to the state, contact information for the state entity which receives appeal hearing requests, and information on who to request and appeal, E. The name, address, and telephone number of the State Long Term Care Ombudsman .XIV. Documentation: When a resident is transferred/discharged , Social Services Staff include a copy of the written notice of transfer/discharge provided to the resident in his/her personal representative in the resident's medical record; E/ Proper to discharging the resident, the Facility will prepare a Discharge Summary and will document the summary in the resident's medical record. At a minimum, the Discharge Summary will contain a summary of the resident's status, including a description of the resident's: i. Medically defined condition(s) and prior medical history; ii. Medical status measurement ., iii. Physical, mental, psychosocial functional status ., iv. Sensory and physical impairments ., v. Nutritional status and requirements, vi. Special treatments or procedures, vii. Discharge potential, viii. Dental condition, ix. Ability to participate in activities, x. Rehabilitation potential, xi. Cognitive status, xii. Drug therapy; .H. The medical record will contain written documentation from a Physician if the resident is transferred/discharged because: i. The safety of individuals in the Facility is endangered by the resident's presence; .I. The resident or his/her representative will be provided with a copy of the Discharge Care Plan and Discharge Summary.

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F 0624 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prepare residents for a safe transfer or discharge from the nursing home. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48236 Based on interview and record review, the facility failed to provide and document sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility for two of nine (Residents #1 and #2) residents reviewed for discharges. The facility failed to provide and document that Residents #1 and #2 were given sufficient preparation and orientation prior to discharging the residents from the facility. These failures could place residents at risk of being discharged without a safe and effective transition of care, an accurate reason for discharge and inaccurate information communicated to the receiving health care institution or provider. Findings included: 1. Record review of Resident #1's Admission Record dated 08/15/24 reflected Resident #1 was an [AGE] year-old female with an original admitted [DATE]. Record review of Resident #1's MDS assessment dated [DATE] reflected the resident had a BIMS score of 05, which meant the resident had a severe cognitive impairment. MDS also revealed that Resident had Behavioral Symptoms of verbal behavioral symptoms directed toward other 1-3 days per week. MDS also revealed that Resident #1 has diagnoses of non-Alzheimer's dementia, hypertension, renal insufficiency, hyperlipidemia, anxiety, and depression. Record review of Resident #1's undated care plan reflected: Goal . Resident will not verbally abuse others. Care plan did not reflect a date or incident of physical aggression. The care plan only reflected information about verbal aggression. Record review of Resident #1's care plan conference summary dated 05/01/24 revealed, Mood/Behavior-Pleasant and appropriate/easily agitated. Record review of Resident #1's Progress note dated 07/10/24 at 12:34 PM by ADON A reflected: Resident was in WC on 100 hall wheeling from dining room to her room and saw another resident sitting in her WC in her door way. Resident #1 took her shoe off and hit the other resident on both arms. The other resident started yelling. The other resident [sic] to BOM office and reported incident. Resident #1 placed on one on one with staff. MD, ADMIN, DON, RP notified. Record review of Resident #1's Progress note dated 07/10/24 at 9:07 PM by LVN C reflected:Resident discharged to home this evening. Picked up by her [family member] Resident discharged with her medications and took with all her belongings. Record review of the Incident Report dated 07/10/24 at 12:30 PM written by ADON A reflected: Head to toe assessment done and no marks of any kind noted on this resident as of yet No injuries post incident. (continued on next page)

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	676176	A. Building B. Wing	08/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Crowley Nursing and Rehabilitation	920 E Fm 1187 Crowley, TX 76036

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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 0624 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 08/14/24 at 1:10 PM with Resident #1's POA and husband revealed they received a phone message voicemail from the BOM on 07/10/24 in the afternoon. When the POA and her her husband returned the phone call later that afternoon, they were told the facility had faxed out referrals to other nursing facilities because Resident #1 was a danger to others. They were also informed that another facility accepted her, and they would be transferring her later that day. The POA stated they would not allow the facility to transfer their mother without visiting the facility first. The POA and her husband went to the facility and picked up Resident #1 that evening and took her home with them. Interview on 08/15/24 at 12:58 PM with LVN E revealed she had worked at the facility four years. LVN E also revealed she had been Resident's #1's nurse previously when she worked on the secured unit. LVN E stated Resident #1 was verbally aggressive. LVN E said the incident that occurred on 07/10/24 was the only incident that involved Resident #1 hitting another resident. LVN E also revealed that Resident #1 had improved and was transferred from the secured unit to Hall 100. Resident #1 had been on her hall about 3-4 months. LVN E stated she did not believe they would transfer Resident #1 off the secured unit if she had physical aggression toward other residents. Interview on 08/15/24 at 1:20 PM with CNA D revealed she had provided care to Resident #1. CNA D stated the resident was verbally aggressive with residents and staff, but she had not known Resident #1 to hit a resident before this incident. Interview on 08/15/24 at 2:20 PM with the BOM revealed she was the highest level of management in the building when the incident occurred with Resident #1. The BOM stated she contacted the Administrator about the incident when it occurred. The BOM also said that to her knowledge, no injury occurred to the resident that Resident #1 struck with her shoe. The BOM also revealed after informing the Administrator of the incident involving Resident #1, the Administrator stated to discharge the resident. The BOM stated she called and left a message for Resident #1's POA. The BOM said the POA returned the call and said she would come and pick up the resident because she did not want Resident #1 discharged to a facility that day that she had no knowledge about and had not seen. The BOM said that Resident #1 had not been physically aggressive towards other residents to her knowledge. Interview on 08/15/24 at 3:54 PM with ADON B revealed she provided care to Resident #1. ADON B stated Resident #1 was verbally aggressive when she was on the unit, but Resident #1 was not physically aggressive toward other residents. ADON B concluded by stating that she had seen other residents hit other residents with no resulting injury, but they were not discharged . Those residents had care planned interventions such as separating the residents before there was a discharge discussed. Interview on 08/15/24 at 5:30 with the DON revealed she did not work at the facility at the time of the incident. There was another DON at the time of the incident. However, the DON was not in the building and was away on vacation at the time. The DON stated there should have been a care plan meeting to reduce future incidents involving psych, medical, and any testing that could rule out any behavioral issues and possibly moving her to a different hall before enforcing an immediate discharge. The DON also stated if these measures did not help the resident, then the facility could examine possibly moving her to a different hall. Then the DON said if this did not help, then the facility could look at moving Resident #1 back to the secured unit. The DON could not locate the 48-hour discharge notice that she acknowledged should be in the EHR. The DON also could not locate a physician's note reflecting Resident #1 was a harm to herself or others. The DON stated the risk to the resident of an unsafe discharge was the resident does not have proper resources set up. (continued on next page)

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F 0624 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 08/15/24 at 6:04 PM with the Administrator revealed he was on vacation when Resident #1 was discharged . The Administrator stated he was not aware the resident was discharged so quickly, meaning the same day the incident occurred. The Administrator also stated they typically issued a formal discharge and did not discharge a resident the same day as an incident occurred. The Administrator said recently there was past physical aggression on the secured unit, so he reacted too quickly to discharge Resident #1. The Administrator also revealed they did not have a letter from the Medical Director reflecting Resident #1 was a threat to herself or others and was unaware that was needed. The Administrator stated because their policy was not followed, there were not resources set up for the resident prior to discharge, which created a risk to the resident's physical and mental health. 2. Record review of Resident #2's Admission Record dated 08/15/24 reflected Resident #2 was an [AGE] year-old male with an original admitted [DATE]. Record review of Resident #2's MDS assessment dated [DATE] reflected the resident had a BIMS score of 11, which meant the resident had a moderate cognitive impairment. MDS also revealed that Resident #2 had 0 behaviors and diagnoses of Alzheimer's disease, muscle weakness, cognitive communication deficit, difficulty in walking, and repeated falls. Record review of Resident #2's undated care plan reflected no focus, goals, or interventions related to physical aggression or sexual inappropriateness. Record review of Resident #2's Notice of Proposed Transfer w Discharge (Texas) dated 06/03/24 reflected the transfer/discharge to home with [family member] Effective: 6/5/24. The document also reflected: Reason for proposed Transfer/discharge Safety of individuals in the facility is endangered. This was issued as a 48-hour emergency discharge on 06/03/24. Record review of Resident #2's Progress Notes dated 05/31/24 at 3:20 PM written by ADON A reflected: Staff member reported to this staff member [sic] reported to this nurse that she observed resident touching another resident's breast. When asked this resident stated that he doesn't remember if he touched her breast or not. He then stated that his memory isn't that good. The residents were separated. Admin, DON, MD, RP for both residents notified. This resident placed on one on one with staff. Record review of Resident #2's Progress Notes dated 05/31/24 at 10:32 PM written by the Social Worker reflected: .POA .was open to alternative placement but did not want to take the resident home. SW sent out residents clinicals to multiple different facilities and awaits answer. Resident remains on one on one. Record review of Resident #2's Progress Notes dated 06/04/24 at 9:09 AM written by LVN F reflected: Resident continues on 1:1 for behaviors. Some tearfulness noted this morning R/T upcoming discharge home. Resident says, 'I will miss everyone.' Resident verbally consoled by staff. Record review of Resident #2's Progress Notes dated 06/05/24 at 11:00 PM written by LVN D reflected: Resident discharged home with [family member] with meds and all personal belongings in good condition (continued on next page)

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F 0624 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 08/15/24 at 12:53 PM with LVN G revealed she never saw Resident #2 touch a resident inappropriately, and she did not believe that he did. LVN G said she never heard Resident #2 talk inappropriately to a resident either. Interview on 08/15/24 at 1:27 PM with CNA D revealed she never saw Resident #2 being sexually aggressive or inappropriate with a resident. CNA D also said she never saw Resident #2 be physically aggressive toward residents either. Interview on 08/15/24 at 1:31 PM with Laundry Aide H revealed she observed Resident #2 with his hand on a female's breast on the outside of her shirt. Laundry Aide H stated Resident #2 dropped his hand when he was observed by her. She stated she had never seen Resident #2 touch another resident inappropriately prior to this incident. She said she reported the incident immediately to administration. Interview on 08/15/24 at 4:03 PM with ADON B revealed she was Resident #2's nurse previously. ADON B stated she had not heard of Resident #2 touching a resident inappropriately prior to this incident. ADON B also said residents in the past would have interventions put in place before discharge, such as being placed on a secured unit. Interview on 08/15/24 at 5:02 PM with the DON revealed she did not work at the facility at the time of the incident. There was another DON at the time of the incident. The DON stated she had never seen the resident be physically or sexually aggressive toward other residents. The DON also stated that before you discharge a resident, you should attempt interventions. The DON said that possible interventions that could have been attempted were separating and relocating the residents involved in an incident. The DON said one on one was a possible intervention. The DON was unable to locate a note from the physician stating that the resident was a harm to himself or others. The DON revealed she was unaware of the discharge policy. The DON concluded by stating there was risk of harm to the resident when there was an unsafe discharge. Interview on 08/15/24 at 6:19 PM with the Administrator revealed there was not a letter from the physician or medical director stating that Resident #2 was a harm to himself or others The Administrator revealed that he determined when a resident should be discharged without consulting the medical director or the resident's physician. The administrator stated that if he deemed a resident a threat to themselves or others, he issued a discharge notice. The Administrator also revealed no one oversaw this process or monitored the process. The Administrator stated because their policy was not followed, there was a possibility of risk to the resident's physical and mental health. Review of the facility's Transfer or Discharge Documentationpolicy and procedure, dated December 2016, reflected: (continued on next page)

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F 0624 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	When a resident is transferred or discharged , details of the transfer or discharge will be documented in the medical record and appropriate information will be communicated to the receiving health care facility or provider .the following information will be documented in the medical record .If the resident is being transferred or discharged because his or her needs cannot be met at the facility, documentation will include . the specific resident needs that cannot be met; the facility attempt to meet those needs; and the receiving facility services(s) that are available to meet those needs .A summary of the resident's overall medical, physical and mental condition .Should the resident be transferred or discharged for any of the following reason, the basis for the transfer or discharge will be documented in the resident's clinical record by the resident's Attending Physician: The transfer or discharge is necessary for the resident's welfare, and resident's needs cannot be met in the facility .The safety of individuals in the facility is endangered due to the clinical or behaviors status of the resident; or the health of individuals in the facility would otherwise be endangered .Information will be communicated to the receiving facility or provider .The basis for the transfer or discharge .The specific resident needs that cannot be met; the facility's attempt to meet those needs; and the receiving facility's services that are available to meet those needs .Contact information of the practitioner responsible for the care of the resident .Comprehensive care plan goals; and all other necessary information, including a copy of the resident's discharge summary, and any other documentation, as applicable , to ensure a safe and effective transition of care.