STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676183	A. Building B. Wing	04/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Huntington Health Care & Rehabilitation Center	220 E Ash Street Huntington, TX 75949

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 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** Based on interview and record review, the facility failed to provide documentation for transfer or discharge by resident's physician for 1 of 1 resident (Resident #1) reviewed for discharge requirements. The facility failed to provide a reason for Resident #1's discharge by the resident's physician and the specific resident needs the facility could not meet, the facility's efforts to meet those needs and the specific services the receiving facility would provide to meet the needs of the resident which could not be met at current facility. This failure could place residents at risk of not having the needed records when transferring care and services and causing a disruption in their care and/or services. Findings included : Record review of Resident #1's undated face sheet reflected an [AGE] year-old male who was admitted to the facility on [DATE] with diagnoses including Hodgkin lymphoma (a type of cancer that affects the lymphatic system), diabetes, (a condition that affects blood sugar levels), dementia, (a group of systems affecting memory, thinking, and social abilities), and anxiety disorder, (a group of mental health conditions that cause fear, dread and symptoms that are out of proportion to the situation). Record review of Resident #1's initial MDS dated [DATE] reflected no BIMS needed as Resident #1 was rarely/never understood, had memory problems and moderately impaired cognition skills for daily decision making. Section D reflected Resident #1 having several days of being short tempered, easily annoyed. Section E reflected Resident #1 having 1 to 3 days of physical and verbal behavioral symptoms directed towards others and wandering. Record review of Resident #1's baseline care plan dated 2/10/25 reflected the following: Resident #1 could not communicate easily with the staff and did not understand the staff. Resident #1 required set up or clean-up assistance with ADL's. Resident #1 was alert, and cognitively impaired. Resident #1 was taking psychotropic medications. (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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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #1's nurse progress note dated 2/10/25 at 3:00 p.m. signed by LPN D reflected Resident #1 arrived at the facility via family transport. Resident #1 was alert and oriented to self. Record review of Resident #1's nurse progress note dated 2/10/25 at 4:32 p.m. signed by LVN E reflected a med review was performed with the RP and MD. Received an order to increase Ativan to 1 mg three times a day due to anxiety. Record review of Resident #1's nurse progress note dated 2/10/25 at 6:20 p.m. signed by LPN D reflected the following: Elopement Evaluation: History of elopement while at home. Wandering behavior, a pattern or goal directed. Wanders aimlessly or non-goal directed. Wandering behavior likely to affect the safety or well-being of self/others. Record review of Resident #1's nurse progress note dated 2/11/25 at 5:06 p.m. signed by the SW reflected the following: Resident recently admitted into the facility, residing on the memory care unit. History of wandering, and resident was noted to be wandering on the unit. Record review of Resident #1's nurse progress note dated 2/12/25 at 2:32 p.m. signed by LVN F reflected CNA C was exiting the secured unit when Resident #1 came up and was trying to exit as well. Resident #1 was banging on the door, then grabbed CNA C's hands and was stomping her feet trying to get her out of his way so that he could exit the unit. The Administrator came and spoke with Resident #1 and calmed him down. Resident #1 then went to sit in the chair in the hallway of the secured unit. Record review of Resident #1's nurse progress note dated 2/12/25 at 3:43 p.m. signed by LVN F reflected CNA H's statement: [Resident #1] was trying to get out another resident's window. I tried to redirect him, and he threatened to hit me in the face, and he finally walked out of the resident's room and went into the tv room and tried to get out the window. Me and [LVN B] finally got him out of the room. He then grabbed [Resident #2's] wheelchair and started pushing her really fast and picking the wheelchair up trying to dump her out. [Resident #1] was putting his fist at [LVN B] telling her he was going to hit her. I then ran off the unit to get the Administrator. When I got back [Resident #3] had punched [Resident #1] because he was threatening to hit the women. LVN B's statement reflected: [Resident #1] became very agitated when I and [CNA H] attempted to reorient him. [Resident #1] kept trying to open the doors to the secure unit to go home, and when he saw he couldn't open the doors he then began trying to open the windows. I was able to get him away from the windows and back into the main hallway. Once he was in the main hallway he got behind another resident's wheelchair and started pushing and shoving her into the wall. I ran in front of the wheelchair to prevent the resident from falling out of the chair while [Resident #1] kept trying to punch me and shove other residents. At the same time this was happening, [CNA H] ran out of the unit to get the Administrator and other nurses. Between all of them, they were able to get [Resident #1] in his room and calm him down. Resident now sitting in his room with family member and calm at this time. Record review of Resident #1's nurse progress note dated 2/12/25 at 11:58 p.m. signed by LVN G reflected that Resident #1 remained in the secured unit, family member in the room at the moment. Resident #1 showed no signs or symptoms of acute distress, denied being in any pain or discomfort and showed no signs of aggression at this moment. Fluids at bedside and call light in reach. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #1's nurse progress note dated 2/13/25 at 10:30 a.m. and signed by the SW reflected Resident #1 had exhibited behaviors since admission, awaiting final acceptance from behavioral hospital. Record review of Resident #1's nurse progress note dated 2/13/25 at 5:04 p.m. signed by LVN F reflected that Resident #1 was discharged to the behavioral hospital. Record review of Resident #1's discharge summary with a discharge date of 2/13/25 signed by the Medical Director reflected the following: Resident #1 was having behaviors during stay at the facility and was transported to a behavioral hospital. Resident #1 was not accepted back to the facility at this time. Facility attempted to assist with placement. Record review of behavioral hospital records dated 3/4/25 reflected the following: Patient is very flat and despondent. I just [NAME] get through to people, he is bizarre and tangential. He is on edge and can be violent. He was kicking a nurse recently at the nurses station, he is very impulsive. The patient returned to behavioral hospital after being discharged on 2/24/25 and admitted to the hospital with community acquired pneumonia. Patient originally admitted to behavioral hospital for violence and aggression. While at the hospital, this patient continued to show signs of increased agitation and physical aggression towards others. Hospital staff reported he physically kicked a nurse resulting in the hospital calling a code grey (signifies an active aggressor situation, requiring immediate action) and this patient being placed in restraints. Behavioral hospital staff report behaviors are demanding, intrusive and easily agitated. Patient placed on 1:1 (1 staff member to 1 resident) for safety. This patient lacks insight and has impaired judgement. He remains unstable and a danger to others requiring admission to complete treatment. During an interview on 4/2/25 at 12:50 p.m. the SW stated she was not sure how the 30-day notice worked when a resident was discharged to another facility, as they were not our resident anymore. During an interview on 4/2/25 1:00 p.m. LVN A stated she had worked in the facility since 1/27/25. LVN A stated Resident #1 was very temperamental, and one time he had barricaded the door so no one could get in or out of the memory care unit. LVN A stated Resident #1 told her he was going to San [NAME] to see his parents. LVN A stated that occurred the day before he was sent out. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/2/25 1:21 p.m. LVN B stated she had worked in the facility for 1 year and 2 months. LVN B stated the night before the incident Resident #1 had some agitation but was able to be calmed down. LVN B stated in the afternoon on the day of the incident, it was like a switch flipped. LVN B stated Resident #1 wanted to leave the facility. LVN B stated she took Resident #1 to the tv room and gave him some lunch, and about 45 minutes later he became very aggressive. Resident #1 began banging on the doors and the windows. LVN B stated the aide and her reoriented Resident #1 for about 5 minutes. Resident #1 stated he was leaving one way or another and would do away or kill anyone who tried to stop him. LVN B stated when they took Resident #1 to the tv room, they tried to separate him from the other residents. Resident #1 opened the window in the tv room and tried to crawl out. Resident #1 had his head out the window. LVN B stated they talked to him and got him back in. LVN B stated Resident #1 came running down the hall and got behind Resident #2. Resident #1 kept pushing her in her wheelchair and tried running her into the wall. LVN B stated Resident #1 then kept lifting her wheelchair up and down. LVN B stated Resident #1 kept cussing and threatening the staff. LVN B stated the aide went and got more help. LVN B stated a family member was also notified and came to the facility. LVN B stated when a staff member was coming into the secured unit, Resident #1 pushed his way out the door and ran out of the unit. LVN B stated Resident #1 was transferred out the next day, and the family member stayed with him until he was transferred. LVN B said Resident #1 had grabbed her but did not hurt her. During an interview on 4/2/25 2:00 p.m. the DON stated that Resident #1 was admitted to the facility from home where he had care takers 24 hours a day. The DON stated Resident #1 would get out of the house and would go out in the street. The DON stated the police said he almost got hit by a car and told the family something had to be done, or they would have to do something. The DON stated on the day of the incident Resident #1's family member stayed with him until he was transferred. The DON stated she had talked to Family Member J the beginning of the week he was to be discharged from the behavioral hospital but did not remember the exact date. The DON stated Family Member J was upset Resident #1 was not coming back and stated she had not been issued a 30-day notice. The DON stated she told Family Member J that due to Resident #1's behavior, he posed a threat to the other residents. The DON stated Family Member J was mad and told the DON that if she had any other concerns she could call her other family member. The DON stated she had spoken to the Admissions Coordinator and the DON at the behavioral hospital. The DON at the behavioral hospital said the facility they had no choice to take Resident #1 back, and that she was calling the State. The DON stated she contacted the Ombudsman and told her what had happened. The Ombudsman told her she was making the right decision, and to make sure everything was documented, as the behavioral hospital may report them. The DON stated the SW at the behavioral hospital was helping them with referrals. The DON stated Resident #1's behaviors had not changed while at the behavioral hospital. The DON stated there should have been a 30-day notice given, but she thought that his behaviors would improve after going to the behavioral hospital. The DON stated she was confident with her decision to not accept Resident #1 back in the facility in order to protect the other residents and the staff. The DON stated Family Member K who sat with Resident #1 until he was transferred stated she was not surprised this happened. The DON stated the behavioral hospital was notified on 3/6/25 that Resident #1 would not be able to return to the facility, and both Family Members J and K were also made aware. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/2/25 3:15 p.m. the Administrator stated Resident #1 had tried to attack another resident on 2/12/25 and was sent out the next day to the behavior hospital. The Administrator stated a family member sat with Resident #1 until he was sent out. The Administrator stated he had spoken to Family Member J on the day of the incident, and she had asked if Resident #1 was going to be able to return to the facility. The Administrator stated he told her that if Resident #1's behavior improved he could, if not, he would not be able to return, and that he could not make her any promises. Family member J stated she understood. The Administrator stated Family member K was upset due to the behavioral hospital telling the family that the nursing home had no intentions of ever taking Resident #1 back, which was not true. The Administrator stated he had a discussion with Family Member J before Resident #1 was sent out letting her know that there was a chance of Resident #1 not being able to return to the facility, depending on his behaviors. The Administrator stated Family Member K was told the same thing. The Administrator said a 30-day notice was not provided to Resident #1. The Administrator said the discharge summary signed by the Medical Director did not include the specific resident needs the facility could not meet. The Administrator stated they did not have any policies pertaining to discharges and followed CMS and TAC guidelines. During an interview on 4/3/25 10:17 a.m. CNA C stated she had worked in the facility for 12 years. CNA C stated she was working the day Resident #1 was sent out. CNA C stated Resident #1 was very physical, always trying to hit the staff. CNA C stated he had stomped on her foot one day stating he wanted to go home. CNA C said every time the door to the unit was open, he would try to get out. Record review of the State Operations Manual section 483.15 reflected the following: §483.15(c) Transfer and discharge- §483.15(c)(1) Facility requirements- .(i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless- (A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; (C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident; (D) The health of individuals in the facility would otherwise be endangered; . §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	(i) Documentation in the resident's medical record must include: (A) The basis for the transfer per paragraph (c)(1)(i) of this section. (B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s). (ii) The documentation required by paragraph (c)(2)(i) of this section must be made by- (A) The resident's physician when transfer or discharge is necessary under paragraph (c) (1) (A) or (B) of this section; and (B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care.