

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676186	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/19/2024
NAME OF PROVIDER OR SUPPLIER Cambridge Ltc Partners Inc		STREET ADDRESS, CITY, STATE, ZIP CODE 1621 Butler Dimmitt, TX 79027	

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 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48161</p> <p>Based on interviews and record review; it was determined the facility failed to ensure that in accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are complete, accurately documented, and readily accessible for 1 of 6 residents reviewed for clinical records (Resident #1) in that:</p> <p>The facility failed to ensure Resident #1's concerns about the prior administrator were documented and addressed in social services notes.</p> <p>The facility's failure to ensure medical records on each resident were complete, accurately documented, and readily accessible, placed all residents requiring care at risk for incorrect or omitted treatment, duplicated treatments, poor self-esteem and self-worth, and a failure to ensure continuity of care.</p> <p>Findings included:</p> <p>Record review of Resident #1's face sheet dated 09/19/2024 reflected a [AGE] year-old-female admitted to the facility on [DATE]. Resident #1's current diagnoses included but not limited to diffuse traumatic brain injury with loss of consciousness of unspecified duration, schizoaffective disorder (mood disorder), bipolar type (extreme mood swings), anxiety disorder, major depressive disorder, recurrent severe without psychotic features, and cognitive communication deficit (difficulty in communication).</p> <p>Record review of Resident #1's quarterly MDS assessment dated [DATE] reflected Resident #1 had a BIMS score of 15 out of 15 indicating she was cognitively intact.</p> <p>Record review of Resident #1's social services notes dated 09/11/2024 reflected a visit was conducted with Resident #1 by SW concerning Resident #1's boyfriend and their relationship, there was no documentation relating to the concerns Resident #1 stated in the visit about a past employee asking Resident #1 to go to bed with him.</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 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 09/19/2024 at 10:55 AM, the SW who stated she and Resident #1 were having a conversation about intimacy due to Resident #1 having a relationship with another resident in the facility. During this conversation Resident #1 stated the PADM asked her to go to bed with him and got mad at her when she was holding hands with her boyfriend during dinner. The SW stated the PADM had been gone since December 2024 and Resident #1 could not tell her when this incident happened. The SW stated she immediately informed the current ADM about the allegation but did not document the information in her social services notes. The SW stated she has followed up with Resident #1 and has not seen any behavioral changes since making the outcry. The SW stated a possible negative outcome for not having accurate documentation would be staff would not be aware of the incident.</p> <p>During an interview on 09/19/2024 at 1:00 PM, Resident #1 stated she hated the PADM and she was glad he was gone. When asked about what upset her about the PADM, Resident #1 said he asked her to clean his house, Resident #1 said she liked to clean houses but stated she told the PADM she was not going to clean his house because she had a boyfriend. Resident #1 stated she was happy and felt safe in the facility, she had no other concerns relating to the PADM.</p> <p>During an interview on 09/19/2024 at 3:15 PM, RN A stated that all licensed staff were responsible for documenting in each resident's record. RN A stated that a possible negative outcome for not documenting what a resident's status would be that oncoming staff would not be aware of the actual status of the resident .</p> <p>During an interview on 09/19/2024 at 3:18 PM, the ADON who stated all administrative personnel were responsible to ensure documentation was accurate and complete. The ADON also stated the visit between Resident #1 and the SW should have been documented. The ADON said a possible negative outcome for not having complete records would be no paper trail on the incident and staff would not be aware of the incident.</p> <p>During an interview on 09/19/2024 at 3:20 PM, the DON who stated all licensed personnel were responsible for documenting in each resident's record and all interactions should be documented. The DON stated administrative personnel were responsible in monitoring the documentation and the social service visit between Resident #1 and the SW should have been documented. The DON stated a possible negative outcome for not having correct documentation would be the record would not accurately reflect the resident's situation.</p> <p>Record Review of Documentation in Medical Record Policy dated 09/01/2024 reflected the following:</p> <p>Each resident's medial record shall contain an accurate representation of the actual experiences of the resident and include enough information to provide a picture of the resident's progress through complete, accurate and timely documentation.</p> <p>.Licensed staff and interdisciplinary team members shall document all assessments, observation and services provided in the resident's medical record in accordance with state law and facility policy .</p>		