STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676186	A. Building B. Wing	01/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cambridge Ltc Partners Inc	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)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46534 Based on interview and record review the facility failed to immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative when there was a significant change in the resident's physical, mental, or psychosocial status in either life-threatening conditions or clinical complications and a decision to transfer or discharge the resident from the facility for 1 (Resident #1) of 5 residents reviewed for notification. LVN D failed to notify Resident #1's family and physician when Resident #1 was found unresponsive in his room and sent to the hospital via ambulance. This failure could cause residents to feel alone and/or abandoned by their family members in times of crisis. Findings Included: Record review of Resident #1's admission record dated 01/25/25 revealed a [AGE] year-old male admitted to the facility on [DATE] with diagnoses that included, but were not limited to, unspecified dementia with other behavioral disturbance (breakdown of thought process causing disruptive behavior), psychotic disorder with delusions (severe mental illness including distorted beliefs), generalized anxiety disorder (inability to control constant worrying), Alzheimer's disease with late onset (a progressive disease that destroys memory and other important mental functions), and atherosclerotic heart disease of native coronary artery (fats, cholesterols, and other substances collected on the inner walls of heart arteries). The admission record listed Resident #1's family member A and her phone number. Record review of Resident #1's MDS tab in his EHR revealed no comprehensive assessment was completed. Record review of Resident #1's care plan revealed it was initiated on his admitted , 01/17/25. Record review of Resident #1's progress notes revealed the following notes: A note by LVN D written on 01/24/25 at 05:59 AM which indicated Resident #1 was sent to the hospital via ambulance due to being found unresponsive at 05:58 AM. (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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A note by ADON written on 01/24/25 at 08:25 AM which indicated an ER nurse called and told ADON Resident #1 was being air lifted to a larger hospital and that the ER had notified his family and they would be waiting at the larger hospital for his arrival. During an interview on 01/25/25 at 09:51 AM Resident #1's family member A and family member B stated they were not contacted by the facility when Resident #1 was transferred to the hospital due to being unresponsive. They said the first they heard was at 08:30 AM on 01/24/25 when a nurse from the emergency room called Resident #1's family member A and said Resident #1 was being taken by life flight to the bigger city and hospital because he was unresponsive and on life support. During an interview on 01/25/25 at 01:36 PM LVN E stated when a resident is transferred to the hospital the nurse is to call the family, physician, DON, ADON, and ADM. She stated it was important to call the family so they could meet the resident at the hospital because you never know what is going to happen. During an interview on 01/25/25 at 04:56 PM LVN D stated she did not call Resident #1's family or physician when he was transferred to the hospital via ambulance the morning of 01/24/25. She stated, Honestly .I didn't get a chance to (notify Resident #1's family or physician) because it was a cluster that morning. I immediately called DON and she told me to send him out right away and I was running back and forth to keep an eye on him and get his paperwork printed off. I told the other nurse on shift to call 911 and say we needed them because he was unresponsive. LVN D stated she sent paperwork with Resident #1 to the hospital. During an interview on 01/25/25 at 05:49 PM ADON stated she expected her nurses to notify physician and family members of any resident who was sent to the hospital. She stated she did not know why Resident #1's family was not notified when he was sent to the hospital. She stated on the morning of 01/24/25 she was preparing to sit down at the nurses' desk and call Resident #1's family when the hospital called and told her they had already called the family. ADON stated a possible negative outcome of a resident's family not being notified was, They (family) could get upset and they need to know where their family is at. During an interview on 01/25/25 at 05:51 PM DON stated she expected her nurses to notify physician and family members if a resident was sent to the hospital. She stated she did not know why Resident #1's family was not notified except that the nurse was an agency nurse, and Resident #1 was sent out to the hospital right at shift change. She stated a possible negative outcome to the resident of their family not being notified was they (resident) might feel like, 'My family doesn't care about me.' Record review of facility policy titled Notification of Changes and dated 2024 revealed the following: .The purpose of this policy is to ensure the facility promptly informs the resident consults the resident's physician; and notifies, consistent with his or her authority, the resident's representative when there is a change requiring notification. The facility must inform the resident, consult with the resident's physician and/or notify the resident's family member or legal representative when there is a change requiring such notification. Circumstances requiring notification include: . 2. Significant change in the resident's physical, mental or psychosocial condition such as deterioration in health, mental or psychosocial status. This may include a. Life-threatening conditions, or b. Clinical complications. 4. A transfer or discharge of the resident from the facility.

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46534 Based on interviews and record reviews the facility failed to develop and implement written policies and procedures that prohibit and prevent abuse, neglect, and exploitation of resident and misappropriation of resident property for 1 (Resident #1) of 5 residents reviewed for abuse. The facility failed to implement their policy titled Abuse, Neglect and Exploitation when CNA A failed to report bruising to Resident #1's ribcage she found on 01/24/25 during a brief change. This failure could place residents at risk of abuse/continued abuse. Findings Included: Record review of Resident #1's admission record dated 01/25/25 revealed a [AGE] year-old male admitted to the facility on [DATE] with diagnoses that included, but were not limited to, unspecified dementia with other behavioral disturbance (breakdown of thought process causing disruptive behavior), psychotic disorder with delusions (severe mental illness including distorted beliefs), generalized anxiety disorder (inability to control constant worrying), Alzheimer's disease with late onset (a progressive disease that destroys memory and other important mental functions), and atherosclerotic heart disease of native coronary artery (fats, cholesterols, and other substances collected on the inner walls of heart arteries). The admission record listed Resident #1's family member A and her phone number. Record review of Resident #1's MDS tab in his EHR revealed no comprehensive assessment was completed. Record review of Resident #1's care plan revealed an initiation date of 01/17/25. Record review of Resident #1's assessments tab in his EHR revealed one skin assessment performed on 01/17/25. Record review of Resident #1's skin assessment dated [DATE] and completed by ADON revealed no bruising to his ribcage. During an interview on 01/25/25 at 09:51 AM Resident #1's family member A stated Resident #1 had a huge bruise on his side when he got to the hospital. Resident #1's family member A stated she sent a picture of the bruise to the person who handled her call-in complaint. During an interview on 01/25/25 at 01:36 PM LVN E stated if a resident had a new bruise CNAs and especially shower aides, were to inform the nurse immediately so the nurse could investigate to see if they could find out how the bruise happened. During an interview on 01/25/25 at 01:46 PM CNA F stated if she noticed a bruise on a resident, she would report it to the nurse. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 01/25/25 at 01:52 PM CNA G stated if she noticed a bruise on a resident, she would report it to the nurse. During an interview on 01/25/25 at 02:25 PM CNA H stated if she noticed a bruise on a resident, she would report it to the nurse. During an interview on 01/25/25 at 05:05 PM CNA I stated if she noticed a new bruise on a resident, she would report it to the nurse. During an interview on 01/25/25 at 05:27 PM CNA A stated she noticed a bruise on Resident #1's ribcage on 01/24/25 when she and CNA B were changing Resident #1's brief. CNA A stated she pulled Resident #1's shirt up so it would not get closed in his brief and that is when she noticed the bruise. She was not sure which side it was one. CNA A stated the bruise was not too big and was purplish in color. CNA A stated she did not tell anyone about the bruise because we were working with agency nurses and when you tell them things like that they just say, 'Okay.' During an interview on 01/25/25 at 05:49 PM ADON stated CNAs were to report any skin issues observed to include bruising to the nurse on duty. During an interview on 01/25/25 at 05:51 PM DON stated she expected CNAs to report any change of condition to the nurse so an investigation could be completed. During an interview on 01/27/25 at 01:38 PM LVN E stated a possible negative outcome of not reporting an injury of unknown origin was it could lead to resident abuse, neglect, harm. During an interview on 01/27/25 at 01:41 PM DON stated a possible negative outcome of not reporting an injury of unknown origin was it could lead to another thing (injury). Record review of facility policy titled Abuse, Neglect and Exploitation and dated 2024 revealed the following: . It is the policy of this facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property. Possible indicators of abuse include, but are not limited to: . 3. Physical injury of a resident, of unknown source .

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46534 Based on interviews and record reviews the facility failed, in accordance with accepted professional standards and practices, to maintain medical records on each resident that are complete, accurately documented, readily accessible, and systematically organized for 1 (Resident #1) of 5 residents reviewed for accuracy of medical records. The facility failed to list the correct behavioral hospital on Resident #1s Admission Record. The facility failed to perform a skin assessment on Resident #1 for three days (01/18/25, 01/19/25, and 01/20/25) following his admission skin assessment, as per their Skin Assessment policy. 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, and a failure to ensure continuity of care. Findings Included: Record review of Resident #1's admission record dated 01/25/25 revealed a [AGE] year-old male admitted to the facility on [DATE] with diagnoses that included, but were not limited to, unspecified dementia with other behavioral disturbance (breakdown of thought process causing disruptive behavior), psychotic disorder with delusions (severe mental illness including distorted beliefs), generalized anxiety disorder (inability to control constant worrying), Alzheimer's disease with late onset (a progressive disease that destroys memory and other important mental functions), and atherosclerotic heart disease of native coronary artery (fats, cholesterols, and other substances collected on the inner walls of heart arteries). The admission record noted Resident #1 was admitted from [name of behavioral hospital C]. Record review of Resident #1's MDS tab in his EHR revealed no comprehensive assessment was completed. Record review of Resident #1's care plan revealed it was initiated on his admitted , 01/17/25. Record review of the Miscellaneous tab in Resident #1's EHR revealed paperwork from behavioral hospital D. Record review of the Assessments tab in Resident #1's EHR revealed one skin assessment dated [DATE]. Record review of Resident #1's skin assessment revealed it was completed by ADON at 04:34 PM on 01/17/25. Record review of Resident #1's progress notes revealed no note regarding admission to the facility. In a note written by ADON on 01/17/24 at 04:37 PM she noted, . Notes: transferred from [name of behavioral hospital D] hospital . (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #1's paperwork from behavioral hospital D revealed no discharge date . The last exam by a physician was dated 01/13/25. During an interview on 01/25/25 at 09:51 AM Resident #1's family member A and family member B stated Resident #1 was admitted to the facility from behavioral hospital D. During an interview on 01/25/25 at 05:49 PM ADON stated she was unaware the facility policy Skin Assessment stated the facility would do a skin assessment on a new admit for the first 4 days and then weekly. She stated she though skin assessments were to be done weekly. During an interview on 01/27/25 at 01:38 PM LVN E stated a possible negative outcome of inaccurate medical records and/or not following facility policy was, We need to know everything we can about a resident to care for them correctly. During an interview on 01/27/25 at 01:41 PM DON stated miscommunication was a possible negative outcome of inaccurate medical records and/or not following facility policy. Record review of facility policy titled Skin Assessment and dated 2024 revealed the following: . A full body, or head to toe, skin assessment will be conducted by a licensed or registered nurse upon admission/re-admission, daily for three days, and weekly thereafter . Record review of facility policy titled Documentation in Medical Record and dated 2024 revealed the following: . Each resident's medical 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. 1. Licensed staff and interdisciplinary team members shall document all assessments, observations, and services provided in the resident's medical record in accordance with state law and facility policy. 2. Documentation shall be completed at the time of service, but no later than the shift in which the assessment, observation, or care service occurred. a. Documentation shall be factual, objective, and resident centered. i. False information shall not be documented. b. Documentation shall be accurate, relevant, and complete .