STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676259	A. Building B. Wing	09/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Shinnery Oaks Community	711 West Broadway Denver City, TX 79323

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 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** 49154 Based on interview and record review the facility failed to ensure in accordance with accepted professional standards and practices, medical records maintained on each resident were accurately documented for 1 of 17 (Resident #47) residents reviewed for accuracy of records. 1. The facility failed to document communication between staff and the MD when Resident #47 was attempting to elope from the facility on 8/30/24. 2. The facility failed to record verbal orders in the EHR when the MD ordered Resident #47 be moved to the secured unit. These failures could place residents at risk for not receiving needed care or treatment after an incident occurred. Findings Included: Record review of Resident #47's undated face sheet reflected Resident #47 was an [AGE] year-old female whose admitted to the facility was on 6/17/24. Resident #47 had the following diagnoses: Neurocognitive disorder with Lewy bodies (memory loss); psychotic disorder with delusions due to known physiological condition (mental health condition with false beliefs); restlessness and agitation (inability to relax and be still); dementia in other diseases classified elsewhere, unspecified severity, with mood disturbance (memory loss and a mental health condition that affects the emotional state); major depressive disorder, recurrent severe without psychotic features (mental health condition); dementia in other diseases classified elsewhere, severe, with behavior disturbance (memory loss and disruptive behaviors); hallucinations (false perceptions that were not true); and chronic obstructive pulmonary disease (airflow blockage and breathing-related problems). Record review of Resident #47's Care plan dated 6/28/24 revealed Resident #47 was an elopement risk related to being in a disoriented place and impaired safety awareness. The goal was that Resident #47's safety will be maintained through the review date. Interventions were to distract Resident #47 from wandering by offering pleasant diversions, structured activities, food, conversation, television, and books. Also, to provide Resident #47 with structured activities for toileting, walking inside and outside, reorientation strategies including signs, pictures, and memory boxes. (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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record Review of Situation, Background, Assessment Recommendation (SBAR) Communication form and Progress Note for RN's/Licensed Practical Nurses (LPN)/LVN's dated 8/31/24 revealed Resident #47's mental status evaluation (compared to baseline) had an altered level of consciousness, increased confusion or disorientation, new or worsened delusions or hallucinations, and other symptoms or signs of delirium. Additionally, the behavioral evaluation revealed Resident #47 was a danger to self or others, had verbal aggression, physical aggression, a personality change, and had signs and symptoms of agitation. Record review of Resident #47's EHR physician orders dated 9/25/24, revealed there was no order of the verbal orders made by the physician to move Resident #47 to the secured unit on 8/30/24. Record review of Resident #47's progress notes dated 8/26/24 - 9/26/24, revealed no documentation by LVN A of the communication between she and the physician regarding Resident #47's elopement behaviors that occurred on 8/30/24. During an interview on 9/25/24 at 5:58 PM, Family Member #1 stated she received a call from the facility several weeks ago requesting permission to move Resident #47 to the secured unit due to behaviors, and she consented due to Resident #47's behaviors and exit seeking. During an interview on 9/27/24 at 11:50 AM, the SW stated Resident #47 admitted to the facility into a regular room, however, she was recently moved to the secured unit when she began exit seeking. She stated Resident #47 was never able to successfully elope from the facility. She stated Resident #47 was hitting staff, pushing trash barrels at staff, she was agitated, and she threw a water pitcher. She stated Resident #47 pushed her roommate's wheelchair in the hallway into other resident's doorways. She stated Resident #47 was hallucinating and told her she knew she was seeing things that were not real. She stated Resident #47 was moved to the secured unit before she went to the behavior hospital. She stated she contacted Resident #47's family member on 8/30/24 who consented to moving her to the secured unit. The SW stated the facility tried to implement other avenues, such as a wander guard to ensure Resident #47's safety was least restrictive; however, they could no longer do it and it was decided she be moved to the secured unit to ensure her safety. She stated Resident #47 went to the behavior hospital for assessment and returned on 9/18/24. When she returned, she started having behaviors immediately throwing things, crawling on the floor, and undressing. She said they contacted the behavior hospital and were told there was nothing they could do for her due to her diagnosis of Lewy body dementia. She stated she contacted another behavior hospital who also denied her due to the acuity on their unit. She stated the nurse was responsible to contact the physician for orders. She stated nursing staff decided when to place a resident on the secured unit, so she had not received training on what all was needed to place a resident on the secured unit. She stated the department heads trained staff. She stated she did not know what a potential negative outcome could be to the resident for not having written orders before placing a resident on the secured unit. During an interview on 9/27/24 at 11:55 AM, the ADM stated the facility obtained verbal orders from the MD prior to moving Resident #47 to the secured unit but the staff member did not document it in the EHR due to the behaviors that were going on at the time they were speaking to the physician. The ADM stated he was trying to determine which nurse obtained the verbal orders from the physician. The ADM stated the facility did not have a written order, but he was trying to get it and would enter it into the EHR. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 9/27/24 at 12:01 PM, the MD stated Resident #47 had Lewy body dementia, threw coffee on people, and she was very aggressive. He stated she was sent to a behavior hospital for assessment and returned to the facility after she was discharged . He stated she needed to be on the secured unit because she was very aggressive. He stated he was notified by the nurse and gave verbal orders prior to her being moved to the secured unit. He stated usually the facility sent him the written orders and he signed and returned them. During an interview on 9/27/24 at 1:35 PM, LVN A stated facility policy to place a resident on the secured unit were that they must call the physician to get direction when there were concerns about a resident, the resident must show signs of being an elopement risk, and they must notify the family and ask for permission. LVN A stated this all must be done before the resident was moved to the secured unit. She stated she was the CN on 8/30/24 and she was responsible to call the physician and make notifications for any concerns about residents. She stated the SW could help make notifications. She stated she called the physician on 8/30/24 to talk to him about how Resident #47 was constantly exit seeking as well as her behaviors. She stated the physician gave her verbal orders to move Resident #47 to the secured unit as he felt it was necessary. She stated the SW called the family and told them the physician ordered the resident to move to the secured unit and she asked them for permission, and they consented. She stated she was responsible to transcribe orders on the same day, as well as document her conversation with the physician in the EHR since she was the staff that spoke with him. She stated she was trained to transcribe orders and document all conversations leading up to the order request immediately as soon as they had time when things were settled down and the resident was safe. She stated she believed she failed to do those things because of how hectic things were with Resident #47 during that time. She stated she was trained by the ADON and the DON. She stated she was trained during orientation to document everything as well as the importance of documentation. She stated documentation was also discussed monthly during staff meetings. She stated she had received training on documentation at least five times that year. She stated she was not aware she did not put the order in the EHR until that day. She stated a possible negative outcome was that the physician would not be aware the resident was on the secured unit. She stated being on the secured unit could cause residents to have depression and feel isolated, so it was important for there to be a physician order. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 9/27/24 at 1:55 PM, the ADON stated in order to place a resident on the secured unit, the facility must complete an assessment on the resident, the resident must be exit seeking or they must be a danger to themselves or others. She stated initially Resident #47 had a wander guard (a sensor placed on the wrist that activates an alarm when exiting the facility) when she was on the regular unit, but her exit seeking got progressively worse where she was trying to find her way out of every exit in the facility by slamming her walker against the exit doors. She stated it was no longer safe for Resident #47 to be on the regular unit. She stated staff must get verbal orders from a physician to place a resident on the secured unit. She stated CNs were responsible to communicate with physicians or she could, if needed. She stated all physician orders go into the EHR. She stated the nurse that got the order must enter it into the EHR as soon as the resident was safe or at least before they leave their shift that day. She stated there must be documentation in the EHR showing information that led up to the order request. She stated all written orders must be scanned and uploaded into the EHR. She stated she and the DON were responsible for training staff on documentation requirements. She stated in-services were done with staff often and this was also discussed during their monthly meetings. She stated they also complete in-services with staff immediately for concerns that needed to be addressed immediately. She stated she expected staff to document any concerns, observations, issues, and orders in the EHR. She stated a negative outcome was that the resident could miss care, medications, or necessary treatment when pertinent information was missing from their EHR. During an interview on 9/27/24 at 2:25 PM, the DON stated facility policy to place residents on the secured unit was that residents must be exit seeking, the facility must complete an assessment, and the facility must get orders from the physician and approval from the family prior to placing the resident on that unit. The DON stated the CN was responsible to obtain verbal orders from the physician and then write the order in the EHR as soon as they get the verbal order from the physician. The DON stated the EHR was the only place to find the orders. The DON stated verbal orders were received for Resident #47 prior to moving her on the secured unit. The DON stated the CN was supposed to document the reasons for the request for the move in the progress notes. She stated herself and the ADON trained staff to document orders and progress notes during monthly meetings and during daily meetings to go over what was missed or was needed. She stated she expected staff to document accurately, timely, and precisely in the EHR because it did not happen if it was not charted. She stated she was not aware the facility did not have signed physician orders for Resident #47 to be moved to the secured unit. She stated Resident #47 went to a behavior hospital and returned on 9/18/24. She stated Resident #47 had Lewy body dementia and was cognitively intact when she admitted on [DATE]. The DON stated she used a walker, she was friendly, and she played bingo. She stated Resident #47 became paranoid within 2 months and she hallucinated. She said Resident #47 got worse, and started going in other resident's rooms, her verbal and physical aggression increased, and then she began trying to elope from the facility. She stated Resident #47 told staff she was going to leave. She stated Resident #47 had a wander guard, but it was determined this was not enough to keep her safe and the facility felt she needed to be moved to the secured unit. The DON stated staff spoke to the family who approved it. The DON stated since then, Resident #47 went to the behavior hospital for assessment and treatment. The DON stated a negative outcome of placing a resident on the secured unit inappropriately was it would isolate the resident and could cause depression due to having less stimuli. The DON stated the facility could face legal issues placing restrictions on residents without physician orders. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 9/27/24 at 2:41 PM, the ADM stated for a resident to be placed on the secured unit, the facility must determine if the secured unit would create a better well-being for the resident, they must discuss and obtain permission from family, and they must discuss and obtain an order from the physician prior to placing a resident on the secured unit. The ADM stated the facility must try all other least restrictive interventions prior to placing a resident on the secured unit. The ADM stated the CN nurse on duty was responsible to obtain orders from the physician, document the orders, and document the reason for obtaining the order in progress notes in the EHR. The ADM stated then the CN should write and send them out to the physician for a signature. The ADM stated all documentation and orders should be written timely or preferably before they leave for their shift that day. The ADM stated the facility tried to send orders to the physician weekly for signatures. The ADM stated Resident #47 was admitted to the facility on [DATE] and at that time she was cognitively intact, and they had good conversations. He stated within a couple of months, she began making false accusations, she became paranoid, and her aggressive behaviors at night increased. He stated Resident #47 also made comments and attempted to leave the facility. He stated resident #47 had a wander guard (a sensor placed on the wrist that activates an alarm when exiting the facility). He stated the facility determined that due to Resident #47's behaviors and the facility's numerous exits that she be placed on the secured unit to better ensure her safety. He stated Resident #47 was moved to the secured unit on 8/30/24. He stated Resident #47 went to a behavior hospital from 9/5/24 and returned on 9/18/24. The ADM stated he was not aware the facility did not have signed written orders for Resident #47 to be placed on the secured unit. He stated staff were trained to document reasons for obtaining orders, and all communication with physicians. He stated the ADON and the DON were responsible to train staff. He stated the DON and ADON completed documentation training regarding when to document and how to document on a monthly basis with staff. He stated he expected staff to document behaviors, interventions, responses, and contact with family and the physician in the EHR. He stated not having the signed written orders did not have a negative effect on the resident. He stated written orders showed they had actions in place for the resident and provided greater information from staff to staff. He stated having the written order was a paper compliance that they were required to have because the State said they have to. He stated he did not think there was a negative outcome to the resident if they were properly placed there whether the facility had an order or not. Record review of the facility policy, Memory Care Admission Policy (undated), revealed in part the following: Admission Policy for Secured Memory Care Unit Purpose: This policy outlines the criteria and procedures for admitting residents to the secured memory care unit, ensuring a safe and supportive environment for individuals with cognitive impairments. Scope: This policy applies to all admissions to the secured memory care unit of [facility]. Admission Criteria: 4. Admission Order: 1. Admission to the secured unit must be made by a licensed provider. (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 the facility policy, Charting and Documentation (revised July 2017), revealed in part the following: Policy Statement All services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional or psychosocial condition, shall be documented in the resident's medical record. The medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care. Policy Interpretation and Implementation 7. Documentation of procedures and treatments will include care-specific details, including: a. the date and time the procedure/treatment was provided; b. the name and title of the individual(s) who provided the care; c. the assessment data and/or any unusual findings obtained during the procedure/treatment; d. how the resident tolerated the procedure/treatment; e. whether the resident refused the procedure/treatment; f. notification of family, physician or other staff, if indicated; and g. the signature and title of the individual documenting. Record review of the facility policy, Telephone Orders (revised February 2014), revealed in part the following: Policy Statement Verbal telephone orders may be accepted from each resident's Attending Physician. Policy Interpretation and Implementation 1. Verbal telephone orders may only be received by licensed personnel (e.g., RN, LPN/[NAME], pharmacist, physician, etc.). Orders must be reduced to writing, by the person receiving the order, and recorded in the resident's medical record. 2. The entry must contain the instructions from the physician, date, time, and the signature and title of the person transcribing the information. Telephone orders must be countersigned by the physician during his or her next visit. Record review of the facility policy, Verbal Orders (revised February 2014), revealed in part the following: (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Policy Interpretation and Implementation 4. The individual receiving the verbal order must write it on the physician's order sheet as "v.o. (verbal order) or t.o. (telephone order). 5. The individual receiving the verbal order will: a. read the order back to the practitioner to ensure that the information is clearly understood and correctly transcribed; b. record the ordering practitioner's last name and his or her credentials (MD, NP, PA, etc.); and c. record the date and time of the order. 6. The practitioner will review and countersign verbal orders during his or her next visit Record review of the facility policy, Medication and Treatment Orders (revised July 2016), revealed in part the following: Policy Statement Orders for medications and treatments will be consistent with principles of safe and effective order writing. Policy Interpretation and Implementation 7. Verbal orders must be recorded immediately in the resident's chart by the person receiving the order and must include prescriber's last name, credentials, the date and the time of the order.