

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676292	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/07/2025
NAME OF PROVIDER OR SUPPLIER Luling Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 501 W Austin St Luling, TX 78648	

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 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44317</p> <p>Based on interviews and record reviews, the facility failed to ensure that all alleged violations involving exploitation or mistreatment were reported immediately, but not later than 24 hours after the allegation was made, if the events that caused the allegation did not involve abuse or result in serious bodily injury, to the State Survey Agency in accordance with state law through established procedures for 1 (Resident #1) of 3 residents reviewed for misappropriation of property.</p> <p>The facility failed to report to the state agency when the facility was notified that CNA A requested and accepted money from Resident #1 on the weekend of 11/09/24 and 11/10/24.</p> <p>This failure could place residents at risk for further misappropriation.</p> <p>Findings included:</p> <p>Review of Resident #1's undated face sheet reflected a [AGE] year-old male initially admitted to the facility on [DATE], went out to another facility on 11/01/24, and was readmitted on [DATE]. His diagnoses included hypertension (high blood pressure), diabetes mellitus (a condition that affects the way the body processes blood sugar), cerebrovascular accident (stroke), hemiplegia (paralysis of one side of the body), post-traumatic stress disorder, borderline personality disorder (a disorder that affects the way one feels about themselves, relates to others, and behaves), and difficulty walking.</p> <p>Review of Resident #1's quarterly MDS assessment, dated 10/15/24, Section C (Cognitive Patterns) reflected a BIMS score of 10 indicating moderately impaired cognition.</p> <p>Review of Resident #1's comprehensive care plan, revised 09/04/24, reflected in part. Problem: Resident has episodes of adverse behaviors - fabricates/facts/unreliable historian/manipulates staff. Goal: the number of behavioral episodes will decrease throughout the next quarter. Approach: Two staff for care whenever possible, redirect, psych services .</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 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of an email dated 11/12/24 at 11:18 AM from the ADM to the RDO reflected the CEO from the [hospital name] reported, One of her staff members (who knows CNA A) saw Resident #1 give CNA A money. The staff member reported to the charge nurse. The charge nurse went and talked with Resident #1 who then told the charge nurse it was none of his business. The charge nurse told Resident #1 he wanted to make sure he was not being exploited. Resident #1 confirmed he gave money to CNA A. Resident #1 stated CNA A had a deadbeat husband and kids. She needed the money. Resident #1 stated they were friends, and he has done it before .</p> <p>During an interview on 01/07/25 at 11:45 AM, the ADM stated he was notified by the CEO of the hospital where Resident #1 was receiving care. The ADM was informed that CNA A was observed requesting and receiving money from Resident #1. He stated he received statements from the staff at the hospital and spoke with CNA A. He stated CNA A made the statement, He will never say he gives me money. The ADM stated the resident was not in his facility so technically he was not a resident at the time. He stated the resident had planned on returning to the facility. He stated CNA A was an employee of his facility at the time, but she had since been terminated. He stated since the termination, CNA A continued to have contact with Resident #1. The ADM stated he investigated all complaints of ANE and reported to the state within two hours if there was an injury and within 24 hours for non-injury incidents .</p> <p>During an interview on 01/07/25 at 12:24 PM, Resident #1 stated he wished everyone would mind their own business about the money. He stated he did not give CNA A any money, but it is his money, and he can do what he wants with it. He stated he did not get much money because the facility took it all. He stated he felt bad because she lost her job and got evicted.</p> <p>During a telephone interview on 01/07/24 at 3:17 PM, the RDO stated he did recall the allegation of a CNA taking money from a resident who was not at the nursing facility when it happened. He stated after the CEO from the hospital reported it to the facility ADM, they went to the other hospital to interview the resident. He stated it took several follow-ups. He stated he could not remember if the incident was reported to the state since the resident was not at their facility at the time. He stated the aide was suspended during the investigation and terminated. He stated the administrator was responsible for reporting to the state.</p> <p>Review of the facility policy, Preventing Resident Abuse, revised 02/2023, reflected in part, Our facility will not condone any form of resident abuse and will continually monitor facility's policies, procedures, training programs, systems, etc. to assist in preventing abuse.</p> <p>Review of the facility policy, Resident Rights, revised 02/2021, reflected in part, Employees shall treat all residents with kindness, respect, and dignity. 1. Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to: c. be free from abuse, neglect, misappropriation of property, and exploitation .:</p> <p>The polices provided did not address reporting of abuse, neglect, or exploitation.</p> <p>Review of Resident #1's progress note dated 12/18/24 at 1:15 PM reflected, Parole officer was in today to visit with Resident #1. Parole officer advised ADON that he would not be approving any day passes with relatives or family members of CNA A.</p>		