STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676338	A. Building B. Wing	10/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Coon Memorial Home	210 Texas Blvd Dalhart, TX 79022

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 0603 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from separation (from other residents, his/her room, or confinement to his/her room). **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47159 Based on Observation, Interview and Record Review the facility failed to ensure residents were free from involuntary seclusion for 6 of 21 (Residents #1, #2, #9, #12, #15 and #17) residents reviewed for involuntary seclusion. Residents #1, #2, #9, #12, #15 and #17 were placed in the secure unit but did not have documentation of the clinical criteria for placement by the Resident's Physician, along with information provided by the interdisciplinary team. There were no Physician Orders for placement on the secure unit in any of the 6 resident's clinical records. There were no updates to Care Plans for placement on the secure unit in any of the 6 resident's clinical records. Residents of the secure unit and their Resident Representatives were not given the access code to freely enter or exit the secured unit. This failure could place Residents #1, #2, #9, #12, #15 and #17 at risk of isolation and psychosocial harm. Findings included: Record review of Resident #1's clinical record face sheet revealed a [AGE] year-old male with an admitted [DATE], and a diagnosis of Alzheimer's Disease (a condition that causes the brain to shrink and brain cells to eventually die). Observation of Resident #1 revealed he was clean, dressed and interacting appropriately with staff and other residents during an activity with the Activity Director. An interview with Resident #1 on 10/15/2024 at 1:12PM revealed his son came to pick him up earlier today to have lunch in the community. Resident #1 stated he had just moved into his current room on the secure unit. Resident #1 stated he stated he did not know the code to open the door of the secure unit. Record review of Physician Orders for Resident #1 revealed no Physician's Order indicating the need for placement on the secure unit. Record review of Resident #1's Quarterly MDS dated ,d+[DATE]//2024 revealed a BIMS score of 04, indicating severe cognitive impairment. Review of Resident #1's Care Plan dated 10/06/2024 revealed Resident #1 was at risk for elopement and wandering behavior but did not indicate an actual elopement had taken place. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676338	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/16/2024
NAME OF PROVIDER OR SUPPLIER Coon Memorial Home		STREET ADDRESS, CITY, STATE, ZIP CODE 210 Texas Blvd Dalhart, TX 79022	

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 0603 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #2's clinical record face sheet revealed a [AGE] year-old female with an admitted [DATE], and a diagnosis of Unspecified Dementia (a gradual decline in memory, thinking, behavior and social skills) Unspecified Severity, with Other Behavioral Disturbance. Observation of Resident #2 revealed she was clean, dressed and interacting appropriately with staff and other residents during an activity with the Activities Director. An interview with Resident #2 on 10/15/2024 at 1:20 PM revealed she enjoyed the activities provided by the Activities Director and had many friends who lived close to her. Resident #2 stated she did not know the code to open the door of the secure unit. Record review of Physician Orders for Resident #2 revealed no Physician Order indicating the need for placement on the secure unit. Record review of Resident #2's Quarterly MDS dated [DATE] revealed a BIMS score of 99, indicating severe cognitive impairment. Record Review of Resident #2's Care Plan dated 08/31/2024 revealed resident #2 had a Skin Tear/Potential for Skin Tear of arms/legs/torso of the resident related to fragile skin. There was no indication in the Care Plan Resident #2 was an elopement risk or had an elopement attempt had taken place. Record review of Resident #15's clinical record face sheet revealed an [AGE] year-old female who was admitted to the facility on [DATE] with a diagnosis of Unspecified Dementia, Unspecified Severity, With Behavioral Disturbance and Anxiety. Observation of Resident #15 revealed she was clean, dressed and interacting appropriately with staff and other residents during an activity with the Activities Director. An interview with Resident #15 on 10/15/2024 at 1:28PM revealed she would answer yes and no questions by shaking her head. Resident #15 indicated she enjoyed activities with other residents. Resident #15 indicated she did not know the code to open the door of the secure unit. Record review of Physician Orders for Resident #15 revealed no Physician Order indicating the need for placement on the secure unit. Record review of Resident #15's Quarterly MDS dated [DATE] revealed a BIMS score of 99, indicating severe cognitive impairment. Record Review of Resident #15's Care Plan dated 10/10/2024 revealed Resident #15 was at risk for falls related to being wheelchair bound. There was no indication in the Care Plan Resident #15 was an elopement risk or had an elopement attempt. An interview with the Rounding Provider on 10/15/2024 at 1:34PM revealed she had not written orders for any residents to be placed on the secure unit and there was no clinical determination as to when a resident required placement on the secure unit. She stated residents were placed on the secure unit for their own safety or the safety of others. She stated she was not aware of any documentation which was signed by the Resident or the Resident's Representative, giving written consent for the Resident's placement on the secure unit. An interview with the Administrator on 10/15/2024 at 2:04PM revealed there was no policy and procedure for admitting residents to the secure unit. She stated most residents on the unit tended to wander or had an elopement attempt. She stated Residents and/or Resident Representatives did not sign any paperwork giving consent for their resident to be placed on the secure unit and some Residents and/or Resident Representatives had chosen the placement, so the resident could have a private room. An interview with the DON on 10/15/2024 at 2:51PM revealed documentation for placement on the secure unit could be found in each resident's Progress Notes. The DON stated residents on the secure unit tended to wander or had an elopement attempt. Record review of Progress Notes for Residents #1, #2, #9, #12, #15 and #17 did not reveal documentation of wandering, an elopement attempt or an actual elopement. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676338	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/16/2024
NAME OF PROVIDER OR SUPPLIER Coon Memorial Home		STREET ADDRESS, CITY, STATE, ZIP CODE 210 Texas Blvd Dalhart, TX 79022	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0603 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/16/2024 at 8:59AM record review of Physician Orders revealed Residents #1, #2, #9, #12, #15 and #17 now had a verbal, but not written order from the Rounding Provider for placement on the secure unit. Record review of Resident #12's clinical record face sheet revealed an [AGE] year-old female who was admitted to the facility on [DATE] with a diagnosis of Tremor, Unspecified. An observation of Resident #12 revealed she was clean, dressed and sitting in her wheelchair watching TV. An interview with Resident #12 on 10/16/2024 at 11:33AM revealed she did not participate in activities and preferred to be alone in her room. Resident #12 stated she was placed on the secure unit because she and her Resident Representative had wanted a private room, when she was admitted to the facility. She stated she was happy having her own room. She stated she was not allowed to have the code to open the door of the secure unit. Record review of Physician Orders for Resident #12 revealed a verbal, but not a written order indicating the need for placement on the secure unit. Record review of Resident #12's Quarterly MDS dated [DATE] revealed a BIMS score of 15, indicating no cognitive impairment. Record Review of Resident #12's Care Plan dated 10/03/2024 revealed Resident #12 was at risk for falls related to being wheelchair bound. There was no indication in the Care Plan Resident #12 was an elopement risk or had an elopement attempt. Record review of Resident #9's clinical record face sheet revealed an [AGE] year-old female who was admitted to the facility on [DATE] with a diagnosis of Alzheimer's Disease, Unspecified and Other Depressive Episodes. An observation of Resident #9 revealed she was watching an activity being done by the Activities Director but was not participating along with the other residents of the secure unit. An interview with Resident #9 on 10/16/2024 at 11:43AM revealed she did not enjoy the activities provided by the Activities Director and preferred to talk with her best friend who was Resident #17. She stated she had been placed on the secure unit when she arrived at the facility because this was the only way she could have a private room. She stated she was alllowed to move freely around the secure unit, but was not allowed to have the code to the door to visit other residents in the facility. Resident #9 stated if she wanted to see her friends on the other side a staff member would open the secure door for her or she would have to wait to see them at activities outside the secure unit. Record review of Physician Orders for Resident #9 revealed a verbal, but no written Physician Order indicating the need for placement on the secure unit. Record review of Resident #9's Quarterly MDS dated [DATE] revealed a BIMS score of 07, indicating severe cognitive impairment. Record Review of Resident #9's Care Plan dated 09/18/2024 revealed Resident #9 was at risk for impaired nutrition, secondary to progression of disease processes. There was no indication in the Care Plan Resident #9 was an elopement risk or had an elopement attempt. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Coon Memorial Home		STREET ADDRESS, CITY, STATE, ZIP CODE 210 Texas Blvd Dalhart, TX 79022	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0603 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #17's clinical record face sheet revealed an [AGE] year-old female who was admitted to the facility on [DATE] with a diagnosis of Unspecified Dementia, Unspecified Severity, Without Behavioral Disturbance, Psychotic Disturbance, Mood Disturbance and Anxiety. An observation of Resident #17 revealed she was watching an activity being done by the Activities Director but was not participating along with the other residents of the secure unit. An interview with Resident #17 on 10/16/2024 at 11:43AM revealed she did not enjoy the activities provided by the Activities Director and preferred to talk with her best friend who was Resident #9. She stated she had been placed on the secure unit when she arrived at the facility because this was the only way she could have a private room. She stated she was alllowed to move freely around the secure unit, but was not allowed to have the code to the door to visit other residents in the facility. Resident #17 stated if she wanted to see her friends on the other side a staff member would open the secure door for her or she would have to wait to see them at activities outside the secure unit. Record review of Physician Orders for Resident #17 revealed a verbal, but no written Physician Order indicating the need for placement on the secure unit. Record review of Resident #17's Quarterly MDS dated [DATE] revealed a BIMS score of 07, indicating severe cognitive impairment. Record Review of Resident #17's Care Plan revealed Resident #17 was at risk for impaired psychosocial well-being secondary to uncomfortable situations with other residents, imbalanced nutrition and impaired cognitive function/ impaired thought processes and agitation related to a diagnosis of Dementia. There was no indication in the Care Plan Resident #17 was an elopement risk or had an elopement attempt. On 10/16/2024 at 12:00PM an interview with the Administrator revealed some of the residents on the secure unit had chosen or their families had chosen to place them on the secure unit, due to a smaller population, desire for specific nurses to give care or the want for a private room. The Administrator was unable to tell me which residents and/or Resident Representatives had chosen placement on the secure unit She stated most of the residents on the secure unit were there when she began her employment in March 2024. An interview on 10/16/2024 at 12:37PM with the Administrator and the DON revealed the DON felt most of the residents on the secure unit could not remember an access code to the keypad. The Administrator stated neither residents nor family members have the access code to the keypad of the secure unit. The DON stated they did not want residents in the secured unit roaming from place-to-place in the facility or residents who do not reside in the secure unit to have the code, to visit with their friends. The Administrator and DON agreed staff would have to let Residents and/or Resident Representatives enter and exit the secure unit. A phone interview with the Resident Representative for Resident #17 on 10/16/2024 at 2:02PM revealed she was not aware of a clinical reason her resident was admitted to the secure unit, but she had wanted a private room and the secure unit was the only place, one could be had. She stated she was not given the code to the door of the secure unit to visit Resident #17 at her convenience. A phone interview with Resident Representative for Resident #9 on 10/16/2024 at 2:16PM revealed Resident #9 had lived with him and a family member prior to admission to the facility and her level of care had become more than they could handle at home. He stated the family wanted Resident #9 to have a private room, and the secure was the only place one could be had. He stated he was not given the code to the door of the secure unit to visit Resident #9 at his convenience. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676338	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Coon Memorial Home	210 Texas Blvd Dalhart, TX 79022

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0603 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A phone interview with Resident Representative for Resident #12 on 10/16/2024 at 2:16PM revealed Resident #12 had lived alone for the 6-years prior to admission to the facility and wanted a private room and did not like to have her belongings touched by other residents. He stated Resident #12 liked to have her TV volume up very loud and needed a private room which could only be provided on the secure unit. He stated he was not given the code to the door of the secure unit to visti Resident #12 at his convenience.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676338	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/16/2024
NAME OF PROVIDER OR SUPPLIER: Coon Memorial Home		STREET ADDRESS, CITY, STATE, ZIP CODE: 210 Texas Blvd Dalhart, TX 79022	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47159 Based on Interview and Record Review the facility failed to develop and implement a comprehensive person-centered Care Plan that included measurable objectives and time frames to meet a resident's medical, nursing and psychosocial needs for 6 of 21 (Residents #1, #2, #9, #12, #15 and #17) reviewed for Care Planning. Residents #1, #2, #9, #12, #15 and #17 were placed in the secure unit of the facility with no documentation of the placement in their Care Plans. This failure could affect the psychosocial and mental well-being of Residents #1, #2, #9, #12, #15 and #17. Findings included: Record review of Resident #1's clinical record face sheet revealed a [AGE] year-old male with an admitted [DATE], and a diagnosis of, Alzheimer's Disease. Review of Resident #1's current Care Plan dated 10/06/2024 revealed Resident #1 was at risk for elopement and wandering behavior but did not indicate an actual elopement had taken place. Resident #1 had a history of sexual acts toward staff and other residents. The goal was listed as little to no episodes of sexual acts toward staff and other residents. The intervention was if reasonable, discuss resident's behavior with him. Explain/reinforce why behavior is inappropriate and/or unacceptable and praise any indication of the resident's progress/improvement in behavior. There was no documentation of Resident #1 being placed on the secure unit in his Care Plan. Record review of Resident #2's clinical record face sheet revealed a [AGE] year-old female with an admitted [DATE], and a diagnosis of Unspecified Dementia, Unspecified Severity, with Other Behavioral Disturbance. Record review of Resident #1's current Care Plan dated 10/11/2024 revealed Resident #1 had been inappropriately touched by a male resident . The goal was not being touched inappropriately by male residents. The intervention was always monitoring Resident #2's whereabouts. There was no documentation of Resident #2 being placed on the secure unit in her Care Plan. Record review of Resident #9's clinical record face sheet revealed an [AGE] year-old female who was admitted to the facility on [DATE] with a diagnosis of Alzheimer's Disease, Unspecified and Other Depressive Episodes. Record Review of Resident #9's current Care Plan dated 09/18/2024 revealed Resident #9 was at risk for impaired nutrition secondary to impaired Cognitive Status. The goal was maintaining current weight +/- 5%. The intervention was giving the resident supplements as ordered, monitoring, and evaluating any weight loss, monitoring, and recording food intake at each meal and offering substitutions as requested or indicated. There was no documentation of Resident #9 being placed on the secure unit in her Care Plan. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #12's clinical record face sheet revealed an [AGE] year-old female who was admitted to the facility on [DATE] with a diagnosis of Tremor, Unspecified. Record Review of Resident #12's current Care Plan dated 10/03/2024 revealed Resident #12 was at risk for over stimulation. The goal was having minimal over-stimulation. The intervention was the resident had ability to make her own decisions regarding activities which might trigger over-stimulation. There was no documentation of Resident #12 being placed on the secure unit in her Care Plan. Record review of Resident #15's clinical record face sheet revealed an [AGE] year-old female who was admitted to the facility on [DATE] with a diagnosis of, but not limited to Parkinson's Disease, with Dyskinesia (Unplanned/Unexplained body movements/jerks), with Fluctuations, Unspecified Dementia with Anxiety and Other Behavioral Disturbances. Record Review of Resident #15's current Care Plan dated 10/10/2024 revealed Resident #15 was at risk for falls. The goal was having no injury from falling out of bed and onto fall mat. The intervention was a fall mat beside bed at all times and determining causative factors of falling. There was no documentation of Resident #15 being placed on the secure unit in her Care Plan. Record review of Resident #17's clinical record face sheet revealed an [AGE] year-old female who was admitted to the facility on [DATE] with a diagnosis of Unspecified Dementia, Unspecified Severity, Without Behavioral Disturbance, Psychotic Disturbance, Mood Disturbance and Anxiety. Record Review of Resident #17's current Care Plan dated 08/18/2024 revealed Resident #17 was at risk for impaired psychosocial well-being secondary to uncomfortable situations with other residents, imbalanced nutrition and impaired cognitive function/impaired thought processes and agitation related to a diagnosis of Dementia. The goal was minimal to no s/s of impaired psychosocial well-being, maintaining weight +/- 5%, consuming 50-75% of meals and minimal to no complications related to decline in cognition. The intervention was administering medications as ordered by MD, notifying MD of any cognitive changes, encouraging resident to talk about how they are feeling, monitoring, and encouraging meal intake, providing diet as ordered, weighing resident every month and staff providing 1:1 activity 3 times per week and social services visits 1:1 weekly and PRN. There was no documentation in the Care Plan of Resident #17 being placed on the secure unit in her Care Plan. An interview with the Rounding Provider on 10/15/2024 at 1:34PM revealed she took part in the Care Plan meetings of all residents within the facility. She stated there was no discussion with the interdisciplinary team about secure unit placement of Residents #1, #2, #9, #12, #15 and #17 during their Care Plan meetings. An interview with the DON on 10/15/2024 at 2:51PM revealed documentation for placement on the secure unit could be found in each resident's Progress Notes. Review of Progress notes for Residents #1, #2, #9, #12, #15 and #17 did not reveal documentation for placement on the secure unit. She stated she took part in all Care Plan meetings for residents within the facility. She could not recall if placement on the secure unit was discussed by the interdisciplinary team. An interview with Resident #12 on 10/16/2024 at 11:33AM revealed she had chosen to live on the secure unit when she arrived at the facility, because she liked her TV volume to be very loud, liked to sleep with her TV on at night and did not want other residents touching her belongings. She was very happy having her own room. She stated she took part in her Care Plan meeings on a regular basis. Resident #12 stated she had not discussed living on the secure unit during her Care Plan meetings. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview with Resident #9 on 10/16/2024 at 11:43AM revealed she was allowed to move freely around the secured unit but was not allowed to have the access code to visit other residents residing in the facility. Resident #9 stated they saw their friends when they attended activities but had to have a staff member open the door to the secure unit, if they wanted to visit friends at any other time. Resident #9 stated she took part in her Care Plan meetings on a regular basis. Resident #9 stated she had not discussed living on the secure unit during her Care Plan meetings. An interview with Resident #17 on 10/16/2024 at 11:43AM revealed she was allowed to move freely around the secured unit but was not allowed to have the access code to visit other residents residing in the facility. Resident #17 stated they saw their friends when they attended activities but had to have a staff member open the door to the secure unit, if they wanted to visit friends at any other time. Resident #17 stated she took part in her Care Plan meetings on a regular basis. Resident #17 stated she had not discussed living on the secure unit duing her Care Plan meetings. An interview with the Administrator on 10/16/2024 at 12:00PM revealed many of the residents on the secure unit were there when she began her employment in March 2024. She stated she took part in all Care Plan meetings for residents within the facility. She could not recall if placement on the secure unit was discussed by the interdisciplinary team during individual Care Plan meetings. An interview with the Administrator and DON on 10/16/2024 at 12:37PM revealed Care Plans for all residents residing on the secure unit, were being updated today. An interview with Resident #17's Resident Representative on 10/16/2024 at 2:02PM revealed Resident #17's Care Plan meeting was attended by the Resident Representative via phone. Resident Representative stated placement of Resident #17 on the secure unit was not discussed during the Care Plan meeting. An interview with Resident #9's Resident Representative on 10/16/2024 at 2:16PM revealed he took part in Resident #9's Care Plan meeting. Resident Representative stated placement of Resident #9 on the secure unit was not discussed during the Care Plan meeting. An interview with Resident #12's Resident Representative on 10/16/2024 at 3:30PM revealed he took part in Resident #12's Care Plan meeting. Resident Representative stated placement of Resident #12 on the secure unit was not discussed during the Care Plan meeting.