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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676481	A. Building B. Wing	08/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bethany Senior Living	118 Trinity Shores Drive Port Lavaca, TX 77979

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 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42402 Based on interview and record review, the facility failed to notify the resident and resident's representative of the discharge and the reasons for the move in writing and in a language and manner they understand, failed to update the recipients of the notice as soon as practicable once the updated information became available, and failed to send a copy of the notice to a representative of the Office of the State Long-Term Ombudsman for 1 of 5 residents (Resident #1) reviewed for discharge, in that: The facility failed to notify Resident #1's RP in writing and did not notify the State Long Term Care Ombudsman by phone or in writing of Resident #1's discharge due to safety concerns. This deficient practice could place residents at risk of being discharged and not allowed to return to the facility, causing a disruption in their care and services and potential decline in health. Findings included: Closed record review of Resident #1's undated face sheet revealed the resident was a [AGE] year-old male admitted to the facility initially on 3/14/2024 with diagnoses that included Hypertension (High pressure in the arteries [vessels that carry blood from the heart to the rest of the body]. Symptoms varies from person to person and generally include unexplained fatigue and headache), Diabetes Mellitus 2 (Type 2 diabetes is a condition that happens because of a problem in the way the body regulates and uses sugar as a fuel.), cognitive deficit (Cognition is the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses), GERD (Gastroesophageal reflux disease is a condition in which stomach acid repeatedly flows back up into the tube connecting the mouth and stomach, called the esophagus) mood disorder, hepatitis (is a liver disease that can have different causes and outcomes, from mild to life-threatening) and hearing loss. Resident #1 discharged to a hospital on 5/11/2024, returned to facility on 5/14/2024 and then discharged to a psychiatric facility on 5/14/2024 for medication review and behavioral placement. Further review of the face sheet revealed the resident's primary payor source was Managed Care Provider. Closed record review of Resident #1's quarterly MDS, dated [DATE], revealed the resident had a BIMS score of 14 indicating he was cognitively intact. Further review of this MDS reveals the resident had no symptoms of delirium, no behaviors documented. (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: 676481	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Closed record review of Resident #1's care plan, dated 3/22/2024, revealed a focus area that included Resident #1 required assistance on staff for ADL care. There was a focus area indicating behaviors of resisting care, refusal of care, hitting staff and cursing at staff. No behaviors towards other residents before the incident leading to his admission to the psychiatric facility on 5/15/2024. Closed record review of Resident #1's EHR revealed a primary physician's note dated 5/1/2024 that indicated the resident had intact judgement and insight. Resident #1 was alert and oriented. Closed record review of a progress note in Resident #1's EHR, dated 5/10/2024 at 4:30 p.m. authored by LVN A, revealed Resident #1 was in the dining room and approached a second resident who Resident #1 claimed to be in his spot and hit him multiple times on the left side of his head. Resident #1 was removed from the area. The hitting was witnessed by Medication Aide B. Resident #1 was immediately placed on one-to-one observation and the RP was notified. The RP voiced she could not come to facility as she was out of town. Resident #1 was asked why he hit another resident and he stated he was in his spot, so he had to show him how to remember. Resident #1 admitted to hitting the other resident. The primary physician was notified. The Social Worker was notified. Closed record review of Resident #1's EHR revealed on 5/11/204 at 7:20 a.m. Resident #1 left the facility via van accompanied by 2 staff members to the local hospital for evaluation and treatment. Closed record review of Resident #1's EHR revealed on 5/14/2024 at 9:40 p.m. Resident #1 returned from the local hospital and the resident's RP was notified. Closed record review of Resident #1's EHR revealed on 5/15/2024 at 8:18 a.m. authored by DON, the RP had been notified of Resident #1's aggressive behaviors and the local hospital had recommended transfer to a behavioral hospital. Resident #1 was transferred to a behavioral facility leaving the nursing facility at 2:32 p. m. on 5/15/2024. Closed record review of Resident #1's EHR from 05/14/2024 to 05/19/2024 revealed there was no documentation of written notification to the resident's RP or the LTC Ombudsman of the resident's discharge from the facility. Record review of a progress note in Resident #1's EHR, dated 5/20/2024 at 1:55 p.m. authored by the facility's SW, revealed the SW had called the resident's RP to provide contact information on Resident #1's transfer to the behavioral center. During an interview on 7/31/2024 at 3:30 p.m. the facility Regional Nurse RN, who was acting DON at facility, stated Resident #1's RP was bringing the resident back to the facility, but the facility had not accepted him back. The Regional Nurse RN further revealed the local hospital had to accept him because he was a fully paid managed care provider at the facility, and they had to make the decision by a process of approval before he could come back to the nursing facility and that had not been done. The Regional Nurse RN further stated she felt Resident #1 was unsafe to other residents in the facility because he stated he would hit again if needed. During an interview on 7/31/2024 at 4:00 p.m., the Administrator stated Resident #1 and his RP had been denied readmission at this date due to no preauthorization approval from the managed care approver and his behaviors. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Bethany Senior Living		STREET ADDRESS, CITY, STATE, ZIP CODE 118 Trinity Shores Drive Port Lavaca, TX 77979	

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 7/31/2024 at 4:35 p.m. with Resident #1's RP, she stated she was not notified by the facility that the resident was being transferred and discharged to another facility and would not be allowed to return to the facility. Resident #1's RP further stated the Ombudsman and her had received an appeal and the resident was allowed to return to the facility. Resident #1's RP stated the facility had told her Resident #1 could not return to facility due to his behaviors. During a phone interview on 7/31/2024 at 4:40 p.m. with the Ombudsman, the Ombudsman stated the facility was required to send her discharge notices. The Ombudsman stated she had not been informed of Resident #1's discharge, and further stated she was notified by Resident #1's RP about the facility not allowing him to return. The Ombudsman stated an appeal was accepted on and he would be allowed to return to the facility. During a phone interview on 8/1/2024 at 10:14 a.m. with Resident #1's primary Physician, he stated Resident #1 had an encounter of hitting another resident. Resident #1's primary Physician stated before the resident had left the facility, he had ordered lab work including a urinalysis to see if any infection was occurring. Resident #1's primary Physician further revealed the lab work came back inconclusive for no infection. Resident #1's primary physician stated Resident #1 was transferred to a behavioral hospital and he had not been accepted back to facility because he nor the facility felt he was appropriate due to his behavior of hitting the other resident. During an interview on 8/1/2024 at 10:30 a.m. with the facility SW stated she had been notified by nursing staff that Resident #1 had hit another resident and was going to be transferred to a behavioral facility by the local hospital that he had gone to for an evaluation. The SW further revealed she had not communicated with the local hospital for the transfer because the managed care provider had already processed it. The SW stated normally the interdisciplinary team which included herself, the DON, and the Administrator communicate with the local hospital for any transfers or anything to do with a resident who is placed in their facility. SW further revealed the DON did that as far as she knew. Telephone attempts to contact Medication Aide B on 8/1/2024 at 12:53 p.m. and 8/2/2024 at 9:15 a.m. were unsuccessful. During an interview with LVN A on 8/2/2024 at 10:27 a.m., LVN A stated she was the charge nurse for Resident #1 on the day he hit another resident. LVN A stated she heard another staff member (Medication Aide B) call for assistance in the dining room and she went. LVN A stated she had been told by Medication Aide B that Resident #1 had hit another resident in the face because he was in his spot. LVN A stated prior to the incident Resident #1 had not hit any other resident. Record review of the facility's policy titled, Transfer or Discharge, dated 2001 (revised October 2022), revealed, Policy Statement: Once admitted to the facility, residents have the right to remain in the facility. Facility-initiated transfers and discharges, when necessary, must meet specific criteria and require resident/representative notification and orientation, and documentation as specified in this policy. Notice of Transfer or Discharge 1. Except as specified below, the resident and his or her representative are given a thirty (30)-day advance written notice of an impending transfer or discharge from this facility. 2. Notice of Transfer is provided to the resident and representative as soon as practicable before the transfer and to the long-term care (LTC) ombudsman when practicable (e.g., in a monthly list of residents that includes all notice content requirements).