STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	745007	A. Building B. Wing	08/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vernon Rehabilitation and Nursing Center	4301 Hospital Dr. Vernon, TX 76384

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 0567 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to manage his or her financial affairs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33198 Based on interview and record review the facility failed to ensure residents who have authorized the facility in writing to manage any personal funds have access to those funds for 2 of 3 residents (Resident #4 and Resident #5) reviewed for personal funds. The facility failed to ensure Resident #4, and Resident #5 had access to their personal funds when requested. This failure could place residents whose funds are managed by the facility at risk of not receiving their personal funds deposited with the facility and not having their rights and preferences honored. Findings included: Record review of Resident #4's face sheet dated [DATE] revealed an admitted [DATE] with diagnoses which included: schizoaffective disorder (a chronic mental illness involving symptoms of schizophrenia and characterized by symptoms such as delusions and hallucinations), hyperlipidemia (high fat levels in the blood), and Overactive bladder (sudden urge to urinate and sometimes involuntary loss of urine). Record review of Resident #4's Comprehensive quarterly MDS assessment dated [DATE], indicated Resident #4 had a BIMS score of 11, which indicated her cognition was moderate. During interview with Resident #4 on [DATE] at 1:40 p.m., she stated she was not able to get her money on [DATE] as scheduled. She was not able to buy some essential needs and was stressed because of it. She stated it took more than 2 weeks to get her money. Resident #4 explained she was told the BOM D quit and there was not anyone to disburse the funds. Record review of Resident #5's face sheet dated [DATE] revealed an admitted [DATE] with diagnoses which included: schizoaffective disorder (a chronic mental illness involving symptoms of schizophrenia and characterized by symptoms such as delusions and hallucinations), hyperlipidemia (high fat levels in the blood), and Constipation (bowel dysfunction). Record review of Resident #5's Comprehensive quarterly MDS assessment dated [DATE], indicated Resident #5 had a BIMS score of 12, which indicated her cognition was moderate. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0567 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview with Resident #5 on [DATE] at 1:52 p.m., he stated he was supposed to receive his monthly personal funds on [DATE] but did not. Resident #1 said he received the money on [DATE] about 17 days later. Resident #5 explained he was not happy because he could not timely attend to his financial needs. He depends on the money to live. He stated he was informed that the BOM D quit the job. During an interview on [DATE] at 1:29 p.m. with ADM C, she said she was the former Administrator for the facility. She stated she quit her employment because the company was not paying vendors for their services including pest control, Medical Director, HVAC and food. She noted OWNER said the company have no money. ADM C explained the facility's BOM D quit, and the residents were not able to get their money as scheduled. She told OWNER to put her in charge of the trust fund temporary, but he refused. The OWNER stated they would work on something to get the residents their money. On the scheduled day, the residents did not get their money. Record review of the facility policy on Resident trust effective [DATE] reflected the following: PURPOSE: To maintain a Resident Trust Account, for the safekeeping of a resident's personal money, if requested to do so, in writing, by the Resident/Responsible Party, in accordance with Federal and State Regulations. POLICY STATEMENT Each Center shall have standardized policies for the handling of resident trust accounts, both active resident funds and the fund of deceased residents. Monitoring systems shall be in place to ensure funds are handled in accordance with applicable state regulations. Resident Trust Fund Petty Cash: The resident trust petty cash fund shall be maintained as follows: a. Receipt slips will be completed for all withdrawals showing: (a) the resident's name, (b) date of withdrawal, (c) amount withdrawn, (d) verifying signature of resident receiving money, and (e) verifying signature of person dispensing money. If the resident cannot sign they can put an X on the receipt and then two Team Members must sign as witnesses. (continued on next page)

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F 0567 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	b. The petty cash fund shall be posted daily to make funds available to residents. The receipt slips will be kept for transactions recorded. on the RFMS System to support the total amount of the electronic fund transfer. c. Cash in the petty cash box + receipts for monies signed out, which should remain in the box until reconciled + receipts in system to be processed (cyber space) + Rapid Pay Card balance must always equal the established balance authorized by the BSC. d. The date used to post withdrawals from petty cash to the resident ledgers should be the date of the petty cash voucher.

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33198 Based on observation, interview, and record review, the facility failed to ensure residents have the right to be free from neglect for 4 of 4 (Resident #1, Resident #2, Resident #3, and Resident #12) residents reviewed for Neglect: The facility did not have staff to provide care for the residents, causing them to do an emergency transfer, with little preparation, and only 24-hour notice to the residents and families. The facility attempted to transfer Resident #1, Resident #2, and Resident #3 in a van that did not appear to be in good repair and did break down, during the transfer, causing residents to be stranded on the roadside for approximately 6 hours. The facility transferred Resident #1, Resident #2, and Resident #3 in a van, with only the van driver, with no nursing staff, no medications, and no one to provide care or other resident needs. Resident #1 and Resident #3 were both transferred to the hospital, requiring treatment for heat related episodes, after being on the van, which was broken down on the side of the road, for approximately 6 hours. Both required admission to the hospital for evaluation and treatment. Resident #2 was noted to be unresponsive after being seated on the van, for over an hour, with the outside temperature noted to be 107 degrees, with no water, requiring EMS to respond for evaluation. An Immediate Jeopardy was determined to have existed from [DATE] through [DATE]. The Immediate Jeopardy was removed on [DATE] due to the facility being closed, with all residents being discharged . However, the facility remained out of compliance at a severity of the potential for more than minimal harm, with a scope of pattern. This failure placed residents at risk of not having their physical or emotional needs met, while being transferred or discharged which placed the residents at risk of physical and emotional injuries, hospitalization and death. The findings included: Resident #1 - Review of Resident #1's Admission Record, dated [DATE], revealed he was a [AGE] year-old male, originally admitted to the facility on [DATE], with current admitted [DATE], with the following diagnoses: Toxic Encephalopathy (brain dysfunction caused by toxic exposure); Alzheimer's Disease; Hypertension; Atrial Fibrillation; Lack of Coordination; Paraplegia; Congestive Heart Failure; Convulsions; Dysphagia; and Cognitive Decline. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of Resident #1's Quarterly MDS, dated [DATE], revealed a BIMS score of 05, indicating severe cognitive impairment. This review revealed Resident #1 was continent of bowel and bladder but did was dependent for toileting hygiene and lower body dressing. Resident #1 required the use of a wheelchair with substantial/maximal assistance to wheel 50 feet and make two turns. Resident #1 required dependent assistance in most ADLs including oral hygiene, toileting, dressing, personal hygiene, bathing and transfers. Review of Resident #1's Care Plan, initiated [DATE], revealed a focus of Potential for dehydration, related to diuretic use and poor fluid intake. The interventions included encourage fluid intake. The goal was for Resident #1 to be free from symptoms of dehydration and maintain moist mucous membrane, good skin turgor through next review. Review of Resident #1's Medication Administration Record (MAR) revealed Divalproex Sodium delayed release, 500 mg, two times daily, related to Convulsions, with a start date of [DATE]. The MAR noted he received the medication at 8:00 AM on [DATE], with the next dose due at 8:00 PM. Review of Resident #1's hospital records revealed he was admitted to the hospital on [DATE] at 8:49 PM, with Chief Complaint of Syncope, it was noted resident was brought in via EMS for having 2 syncopal episodes after sitting on a bus, broken down, on the side of the road for approximately 30 minutes. The diagnoses for the visit were noted as Delirium, History of Stroke, History of Dementia, Heat exhaustion, and history of Seizures. The Medical Decision-Making area of these records revealed the [in part] Patient presented after he had 2 syncopal episodes after prolonged heat exposure. He was initially agitated. He was given IV Ativan. At the time of reassessment, it was suspected the patient may have had a seizure due to prolactin levels being elevated. Resident #1 was discharged to the receiving facility, in Arlington on [DATE] at 8:00 PM. During interview with Resident #1's RP on [DATE] at 1:52 p.m., she said she was the responsible party for Resident #1. RP explained the facility did not notify her that Resident #1 would be moving to another facility. Her other brother told her, and she left work to come and assist with packing his belongings. RP stated this is too much and unsettling for this family, who does things this way. The RP added, Resident #1 was not in good health and the stress of moving away from the family is hard to see. She said the facility did not give the family enough time or options to find another place closer to the family. Resident #3 - Review of Resident #3's Admission Record, dated [DATE], revealed he was a [AGE] year-old male, admitted to the facility on [DATE], with diagnoses of Metabolic Encephalopathy; Hypertension; Diabetes Mellitus; Congestive Heart Failure; Schizophrenia; Lack of Coordination; Cognitive Decline; and Dehydration. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of Resident #3's Admission MDS, dated [DATE], revealed a BIMS score of 7, indicating severe cognitive impairment. Resident required supervision or touching assistance (helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity) for Eating - the ability to use suitable utensils to bring food and/or liquids to the mouth and swallow food and/or liquids once placed before the resident. Resident has a noted diagnosis of Dehydration during this assessment. Resident #3 was continent of bowel and bladder. Resident #3 required moderate assistance in most ADLs including oral hygiene, toileting, dressing, personal hygiene, bathing and transfers. Review of Resident #3's medical records, on [DATE], revealed no care plans in place. Review of Resident #3's hospital records revealed he was admitted to the hospital on [DATE] at 11:25 PM, with Chief Complaint of Syncope, it was noted resident was picked up after being in the van, which had been broken down for over an hour. It was noted the resident was lethargic and was given approximately 1500 ml of fluid prior to arrival. The diagnoses for the visit were noted as Dehydration, being the primary diagnosis, acute kidney injury, orthostatic hypotension, chronic hypertension, and diabetes. Resident #3 was discharged to the receiving facility, in Arlington on [DATE] at 8:00 PM. During interview with Resident #3 on [DATE] at 2:15 p.m., he stated he was not informed that he would be leaving the facility until today ([DATE]). He was told he would be moving to another facility about 3 hours away. Resident #2- Review of Resident #2's Admission Record, dated [DATE], revealed she was a [AGE] year-old female, admitted to the facility on [DATE], with the following diagnoses: Dementia; Hypertension; Lack of Coordination; Cognitive Decline' Schizophrenia; Dysphagia; and Overactive Bladder. Review of Resident #2's Quarterly MDS, dated [DATE], revealed a BIMS score of 04, indicating severe cognitive impairment. Resident #2 was frequently incontinent of bladder and occasionally incontinent of bowel. Resident #2 required the use of a wheelchair with substantial/maximal assistance to wheel 50 feet and make two turns. Resident #12 Record Review of Resident #12's face sheet dated [DATE] indicated a [AGE] year-old male admitted on [DATE] with the diagnosis of hepatic encephalopathy (a brain dysfunction caused by the liver), chronic kidney diseases, hypotension (low blood pressure), Cirrhosis (impaired liver function), thrombocytopenia (low platelets count that can cause bleeding problems) and splenomegaly (enlarge spleen). Record review of Resident #12's unsigned MDS, dated [DATE], revealed resident #12 had unrated BIMS score. Further review of this MDS reveals the resident had no documented behaviors. Record review of Resident #12's care plan, dated [DATE], revealed a potential for decline in function, decline in communication, impaired cognition, impaired decision making, short- and long-term memory loss, decreased safety awareness, and behavior related to disease process. Its goal was to maintain optimal level of function within limitations imposed by disease process in the next review date. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on [DATE] at 1:37pm with RP for Resident #12, she said she was the wife and responsible party for the resident. Resident #12's RP stated she was informed on [DATE] that the facility was closing the next day. She stated none of the staff knew what was going on, they were just told the facility was closing. Resident #12's RP explained no one from the facility offered to help her or resident find a new place. She contacted hospice and arranged for an apartment for Resident #12. During interview with Physician P on [DATE] at 3:00 p.m., revealed he was not aware that the residents were transferring to another facility. He said he had been concerned about the Administration of the facility. He stated they did not have enough staff, including an Administrator. Physician P said he had not been paid for over 6 months. An interview on [DATE] at 1:30pm, with the DON, revealed the Owner told her and the staff on [DATE] at 3:30pm that the facility could possibly close. DON stated on [DATE] the Owner decided the facility would be closing the next day, on [DATE], and residents would be moved to a sister facility 2.5 hours away. DON stated no notice to residents, families, or State agency was given. DON stated there was no closure plan in place, facility did not have an Administrator, everything was just made up as we went. An interview, on [DATE] at 2:00 PM, the Owner revealed the facility had a van on the way to pick a total of 15 residents up, to transfer to a facility in the Arlington area. He stated all residents would be out of the facility by the end of the day. The Owner stated all residents will be sent with a sandwich. He stated their belongings and medications were being loaded into trucks, that would follow them to the receiving facility. During an observation on [DATE] at 2:15 PM, a van arrived at the facility from the receiving facility. The van driver was identified as being an employee from the receiving facility. The van appeared to have body damage noted to the top and bottom left and right rear quarter-panels and bumper, resulting in ,d+[DATE] foot sections of the quarter-panel being ripped and dented. The registration expired on ,d+[DATE], there was a weak area noted to the floor of the van (approximately 1 foot in diameter), which was covered with carpet and marked with an orange cone. The van had seating for a total of 14 residents, including 2 wheelchair bound residents. An interview on [DATE] at 2:45 PM, with RN A, revealed she was only scheduled to work until 2 PM, but had no one to relieve her, she was the only nurse working. An interview on [DATE] at 3:00pm the Ombudsman stated she was made aware of facility closing on [DATE], does not recall time. The Ombudsman stated she spoke with the Owner, and he stated the lack of an Administrator and CNAs was the reason such short notice was given for facility closing and residents being discharged to another facility. An interview on [DATE] at 3:45 PM, the Owner revealed due to staffing concerns the facility was required to conduct an emergency temporary closure. He stated he had been aware of the severity of staffing for approximately 1.5 weeks. The owner revealed multiple staff had resigned from the facility and the facility was utilizing staff from another facility, but was no longer able to utilize this staff. The Owner revealed the facility has been without a licensed Administrator for about 1.5 weeks. He stated he is a licensed Administrator in New York, but not Texas. The Owner revealed residents were notified of temporary closure on [DATE]. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	An interview on [DATE] at 3:45 PM, the Owner revealed 15 residents were being transferred to a sister facility in Arlington, approximately 3 hours from the current facility, on this date. He revealed all control medications and medications requiring temperature control (insulin) will be destroyed and the other facility will be notified to ensure the medications are ordered prior to the residents arriving. The Owner revealed 4 residents had already been transferred to a local facility, 5 residents had already been transferred to a facility approximately 30 minutes from [NAME], and 1 resident was discharged home, with hospice services. During an observation on [DATE] at 4:05 PM, the facility began loading residents into a van, with Resident #2 being the first to be loaded onto the van. An interview on [DATE] at 2:45 PM, with RN A, revealed there was no method for reconciling the medications. She stated she was just pulling the meds (bubble packs) from the drawers and placing them in a plastic bag. She was marking the residents name on the bag and sending them in the vehicle following the van. She stated they were not sending any control medications or temperature-controlled medications such as insulin. During an observation on [DATE] at 5:10 PM, the DON identified Resident #2 sitting on the van with her head down. Resident #2 was unresponsive at this time. The DON requested assistance and a wheelchair. The DON and additional staff removed Resident #2 from the van, via wheelchair and placed her in a bed, in her room. They placed a wet rag on her head, put a fan blowing on her, and began removing her clothes. Resident #2 was wearing long pants, a shirt, and a long sleeve jacket. Resident #2 began to move her eyes at 5:15 PM. CNA A stated Resident #2, you are so hot. At 5:16 PM Resident #2 began responding verbally. At 5:19 PM, EMS was on site to evaluate Resident #2. Interview on [DATE] at 5:20 PM, with Admissions Staff, who was assisting with loading residents onto the van, revealed residents had no water, while waiting on the van. She stated residents did have access to water in their rooms, but the last time they were directly given water was during their lunch meal. Admissions Staff stated residents were given water once the incident occurred with Resident #2 approximately 10 minutes prior to this interview. Admission Staff stated residents did not receive an evening meal but were given a half of a sandwich to take on the van. During an observation on [DATE] at 6:00 PM, Resident #2 was the last resident loaded onto the van. There was a total of 13 residents on the van, with the van driver. No other staff were on the van. The DON stated the facility did not have any nursing staff to send on the van with the residents. No staff would be present, during this transport to administer medications or provide care, if needed. During an observation on [DATE] at 7:40 PM, two investigators leaving the facility, identified the van, with the residents, on the side of the road, with the hood raised. There were sheriff deputies on site and the van was not in working order. During an observation on [DATE] at 8:30 PM, revealed Resident #1, who was on van, was lethargic and fainted. He was assessed by EMT and transferred to the hospital for further evaluation and treatment. During an observation on [DATE] at 8:45p.m., revealed Resident #3, who was on the van, was lethargic and fainted. He was assessed by EMT and transferred to the hospital for further evaluation and treatment. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an observation on [DATE] at 11:28 PM, a bus, rented by the facility, arrived from the metroplex, approximately 3 hours away, to come to complete the transfer of the residents. They began loading residents at that time. During an observation on [DATE] at 1:35 AM, the bus was loaded, with the residents, and began the trip to the receiving facility, approximately 3 hours remaining in the trip. Review of https://www.wunderground.com weather website revealed the temperatures, in the area, on [DATE], were as follows: - 2:53 PM 106* F - 3:53 PM 106* F - 4:53 PM 107* F - 5:53 PM 106* F - 6:53 PM 104* F - 7:53 PM 101* F - 8:53 PM 96* F - 9:53 PM 93* F - 10:53 PM 91* F - 11:53 PM 86* F Record review of the policy, provided by the facility as their Neglect Policy, not titled, but labeled with the receiving facility name, dated [DATE], revealed the following [in part] - Residents will be protected from neglect in accordance with State and Federal Regulations. - Neglect - Failure to provide goods and services necessary to avoid physical harm, mental anguish, mental illness, or necessary services for daily living activities. - Neglect occurs when facility staff fail to monitor and/or supervise the delivery of resident care and services to ensure that care is provided as needed by residents. - Neglect occurs when a facility fails to provide necessary care for residents. Record Review of the Emergency Nursing Home Closure Policy, provided by the Facility Owner, on [DATE], not dated, revealed the following [in part] (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	- Purpose The purpose of this policy is to provide a structured and compassionate approach for the emergency closure of a for-profit nursing home facility in Texas, ensuring the safety and well-being of residents, compliance with state regulations, and clear communication with all stakeholders. - Policy Statement [Facility Name] is committed to ensuring a smooth and respectful transition for residents, staff, and families during the emergency closure of the facility. The closure process will comply with all applicable state and federal regulations, including the Texas Health and Human Services Commission (HHSC) requirements. - Legal and regulatory requirements will be reviewed to ensure compliance. - Regulatory Authorities: Notify the Texas Health and Human Services Commission (HHSC) and other relevant state and federal agencies immediately upon the decision to close. - Placement Coordination: Collaborate with the HHSC and other agencies to identify suitable alternative facilities for residents. Provide residents and families with a list of options and assist in the selection process. - Transition Plan: Develop individualized transition plans for each resident, including transportation arrangements and the transfer of medical records and personal belongings. - Support Services: Provide emotional and psychological support to residents and families throughout the relocation process. Arrange for counseling services if needed. The Owner was notified of the Immediate Jeopardy on [DATE] at 5:00 PM, via telephone and a copy of the Immediate Jeopardy Template was sent to him at that time. An observation on [DATE] at 4:45 PM, revealed the facility doors were locked, with no sign of staff or residents being present in the facility. The facility was confirmed to be closed at this time. The Immediate Jeopardy was removed. However, the facility remained out of compliance at a severity of the potential for more than minimal harm, with a scope of pattern.

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31886 Based on observation, interviews and record review, the facility failed to implement their written policies and procedures to prohibit and prevent neglect for 3 of 3 (Resident #1, Resident #2, and Resident #3) residents reviewed for Neglect. The facility attempted to transfer Resident#1, Resident #2, and Resident #3 in a van that did not appear to be in good repair and did break down, during the transfer, causing residents to be stranded on the roadside for approximately 6 hours. The facility transferred Resident#1, Resident #2, and Resident #3 in a van, with only the van driver, with no nursing staff, no medications, and no one to provide care or other resident needs. Resident #1 and Resident #3 were both transferred to the hospital, requiring treatment for heat related episodes, after being on the van, which was broken down on the side of the road, for approximately 6 hours. Both required admission to the hospital for evaluation and treatment. Resident #2 was noted to be unresponsive after being seated on the van, for over an hour, with the outside temperature noted to be 107 degrees, with no water, requiring EMS to respond for evaluation. An Immediate Jeopardy was determined to have existed from [DATE] through [DATE]. The Immediate Jeopardy was removed on [DATE] due to the facility being closed, with all residents being discharged . However, the facility remained out of compliance at a severity of the potential for more than minimal harm, with a scope of pattern. This failure placed residents at risk of not having their physical or emotional needs met, while being transferred or discharged which placed the residents at risk of physical and emotional injuries, hospitalization and death. The findings included: Record review of the policy, provided by the facility as their Neglect Policy, not titled, but labeled with the receiving facility name, dated [DATE], revealed the following [in part] - Residents will be protected from neglect in accordance with State and Federal Regulations. - Neglect - Failure to provide goods and services necessary to avoid physical harm, mental anguish, mental illness, or necessary services for daily living activities. - Neglect occurs when facility staff fail to monitor and/or supervise the delivery of resident care and services to ensure that care is provided as needed by residents. - Neglect occurs when a facility fails to provide necessary care for residents. Record Review of the Emergency Nursing Home Closure Policy, provided by the Facility Owner, on [DATE], not dated, revealed the following [in part] (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	745007	A. Building B. Wing	08/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vernon Rehabilitation and Nursing Center	4301 Hospital Dr. Vernon, TX 76384

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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 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	- Purpose The purpose of this policy is to provide a structured and compassionate approach for the emergency closure of a for-profit nursing home facility in Texas, ensuring the safety and well-being of residents, compliance with state regulations, and clear communication with all stakeholders. - Policy Statement [Facility Name] is committed to ensuring a smooth and respectful transition for residents, staff, and families during the emergency closure of the facility. The closure process will comply with all applicable state and federal regulations, including the Texas Health and Human Services Commission (HHSC) requirements. - Legal and regulatory requirements will be reviewed to ensure compliance. - Regulatory Authorities: Notify the Texas Health and Human Services Commission (HHSC) and other relevant state and federal agencies immediately upon the decision to close. - Placement Coordination: Collaborate with the HHSC and other agencies to identify suitable alternative facilities for residents. Provide residents and families with a list of options and assist in the selection process. - Transition Plan: Develop individualized transition plans for each resident, including transportation arrangements and the transfer of medical records and personal belongings. - Support Services: Provide emotional and psychological support to residents and families throughout the relocation process. Arrange for counseling services if needed. Resident #1 - Review of Resident #1's Admission Record, dated [DATE], revealed he was a [AGE] year-old male, originally admitted to the facility on [DATE], with current admitted [DATE], with the following diagnoses: Toxic Encephalopathy (brain dysfunction caused by toxic exposure); Alzheimer's Disease; Hypertension; Atrial Fibrillation; Lack of Coordination; Paraplegia; Congestive Heart Failure; Convulsions; Dysphagia; and Cognitive Decline. Review of Resident #1's Quarterly MDS, dated [DATE], revealed a BIMS score of 05, indicating severe cognitive impairment. This review revealed Resident #1 was continent of bowel and bladder but did was dependent for toileting hygiene and lower body dressing. Resident #1 required the use of a wheelchair with substantial/maximal assistance to wheel 50 feet and make two turns. Resident #1 required dependent assistance in most ADLs including oral hygiene, toileting, dressing, personal hygiene, bathing and transfers. Review of Resident #1's Care Plan, initiated [DATE], revealed a focus of Potential for dehydration, related to diuretic use and poor fluid intake. The interventions included encourage fluid intake. The goal was for Resident #1 to be free from symptoms of dehydration and maintain moist mucous membrane, good skin turgor through next review. Review of Resident #1's Medication Administration Record (MAR) revealed Divalproex Sodium delayed release, 500 mg, two times daily, related to Convulsions, with a start date of [DATE]. The MAR noted he received the medication at 8:00 AM on [DATE], with the next dose due at 8:00 PM. (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of Resident #1's hospital records revealed he was admitted to the hospital on [DATE] at 8:49 PM, with Chief Complaint of Syncope, it was noted resident was brought in via EMS for having 2 syncopal episodes after sitting on a bus, broken down, on the side of the road for approximately 30 minutes. The diagnoses for the visit were noted as Delirium, History of Stroke, History of Dementia, Heat exhaustion, and history of Seizures. The Medical Decision-Making area of these records revealed the [in part] Patient presented after he had 2 syncopal episodes after prolonged heat exposure. He was initially agitated. He was given IV Ativan. At the time of reassessment, it was suspected the patient may have had a seizure due to prolactin levels being elevated. Resident #1 was discharged to the receiving facility, in Arlington on [DATE] at 8:00 PM. During interview with Resident #1's RP on [DATE] at 1:52 p.m., she said she was the responsible party for Resident #1. RP explained the facility did not notify her that Resident #1 would be moving to another facility. Her other brother told her, and she left work to come and assist with packing his belongings. RP stated this is too much and unsettling for this family, who does things this way. The RP added, Resident #1 was not in good health and the stress of moving away from the family is hard to see. She said the facility did not give the family enough time or options to find another place closer to the family. Resident #3 - Review of Resident #3's Admission Record, dated [DATE], revealed he was a [AGE] year-old male, admitted to the facility on [DATE], with diagnoses of Metabolic Encephalopathy; Hypertension; Diabetes Mellitus; Congestive Heart Failure; Schizophrenia; Lack of Coordination; Cognitive Decline; and Dehydration. Review of Resident #3's Admission MDS, dated [DATE], revealed a BIMS score of 7, indicating severe cognitive impairment. Resident required supervision or touching assistance (helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity) for Eating - the ability to use suitable utensils to bring food and/or liquids to the mouth and swallow food and/or liquids once placed before the resident. Resident has a noted diagnosis of Dehydration during this assessment. Resident #3 was continent of bowel and bladder. Resident #3 required moderate assistance in most ADLs including oral hygiene, toileting, dressing, personal hygiene, bathing and transfers. Review of Resident #3's medical records, on [DATE], revealed no care plans in place. Review of Resident #3's hospital records revealed he was admitted to the hospital on [DATE] at 11:25 PM, with Chief Complaint of Syncope, it was noted resident was picked up after being in the van, which had been broken down for over an hour. It was noted the resident was lethargic and was given approximately 1500 ml of fluid prior to arrival. The diagnoses for the visit were noted as Dehydration, being the primary diagnosis, acute kidney injury, orthostatic hypotension, chronic hypertension, and diabetes. Resident #3 was discharged to the receiving facility, in Arlington on [DATE] at 8:00 PM. (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During interview with Resident #3 on [DATE] at 2:15 p.m., he stated he was not informed that he would be leaving the facility until today ([DATE]). He was told he would be moving to another facility about 3 hours away. Resident #2- Review of Resident #2's Admission Record, dated [DATE], revealed she was a [AGE] year-old female, admitted to the facility on [DATE], with the following diagnoses: Dementia; Hypertension; Lack of Coordination; Cognitive Decline' Schizophrenia; Dysphagia; and Overactive Bladder. Review of Resident #2's Quarterly MDS, dated [DATE], revealed a BIMS score of 04, indicating severe cognitive impairment. Resident #2 was frequently incontinent of bladder and occasionally incontinent of bowel. Resident #2 required the use of a wheelchair with substantial/maximal assistance to wheel 50 feet and make two turns. During interview with Physician P on [DATE] at 3:00 p.m., revealed he was not aware that the residents were transferring to another facility. He said he had been concerned about the Administration of the facility. He stated they did not have enough staff, including an Administrator. Physician P said he had not been paid for over 6 months. An interview on [DATE] at 1:30pm, with the DON, revealed the Owner told her and the staff on [DATE] at 3:30pm that the facility could possibly close. DON stated on [DATE] the Owner decided the facility would be closing the next day, on [DATE], and residents would be moved to a sister facility 2.5 hours away. DON stated no notice to residents, families, or State agency was given. DON stated there was no closure plan in place, facility did not have an Administrator, everything was just made up as we went. An interview, on [DATE] at 2:00 PM, the Owner revealed the facility had a van on the way to pick a total of 15 residents up, to transfer to a facility in the Arlington area. He stated all residents would be out of the facility by the end of the day. The Owner stated all residents will be sent with a sandwich. He stated their belongings and medications were being loaded into trucks, that would follow them to the receiving facility. During an observation on [DATE] at 2:15 PM, a van arrived at the facility from the receiving facility. The van driver was identified as being an employee from the receiving facility. The van appeared to have body damage noted to the top and bottom left and right rear quarter-panels and bumper, resulting in ,d+[DATE] foot sections of the quarter-panel being ripped and dented. The registration expired on ,d+[DATE], there was a weak area noted to the floor of the van (approximately 1 foot in diameter), which was covered with carpet and marked with an orange cone. The van had seating for a total of 14 residents, including 2 wheelchair bound residents. An interview on [DATE] at 3:00pm the Ombudsman stated she was made aware of facility closing on [DATE], does not recall time. The Ombudsman stated she spoke with the Owner, and he stated the lack of an Administrator and CNAs was the reason such short notice was given for facility closing and residents being discharged to another facility. (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	An interview on [DATE] at 3:45 PM, the Owner revealed due to staffing concerns the facility was required to conduct an emergency temporary closure. He stated he had been aware of the severity of staffing for approximately 1.5 weeks. The owner revealed multiple staff had resigned from the facility and the facility was utilizing staff from another facility, but was no longer able to utilize this staff. The Owner revealed residents were notified of temporary closure on [DATE]. An interview on [DATE] at 3:45 PM, the Owner revealed 15 residents were being transferred to a sister facility in Arlington, approximately 3 hours from the current facility, on this date. He revealed all control medications and medications requiring temperature control (insulin) will be destroyed and the other facility will be notified to ensure the medications are ordered prior to the residents arriving. During an observation on [DATE] at 4:05 PM, the facility began loading residents into a van, with Resident #2 being the first to be loaded onto the van. An interview on [DATE] at 2:45 PM, with RN A, revealed they were not sending any control medications or temperature-controlled medications such as insulin. During an observation on [DATE] at 5:10 PM, the DON identified Resident #2 sitting on the van with her head down. Resident #2 was unresponsive at this time. The DON requested assistance and a wheelchair. The DON and additional staff removed Resident #2 from the van, via wheelchair and placed her in a bed, in her room. They placed a wet rag on her head, put a fan blowing on her, and began removing her clothes. Resident #2 was wearing long pants, a shirt, and a long sleeve jacket. Resident #2 began to move her eyes at 5:15 PM. CNA A stated Resident #2, you are so hot. At 5:16 PM Resident #2 began responding verbally. At 5:19 PM, EMS was on site to evaluate Resident #2. Interview on [DATE] at 5:20 PM, with Admissions Staff, who was assisting with loading residents onto the van, revealed residents had no water, while waiting on the van. She stated residents did have access to water in their rooms, but the last time they were directly given water was during their lunch meal. Admissions Staff stated residents were given water once the incident occurred with Resident #2 approximately 10 minutes prior to this interview. Admission Staff stated residents did not receive an evening meal but were given a half of a sandwich to take on the van. During an observation on [DATE] at 6:00 PM, Resident #2 was the last resident loaded onto the van. There was a total of 13 residents on the van, with the van driver. No other staff were on the van. An interview on [DATE] at 6:00 PM, with the DON revealed the facility did not have any nursing staff to send on the van with the residents. No staff would be present, during this transport to administer medications or provide care, if needed. During an observation on [DATE] at 7:40 PM, two investigators leaving the facility, identified the van, with the residents, on the side of the road, with the hood raised. There were sheriff deputies on site and the van was not in working order. During an observation on [DATE] at 8:30 PM, revealed Resident #1, who was on van, was lethargic and fainted. He was assessed by EMT and transferred to the hospital for further evaluation and treatment. (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an observation on [DATE] at 8:45p.m., revealed Resident #3, who was on the van, was lethargic and fainted. He was assessed by EMT and transferred to the hospital for further evaluation and treatment. During an observation on [DATE] at 11:28 PM, a bus, rented by the facility, arrived from the metroplex, approximately 3 hours away, to come to complete the transfer of the residents. They began loading residents at that time. During an observation on [DATE] at 1:35 AM, the bus was loaded, with the residents, and began the trip to the receiving facility, approximately 3 hours remaining in the trip. Review of https://www.wunderground.com weather website revealed the temperatures, in the area, on [DATE], were as follows: - 2:53 PM 106* F - 3:53 PM 106* F - 4:53 PM 107* F - 5:53 PM 106* F - 6:53 PM 104* F - 7:53 PM 101* F - 8:53 PM 96* F - 9:53 PM 93* F - 10:53 PM 91* F - 11:53 PM 86* F An observation on [DATE] at 4:45 PM, revealed the facility doors were locked, with no sign of staff or residents being present in the facility. The facility was confirmed to be closed at this time. The Owner was notified of the Immediate Jeopardy on [DATE] at 5:00 PM, via telephone and a copy of the Immediate Jeopardy Template was sent to him at that time. An observation on [DATE] at 4:45 PM, revealed the facility doors were locked, with no sign of staff or residents being present in the facility. The facility was confirmed to be closed at this time. The Immediate Jeopardy was removed. However, the facility remained out of compliance at a severity of the potential for more than minimal harm, with a scope of pattern.

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 33198 Based on interviews and record review, the facility failed to send a copy of the notice of transfer or discharge and the reasons for the transfer or discharge in writing to the Office of the State Long-Term Care Ombudsman for two (Resident #1 and Resident #12) of 2 residents reviewed for transfer and discharge. The facility failed to notify Resident #1 and Resident #12's RP in writing and did not notify the State Long Term Care Ombudsman by phone or in writing of the resident's discharge to another facilities. This failure could affect residents at the facility by placing them at risk of being discharged causing disruption in their care and not having access to available advocacy services, discharge/transfer options, and the appeal processes. Findings included: Record Review of Resident #12's face sheet dated 08/07/24 indicated a [AGE] year-old male admitted on [DATE] with the diagnosis of hepatic encephalopathy (a brain dysfunction caused by the liver), chronic kidney diseases, hypotension (low blood pressure), Cirrhosis (impaired liver function), thrombocytopenia (low platelets count that can cause bleeding problems) and splenomegaly (enlarge spleen). Record review of Resident #12's unsigned MDS, dated [DATE], revealed resident #12 had unrated BIMS score. Further review of this MDS reveals the resident had no documented behaviors. Record review of Resident #12's care plan, dated 04/11/24, revealed a potential for decline in function, decline in communication, impaired cognition, impaired decision making, short- and long-term memory loss, decreased safety awareness, and behavior related to disease process. Its goal was to maintain optimal level of function within limitations imposed by disease process in the next review date. During an interview on 08/07/24 at 1:37pm with RP for Resident #12, she said she was the wife and responsible party for the resident. Resident #12's RP stated she was informed on 08/06/24 that the facility was closing the next day. She stated none of the staff knew what was going on, they were just told the facility was closing. Resident #12's RP explained no one from the facility offered to help her or resident find a new place. She contacted hospice and arranged for an apartment for Resident #12. Record review of Resident #1's face sheet dated 08/07/24 revealed he was a [AGE] year-old male admitted on [DATE] with diagnoses including dehydration (loss of fluid), generalized anxiety disorder, paraplegia (paralysis of lower part of the body), hyperlipidemia (high fat levels in the blood), urinary tract infection, cardiomegaly (enlarged heart), and benign prostatic hyperplasia (enlarged prostate). (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #1's significant change MDS dated [DATE] revealed Resident #1 with a BIMS score of 5 indicating severe cognitive impairment. Resident #1 required dependent assistance in most ADLs including oral hygiene, toileting, dressing, personal hygiene, bathing and transfers. Record review of Resident #1 Care Plan dated 02/28/24 revealed the resident had limited physical mobility secondary to diagnosis of paraplegia. The goal was Resident #1 will maintain optimal quality of life within limitations imposed by disease process through the next review. During interview with Resident #1's RP on 08/07/24 at 1:52p.m, she said she was the responsible party for Resident #1. Resident #1's RP explained the facility did not notify her that Resident #1 would be moving to another facility. Her other brother told her, and she left work to come and assist with packing his belongings. Resident #1's RP stated, this is too much and unsettling for this family, who does things this way. The RP added, Resident #1 was not in good health and the stress of moving away from the family is hard to see. She said the facility did not give the family enough time or options to find another place closer to the family. During interview with DON on 08/03/24 at 11:15p.m she was out of town and will not be able to provide the facility policies as requested by the surveyor. The DON explained she was concerned she did not have enough staffs to cover shifts after Monday August 6, 2024. She informed Owner who stated he will provide the needed staff. The DON stated she could not say with certainty there would be staff to take care of the resident on the coming days. She stated the facility had not notified the families that the facility was closing. She stated Owner did not want her to inform the families of the facility intentions transfer the residents and close the facility. The DON was asked to provide information about the discharge of Resident #1 and Resident #8. She said she did not have documentation because she was not informed the resident were transferring until few days before the scheduled transfer. She stated she did not have the following: 1) Resident/Representative verbal or written notice of intent to leave the facility. 2) Comprehensive care plan that includes the resident's goals for admission and discharge 5) Signed physician order of discharge 7) Meeting with Interdisciplinary Team (IDT) about discharge 8) Required 30-day notice to Residents 9) No communication with receiving facility. An interview on 08/07/2024 at 3:45 PM, the Owner revealed due to staffing concerns the facility was required to conduct an emergency temporary closure. The Owner revealed residents were notified of temporary closure on 8/6/24. In an interview with the Ombudsman on 08/07/24 at 3:25p.m, she said she was unaware that the facility was closing. No one from the facility reached out to her. The ombudsman explained on 08/05/24 Resident #14 contacted stating he would like to return to the facility after a brief stay in the hospital. She said Resident #14 would like to go to another facility, but no one will take him. The ombudsman noted Resident 14 did not tell her the facility was closing. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the facility's Transfer or Discharge, Facility-Initiated policy dated effective 06/21/18 reflected the following: The written notice of transfer or discharge will contain the following: a. The reason for the transfer or discharge. b. The effective date of the transfer or discharge. c. The location to which the resident is transferred or discharged . d. A statement that the resident has the right to appeal the action to the State. Department of Health. The statement will include a current phone number. for the department which can be used to initiate an appeal. e. The name, address, and telephone number of the State long-term care ombudsman. f. For nursing facility residents who are mentally ill or who have developmental disabilities, the mailing address and telephone number of the Commission on Quality of Care for the Mentally Disabled which is responsible for the protection and advocacy of such individuals under the Protection and Advocacy for the Mentally Ill Act; and g. For the resident whose health has improved sufficiently to allow a more immediate transfer or discharge; a statement that if the resident appeals the transfer or discharge to the Department of Health within 15 days of being notified of such transfer or discharge, the resident may remain in the facility pending an appeal determination. 4. The facility will provide sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility including an opportunity to participate in deciding where to go. 5. The resident/resident's representative will receive a copy of the resident's (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	discharge instructions, which will include at a minimum: o the individual's preferences and needs for care and supports. o personal identification and contact information, including if applicable, Advance Directives. o Provide contact information of community primary care physician, pharmacy, and community home care agency including personal care services (if applicable) etc. o brief medical history. o current medications, treatments, therapies, and allergies, o arrangements for durable medical equipment. o arrangements for discharge housing placement o arrangements for transportation to follow-up appointments; and o contact information at the nursing home if a problem arises during discharge o Any information regarding follow-up appointment with community care provider in the community and for specialists (as appropriate). o Medication education. o Prevention and disease management education, focusing especially on warning symptoms for when to call the doctor. o Who to call in case of an emergency or if symptoms of decline occur.

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F 0624 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Prepare residents for a safe transfer or discharge from the nursing home. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33198 Based on observation, interview, and record review, the facility failed to ensure residents were provided sufficient preparation and orientation to ensure safe and orderly transfer or discharge from the facility for 4 of 4 (Resident #1, Resident #2, Resident #3, and Resident #12) residents reviewed for Admit/Transfer/Discharge in that: The facility failed to ensure safe and appropriate transfer during an emergency facility closure when Resident #1 and Resident #3 were both transferred to the hospital, requiring treatment for heat related episodes, after being on the van, which was broken down on the side of the road. Both required admission to the hospital for evaluation and treatment. The facility failed to ensure safe and appropriate transfer during an emergency facility closure when Resident #2 was noted to be unresponsive after being seated on the van, for over an hour, with the outside temperature noted to be 107 degrees, with no water, requiring EMS to respond for evaluation. The facility attempted to transfer Resident #1, Resident #2, and Resident #3 in a van that did not appear to be in good repair and did break down, during the transfer, causing residents to be stranded on the roadside for approximately 6 hours. The facility failed to ensure residents were given time to make arrangements to ensure needs were met, only providing them 24 hours notice of the transfer. The facility failed to provide assistance to Resident #12's family, to ensure his needs would be met, while being transferred due to the facility closure. An Immediate Jeopardy was determined to have existed from [DATE] through [DATE]. The Immediate Jeopardy was removed on [DATE] due to the facility being closed, with all residents being discharged . However, the facility remained out of compliance at a severity of the potential for more than minimal harm, with a scope of pattern. This failure placed residents at risk of not being properly transferred or discharged which placed the residents at risk of physical and emotional injuries, hospitalization , and death. The findings included: Resident #1 - Review of Resident #1's Admission Record, dated [DATE], revealed he was a [AGE] year-old male, originally admitted to the facility on [DATE], with current admitted [DATE], with the following diagnoses: Toxic Encephalopathy (brain dysfunction caused by toxic exposure); Alzheimer's Disease; Hypertension; Atrial Fibrillation; Lack of Coordination; Paraplegia; Congestive Heart Failure; Convulsions; Dysphagia; and Cognitive Decline. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	745007	A. Building B. Wing	08/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vernon Rehabilitation and Nursing Center	4301 Hospital Dr. Vernon, TX 76384

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F 0624 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of Resident #1's Quarterly MDS, dated [DATE], revealed a BIMS score of 05, indicating severe cognitive impairment. This review revealed Resident #1 was continent of bowel and bladder but did was dependent for toileting hygiene and lower body dressing. Resident #1 required the use of a wheelchair with substantial/maximal assistance to wheel 50 feet and make two turns. Resident #1 required dependent assistance in most ADLs including oral hygiene, toileting, dressing, personal hygiene, bathing and transfers. Review of Resident #1's Care Plan, initiated [DATE], revealed a focus of Potential for dehydration, related to diuretic use and poor fluid intake. The interventions included encourage fluid intake. The goal was for Resident #1 to be free from symptoms of dehydration and maintain moist mucous membrane, good skin turgor through next review. Review of Resident #1's Medication Administration Record (MAR) revealed Divalproex Sodium delayed release, 500 mg, two times daily, related to Convulsions, with a start date of [DATE]. The MAR noted he received the medication at 8:00 AM on [DATE], with the next dose due at 8:00 PM. Review of Resident #1's hospital records revealed he was admitted to the hospital on [DATE] at 8:49 PM, with Chief Complaint of Syncope, it was noted resident was brought in via EMS for having 2 syncopal episodes after sitting on a bus, broken down, on the side of the road for approximately 30 minutes. The diagnoses for the visit were noted as Delirium, History of Stroke, History of Dementia, Heat exhaustion, and history of Seizures. The Medical Decision-Making area of these records revealed the [in part] Patient presented after he had 2 syncopal episodes after prolonged heat exposure. He was initially agitated. He was given IV Ativan. At the time of reassessment, it was suspected the patient may have had a seizure due to prolactin levels being elevated. Resident #1 was discharged to the receiving facility, in Arlington on [DATE] at 8:00 PM. During interview with Resident #1's RP on [DATE] at 1:52 p.m., she said she was the responsible party for Resident #1. RP explained the facility did not notify her that Resident #1 would be moving to another facility. Her other brother told her, and she left work to come and assist with packing his belongings. RP stated this is too much and unsettling for this family, who does things this way. The RP added, Resident #1 was not in good health and the stress of moving away from the family is hard to see. She said the facility did not give the family enough time or options to find another place closer to the family. Resident #3 - Review of Resident #3's Admission Record, dated [DATE], revealed he was a [AGE] year-old male, admitted to the facility on [DATE], with diagnoses of Metabolic Encephalopathy; Hypertension; Diabetes Mellitus; Congestive Heart Failure; Schizophrenia; Lack of Coordination; Cognitive Decline; and Dehydration. (continued on next page)

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F 0624 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of Resident #3's Admission MDS, dated [DATE], revealed a BIMS score of 7, indicating severe cognitive impairment. Resident required supervision or touching assistance (helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity) for Eating - the ability to use suitable utensils to bring food and/or liquids to the mouth and swallow food and/or liquids once placed before the resident. Resident has a noted diagnosis of Dehydration during this assessment. Resident #3 was continent of bowel and bladder. Resident #3 required moderate assistance in most ADLs including oral hygiene, toileting, dressing, personal hygiene, bathing and transfers. Review of Resident #3's medical records, on [DATE], revealed no care plans in place. Review of Resident #3's hospital records revealed he was admitted to the hospital on [DATE] at 11:25 PM, with Chief Complaint of Syncope, it was noted resident was picked up after being in the van, which had been broken down for over an hour. It was noted the resident was lethargic and was given approximately 1500 ml of fluid prior to arrival. The diagnoses for the visit were noted as Dehydration, being the primary diagnosis, acute kidney injury, orthostatic hypotension, chronic hypertension, and diabetes. Resident #3 was discharged to the receiving facility, in Arlington on [DATE] at 8:00 PM. During interview with Resident #3 on [DATE] at 2:15 p.m., he stated he was not informed that he would be leaving the facility until today ([DATE]). He was told he would be moving to another facility about 3 hours away. Resident #2- Review of Resident #2's Admission Record, dated [DATE], revealed she was a [AGE] year-old female, admitted to the facility on [DATE], with the following diagnoses: Dementia; Hypertension; Lack of Coordination; Cognitive Decline' Schizophrenia; Dysphagia; and Overactive Bladder. Review of Resident #2's Quarterly MDS, dated [DATE], revealed a BIMS score of 04, indicating severe cognitive impairment. Resident #2 was frequently incontinent of bladder and occasionally incontinent of bowel. Resident #2 required the use of a wheelchair with substantial/maximal assistance to wheel 50 feet and make two turns. Resident #12 Record Review of Resident #12's face sheet dated [DATE] indicated a [AGE] year-old male admitted on [DATE] with the diagnosis of hepatic encephalopathy (a brain dysfunction caused by the liver), chronic kidney diseases, hypotension (low blood pressure), Cirrhosis (impaired liver function), thrombocytopenia (low platelets count that can cause bleeding problems) and splenomegaly (enlarge spleen). Record review of Resident #12's unsigned MDS, dated [DATE], revealed resident #12 had unrated BIMS score. Further review of this MDS reveals the resident had no documented behaviors. Record review of Resident #12's care plan, dated [DATE], revealed a potential for decline in function, decline in communication, impaired cognition, impaired decision making, short- and long-term memory loss, decreased safety awareness, and behavior related to disease process. Its goal was to maintain optimal level of function within limitations imposed by disease process in the next review date. (continued on next page)

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F 0624 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on [DATE] at 1:37pm with RP for Resident #12, she said she was the wife and responsible party for the resident. Resident #12's RP stated she was informed on [DATE] that the facility was closing the next day. She stated none of the staff knew what was going on, they were just told the facility was closing. Resident #12's RP explained no one from the facility offered to help her or resident find a new place. She contacted hospice and arranged for an apartment for Resident #12. During interview with Physician P on [DATE] at 3:00 p.m., revealed he was not aware that the residents were transferring to another facility. He said he had been concerned about the Administration of the facility. He stated they did not have enough staff, including an Administrator. Physician P said he had not been paid for over 6 months. An interview on [DATE] at 1:30pm, with the DON, revealed the Owner told her and the staff on [DATE] at 3:30pm that the facility could possibly close. DON stated on [DATE] the Owner decided the facility would be closing the next day, on [DATE], and residents would be moved to a sister facility 2.5 hours away. DON stated no notice to residents, families, or State agency was given. DON stated there was no closure plan in place, facility did not have an Administrator, everything was just made up as we went. An interview, on [DATE] at 2:00 PM, the Owner revealed the facility had a van on the way to pick a total of 15 residents up, to transfer to a facility in the Arlington area. He stated all residents would be out of the facility by the end of the day. The Owner stated all residents will be sent with a sandwich. He stated their belongings and medications were being loaded into trucks, that would follow them to the receiving facility. During an observation on [DATE] at 2:15 PM, a van arrived at the facility from the receiving facility. The van driver was identified as being an employee from the receiving facility. The van did appear to have body damage noted to the top and bottom left and right rear quarter-panels and bumper, resulting in ,d+[DATE] foot sections of the quarter-panel being ripped and dented. The registration expired on ,d+[DATE], there was a weak area noted to the floor of the van (approximately 1 foot in diameter), which was covered with carpet and marked with an orange cone. The van had seating for a total of 14 residents, including 2 wheelchair bound residents. An interview on [DATE] at 3:00pm the Ombudsman stated she was made aware of facility closing on [DATE], does not recall time. The Ombudsman stated she spoke with the Owner, and he stated the lack of an Administrator and CNAs was the reason such short notice was given for facility closing and residents being discharged to another facility. An interview on [DATE] at 3:45 PM, the Owner revealed due to staffing concerns the facility was required to conduct an emergency temporary closure. He stated he had been aware of the severity of staffing for approximately 1.5 weeks. The owner revealed multiple staff had resigned from the facility and the facility was utilizing staff from another facility but was no longer able to utilize this staff. The Owner revealed the facility has been without a licensed Administrator for about 1.5 weeks. He stated he is a licensed Administrator in New York, but not Texas. The Owner revealed residents were notified of temporary closure on [DATE]. (continued on next page)

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	745007	A. Building B. Wing	08/15/2024

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F 0624 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	An interview on [DATE] at 3:45 PM, the Owner revealed 15 residents were being transferred to a sister facility in Arlington, approximately 3 hours from the current facility, on this date. He revealed all control medications and medications requiring temperature control (insulin) will be destroyed and the other facility will be notified to ensure the medications are ordered prior to the residents arriving. The Owner revealed 4 residents had already been transferred to a local facility, 5 residents had already been transferred to a facility approximately 30 minutes from [NAME], and 1 resident was discharged home, with hospice services. An interview on [DATE] at 2:45 PM, with RN A, revealed she was only scheduled to work until 2 PM, but had no one to relieve her, she was the only nurse working. During an observation on [DATE] at 4:05 PM, the facility began loading residents into a van, with Resident #2 being the first to be loaded onto the van. An interview on [DATE] at 2:45 PM, with RN A, revealed there was no method for reconciling the medications. She stated she was just pulling the meds (bubble packs) from the drawers and placing them in a plastic bag. She was marking the residents name on the bag and sending them in the vehicle following the van. She stated they were not sending any control medications or temperature-controlled medications such as insulin. During an observation on [DATE] at 5:10 PM, the DON identified Resident #2 sitting on the van with her head down. Resident #2 was unresponsive at this time. The DON requested assistance and a wheelchair. DON and additional staff removed resident #2 from the van, via wheelchair and placed her in a bed, in her room. They placed a wet rag on her head, put a fan blowing on her, and began removing her clothes. Resident #2 was wearing long pants, a shirt, and a long sleeve jacket. Resident #2 began to move her eyes at 5:15 PM. CNA A stated Resident #2, you are so hot. At 5:16 PM Resident #2 began responding verbally. At 5:19 PM EMS was on site to evaluate resident #2. An Interview on [DATE] at 5:20 PM, with Admissions Staff, who was assisting with loading residents onto the van, revealed residents had no water, while waiting on the van. She stated residents did have access to water in their rooms, but the last time they were directly given water was during their lunch meal. Admissions Staff stated residents were given water once the incident occurred with Resident #2 approximately 10 minutes prior to this interview. Admission Staff stated residents did not receive an evening meal but were given a half of a sandwich to take on the van. During an observation on [DATE] at 6:00 PM, Resident #2 was the last resident loaded onto the van. There were a total of 13 residents on the van, with the van driver. No other staff were on the van. The DON stated the facility did not have any nursing staff to send on the van with the residents. No staff would be present, during this transport to administer medications or provide care, if needed. During an observation on [DATE] at 7:40 PM, two investigators leaving the facility, identified the van, with the residents, on the side of the road, with the hood raised. There were sheriff deputies on site and the van was not in working order. During an observation on [DATE] at 8:30 PM, revealed Resident #1, who was on van, was lethargic and fainted. He was assessed by EMT and transferred to the hospital for further evaluation and treatment. (continued on next page)

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	745007	A. Building B. Wing	08/15/2024

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F 0624 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an observation on [DATE] at 8:45p.m., revealed Resident #3, who was on the van, was lethargic and fainted. He was assessed by EMT and transferred to the hospital for further evaluation and treatment. During an observation on [DATE] at 8:30 PM, revealed Resident #1, who was on van, was lethargic and fainted. He was assessed by EMT and transferred to the hospital for further evaluation and treatment. During an observation on [DATE] at 8:45p.m., revealed Resident #3, who was on the van, was lethargic and fainted. He was assessed by EMT and transferred to the hospital for further evaluation and treatment. During an observation on [DATE] at 11:28 PM, a bus, rented by the facility, arrived from the metroplex, approximately 3 hours away, to come to complete the transfer of the residents. They began loading residents at that time. During an observation on [DATE] at 1:35 AM, the bus was loaded, with the residents, and began the trip to the receiving facility, approximately 3 hours remaining in the trip. Review of https://www.wunderground.com weather website revealed the temperatures, in the area, on [DATE], were as follows: - 2:53 PM 106* F - 3:53 PM 106* F - 4:53 PM 107* F - 5:53 PM 106* F - 6:53 PM 104* F - 7:53 PM 101* F - 8:53 PM 96* F - 9:53 PM 93* F - 10:53 PM 91* F - 11:53 PM 86* F Record review of the Emergency Nursing Home Closure Policy, provided by the Facility Owner, on [DATE], not dated, revealed the following [in part] - Purpose The purpose of this policy is to provide a structured and compassionate approach for the emergency closure of a for-profit nursing home facility in Texas, ensuring the safety and well-being of residents, compliance with state regulations, and clear communication with all stakeholders. (continued on next page)

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	745007	A. Building B. Wing	08/15/2024

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F 0624 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	- Policy Statement [Facility Name] is committed to ensuring a smooth and respectful transition for residents, staff, and families during the emergency closure of the facility. The closure process will comply with all applicable state and federal regulations, including the Texas Health and Human Services Commission (HHSC) requirements. - Legal and regulatory requirements will be reviewed to ensure compliance. - Regulatory Authorities: Notify the Texas Health and Human Services Commission (HHSC) and other relevant state and federal agencies immediately upon the decision to close. - Placement Coordination: Collaborate with the HHSC and other agencies to identify suitable alternative facilities for residents. Provide residents and families with a list of options and assist in the selection process. - Transition Plan: Develop individualized transition plans for each resident, including transportation arrangements and the transfer of medical records and personal belongings. - Support Services: Provide emotional and psychological support to residents and families throughout the relocation process. Arrange for counseling services if needed. The Owner was notified of the Immediate Jeopardy on [DATE] at 5:00 PM, via telephone and a copy of the Immediate Jeopardy Template was sent to him at that time. An observation on [DATE] at 4:45 PM, revealed the facility doors were locked, with no sign of staff or residents being present in the facility. The facility was confirmed to be closed at this time. The Immediate Jeopardy was removed. However, the facility remained out of compliance at a severity of the potential for more than minimal harm, with a scope of pattern.

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Plan the resident's discharge to meet the resident's goals and needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33198 Based on observation, interview, and record review, the facility failed to develop and implement an effective discharge planning process that focused on the resident's discharge goals and included regular re-evaluation of residents to identify changes that require modification of the discharge plan and to reflect these changes in the discharge plan for one of two residents (Resident #1 and Resident #12) reviewed for discharge planning. The facility failed to ensure Resident #1 and #12 had a discharge plan in place. This failure placed residents at risk of not having a plan in place to address residents post discharge needs. Findings included: Record review of a face sheet dated 08/07/24 revealed Resident #1 was a [AGE] year-old male admitted on [DATE] with diagnoses including dehydration (loss of fluid), generalized anxiety disorder, paraplegia (paralysis of lower part of the body), hyperlipidemia (high fat levels in the blood), urinary tract infection, cardiomegaly (enlarged heart), and benign prostatic hyperplasia (enlarged prostate). Record review of Resident #1 significant change MDS dated [DATE] revealed Resident #1 with a BIMS score of 5 indicating severe cognitive impairment. Resident #1 required dependent assistance in most ADLs including oral hygiene, toileting, dressing, personal hygiene, bathing, and transfers. Record review of Resident #1 Care Plan dated 02/28/24 revealed the resident has limited physical mobility secondary to diagnosis of paraplegia. The goal was Resident #1 would maintain optimal quality of life within limitations imposed by disease process through the next review. During interview with Resident #1's RP on 08/07/24 at 1:52p.m, she said she was the responsible party for Resident #1. RP explained the facility did not notify her that Resident #1 will be moving to another facility. Her other brother told her, and she left work to come and assist with packing his belongings. RP stated, this is too much and unsettling for this family, who does things this way. The RP added, Resident #1 was not in good health and the stress of moving away from the family is hard to see. She said the facility did not give the family enough time or options to find another place closer to the family. Record Review of Resident #12's face sheet dated 08/07/24 indicated she was a [AGE] year-old male admitted on [DATE] with the diagnosis of hepatic encephalopathy (a brain dysfunction caused by the liver), chronic kidney diseases, hypotension (low blood pressure), Cirrhosis (impaired liver function), thrombocytopenia (low platelets count that can cause bleeding problems) and splenomegaly (enlarge spleen). Record review of Resident #12's unsigned MDS, dated [DATE], revealed the resident had unrated BIMS score. Further review of this MDS reveals the resident had, no documented behaviors. (continued on next page)

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	745007	A. Building B. Wing	08/15/2024

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #12's care plan, dated 04/11/24, revealed a potential for decline in function, decline in communication, impaired cognition, impaired decision making, short- and long-term memory loss, decreased safety awareness, and behavior related to disease process. Its goal was to maintain optimal level of function within limitations imposed by disease process in the next review date. During an interview on 7/30/24 at 1:37p.m., RP G said she was the responsible party for the resident. RP G stated she was informed on 08/06/24 that the facility was closing the next day. She stated none of the staff knew what was going on, only they were just told the facility was closing. RP G explained no one from the facility offered to help her or resident find a new place. She contacted hospice and arranged for an apartment for Resident #12. During interview with DON on 08/03/24 at 11:15 p.m., she was out of town and will not be able to provide the facility policies as requested by the surveyor. The DON explained she was concerned she did not have enough staffs to cover shifts after Monday August 6, 2024. She informed OWNER who stated he will provide the needed staffs. The DON stated she cannot say with certainty there will be staff to take care of the resident on the coming days. She stated the facility has not notified the families that the facility was closing. She stated OWNER did not want her to inform the families of the facility intentions transfer the residents and close the facility. The DON was asked to provide information about the discharge of Resident #1 and Resident #8. She said did not have documentation because she was not informed the resident were transferring until few days before the scheduled transfer. She stated she did not have the following: 1) Resident/Representative verbal or written notice of intent to leave the facility. 2) Comprehensive care plan that includes the resident's goals for admission and discharge 5) Signed physician order of discharge 7) Meeting with Interdisciplinary Team (IDT) about discharge 8) Required 30-day notice to Resident #1 and #8 9) No communication with receiving facility. During interview with Phy P on 07/29/24 at 3:00 p.m., he said he was the doctor for Resident #1 and Resident #8. Phy P explained he was not aware that the residents were transferring to another facility. He said he has been concerned about the Administration of the facility. They don't have enough staffs including an Administrator. Phy P said he has not been paid for over 6 months. Record review of the facility policy on Transfer and Discharge effective 06/21/18 reflected the following: Title: Discharge and Transfers POLICY: (continued on next page)

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	All individuals have the right to choose the services they receive and the settings in which they receive those services. This right became law under the Americans with Disabilities Act (1990) and with further interpretation by the U.S. Supreme Court in the [NAME] vs. L.C. decision in 1999. This ruling stated that individuals have a right to receive care in the least restrictive (most integrated) setting and that governments (Federal and State) have a responsibility to enforce and support these choices. An individual in a nursing home with adequate decision-making capacity can choose to leave the facility and/or request to talk to someone about returning to the community at any time. The return to community referral portion of MDS 3.0 uses a person-centered approach to ensure that all individuals have the opportunity to learn about home and community-based services and have an opportunity to receive long-term care in the least restrictive setting possible. Individual choices related to returning to community living will vary, e.g., returning to a former home or a different community home, or, the individual may choose to stay in the nursing home. The discharge assessment process requires nursing home staff to apply a systematic and objective protocol so that every individual has the opportunity to access meaningful information about community living options and community service alternatives, with the goal being to assist the individual in maintaining or achieving the highest level of functioning and integration possible. This includes ensuring that the individual or surrogate is fully informed and involved, identifying individual strengths, assessing risk factors, implementing a comprehensive plan of care, coordinating interdisciplinary care providers, fostering independent functioning, and using rehabilitation programs and community referrals. It is the policy of this facility to permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless such transfer or discharge is made in recognition of the resident's right to receive considerate and respectful care and services, and to participate in the development of the comprehensive care plan and in recognition of the rights of other residents in the facility. All residents are assessed for discharge potential by the Comprehensive Care Plan Team upon admission, and at least quarterly thereafter. Each resident will be involved in the development of his/her care plan (to the fullest extent possible), including discharge planning. The resident may be transferred only when the interdisciplinary care team, in consultation with the resident or the resident's designated representative, determine that: 1. The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met after reasonable attempts at accommodation in the facility. 2. The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility. 3. The health of individuals in the facility would otherwise be endangered, the risk to others is more than theoretical and all reasonable alternatives to transfer or discharge have been explored and have failed to safely address the problem. (continued on next page)

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	745007	A. Building B. Wing	08/15/2024

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Vernon Rehabilitation and Nursing Center	4301 Hospital Dr. Vernon, TX 76384

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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 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. The safety of individuals in the facility would otherwise be endangered, the risk to others is more than theoretical and all reasonable alternatives to transfer or discharge have been explored and have failed to safely address the problem. 5. Transfer and discharge shall also be permissible when the resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare, Medicaid or third-party insurance) a stay at the facility. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid. Such transfer or discharge shall be permissible only if a charge is not in dispute, no appeal of a denial of benefits is pending, or funds for payment are actually available and the resident refuses to cooperate with the facility in obtaining the funds. 6. Transfer or discharge shall also be permissible when the facility discontinues operation and has received approval of its plan of closure

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. 33198 Based on observation, interviews, and record review the facility failed the have sufficient nursing staff to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident and determined by considering the number, acuity, and diagnoses of the facility's resident population with accordance with 1 of 1 facility reviewed for sufficient staffing. The facility failed to ensure the facility had sufficient staffing to meet the needs of the residents. This failure could place the residents at risk of resident's needs, safety and psychosocial well-being not being met. Findings Include: Interview on 8/7/24 at 3:45pm the Owner stated he was aware of the severity of staffing for approximately 1. 5 weeks. He stated he had contacted agency staffing, used sister facility staff, and hired a recruiter. He stated he has not been able to obtain staffing. He stated the Lack of staffing was primary reason for closing facility on 8/7/24. Interview on 8/7/24 at 2:45pm RN G stated she was supposed to get off work at 2:00pm, but had no one to relieve her, she stated she was the only nurse working. Interview on 8/7/24 at 4:45pm Bus Driver stated he only drove the bus and was not a certified CNA. Bus Driver stated there will not be any staff riding on the bus, stated if any resident starts to have health problems he will pull over and call 911. Observation and interview on 8/7/24 at 6:00pm, 13 residents were loaded on transportation bus to travel to a sister facility 2.5 hours away. The DON stated no nurse or CNA was available to be sent with the residents. Only the bus driver and no other staff were on bus to travel with residents. Record review of the Facility staffing policy, undated and not signed, indicated: Our facility provides adequate staffing to meet needed care and services for our resident population. Policy Interpretation and Implementation 1. Our facility maintains adequate staffing on each shift to ensure that our resident's needs and services are met. Licensed registered nursing and licensed nursing staff are available to provide and monitor the delivery of resident care services. 2. Certified Nursing Assistants are available on each shift to provide the needed care and services of each resident as outlined on the resident's comprehensive care plan. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. Other support services (e.g., dietary, activities/recreational, social, therapy, environmental, etc.) are adequately staffed to ensure that resident needs are met. 4. Our facility furnishes information from payroll records setting forth the average numbers and types of personnel (in full-time equivalents) on each shift during at least one (1) week of each quarter to appropriate state agencies as required. Such workweek is selected by the state survey agency. 5. Inquiries or concerns relative to our facility's staffing should be directed to the Administrator or his/her designee.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33198 Based on interview and record review the facility failed to provide pharmaceutical services, including the accurate acquiring, administering, and receipt of all drugs and biologicals, to meet the needs of 3 of 3 (Resident #1, #13 and Resident # 14) residents reviewed for pharmacy services. The facility failed to ensure Resident #1, #13, and Resident #14 received their ordered evening medications as indicated on the Medication Administration Record (MAR). This failure could place residents who receive medications at risk of not receiving the intended therapeutic benefit of the medications. Findings included: Resident #1 - Review of Resident #1's Admission Record, dated 08/07/2024, revealed he was a [AGE] year-old male, originally admitted to the facility on [DATE], with current admitted [DATE], with the following diagnoses: Toxic Encephalopathy (brain dysfunction caused by toxic exposure); Alzheimer's Disease; Hypertension; Atrial Fibrillation; Lack of Coordination; Paraplegia; Congestive Heart Failure; Convulsions; Dysphagia; and Cognitive Decline. Review of Resident #1's Quarterly MDS, dated [DATE], revealed a BIMS score of 05, indicating severe cognitive impairment. This review revealed Resident #1 was continent of bowel and bladder but did was dependent for toileting hygiene and lower body dressing. Resident #1 required the use of a wheelchair with substantial/maximal assistance to wheel 50 feet and make two turns. Resident #1 required dependent assistance in most ADLs including oral hygiene, toileting, dressing, personal hygiene, bathing and transfers. Review of Resident #1's Care Plan, initiated 02/28/2024, revealed a focus of Potential for dehydration, related to diuretic use and poor fluid intake. The interventions included encourage fluid intake. The goal was for Resident #1 to be free from symptoms of dehydration and maintain moist mucous membrane, good skin turgor through next review. Review of Resident #1's Medication Administration Record (MAR) revealed Divalproex Sodium delayed release, 500 mg, two times daily, related to Convulsions, with a start date of 12/02/2023. The MAR noted he received the medication at 8:00 AM on 08/07/2024, with the next dose due at 8:00 PM. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #1's hospital records revealed he was admitted to the hospital on 08/07/2024 at 8:49 PM, with Chief Complaint of Syncope, it was noted resident was brought in via EMS for having 2 syncopal episodes after sitting on a bus, broken down, on the side of the road for approximately 30 minutes. The diagnoses for the visit were noted as Delirium, History of Stroke, History of Dementia, Heat exhaustion, and history of Seizures. The Medical Decision-Making area of these records revealed the [in part] Patient presented after he had 2 syncopal episodes after prolonged heat exposure. He was initially agitated. He was given IV Ativan. At the time of reassessment, it was suspected the patient may have had a seizure due to prolactin levels being elevated. Resident #1 was discharged to the receiving facility, in Arlington on 08/08/2024 at 8:00 PM. Record review of Resident #13's face sheet dated 08/07/24, indicated he was a [AGE] year-old male, admitted to the facility on [DATE]. His diagnoses included pressure ulcers, urinary tract infections, thrombocytopenia (a low blood platelets count), Sepsis (a serious condition in which the body responds improperly to an infection), bipolar disorder (mental illness), colostomy status (an opening in the belly that allows stool to pass when the colon is not working properly or is removed), and chronic pain syndrome. Record review of Resident #13's quarterly MDS assessment, dated 05/06/24, indicated his BIMS score was 9, that indicated Resident #13 had moderately impaired cognition. It reflected Resident #13 was diagnosed with paraplegia and required total assistance with most ADLs and transfer. The MDS also indicated resident was receiving antibiotics, antianxiety, and opioid medications as ordered presently. Record Review of Resident #13's care plan initiated 12/12/23 revealed Resident #13 was receiving pain medication therapy related to diagnosis of chronic pain syndrome/muscle spasms. The goal was to make Resident #13 as comfortable as possible through the next review date. Record Review of Resident #13's Medication Administration Record (MAR) dated August 1 through 31st revealed, he was receiving the following medications: Daptomycin-sodium chloride intravenous solution 350-0.9 mg/50 ml. use 500 mg intravenous solution one time a day for abdominal abscess until 09/01/24 (give with 350 mg). Gabapentin oral tablet 600 mg. Give 600 mg by mouth three times a day related to chronic pain. Xanax oral tablet 0.5 mg (alprazolam). Give 1 tablet by mouth three times a day related to generalized anxiety disorder. Robaxin 750 mg oral tablet (methocarbamol). Give 1 tablet by mouth four times a day related to other muscle spasms. Morphine 5 mg. Give 2 tabs to equal 10 mg every 4 hours as needed for pain related to chronic pain syndrome. Tramadol HCL oral tablet 50 mg (tramadol). Give 1 tablet by mouth four times a day related to chronic pain syndrome. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Hydroxyzine HCL oral tablet 10 mg. Give 1 tablet by mouth every 6 hours as needed for itching related to pruritus. Dulcolax Oral tablet delayed release 100 mg (bisacodyl). Give 2 tablets by mouth every 8 hours as needed for constipation. Imodium A-D oral tablet 2 mg (loperamide HCL). Give 1 tablet by mouth every 8 hours as needed for loose stool related to diarrhea. Promethazine HCL oral tablet 25 mg. Give 1 tablet by mouth every 6 hours as needed for nausea with vomiting. Observation on 08/07/24 at 6:00 p.m., revealed Resident #13 was in a van transporting him and 12 other residents to a new facility about 3 hours away. On 08/07/24 at 7:40 p.m. this surveyor saw the same van broke down on road about 2 and half hours from their destination. Surveyor stopped and found Resident #13 in the van. Resident #13 and 12 other residents was transported to a rest station nearby to get out the high heat. While at the rest area, Resident #13 did not receive his evening medication including antibiotic, anxiety and opioid medications. Record review of Resident #14's face sheet dated 08/07/24, indicated he was a [AGE] year-old male, admitted to the facility on [DATE]. His diagnoses included chronic viral hepatitis C (inflammation of the liver), Depression (a mood disorder that causes persistent sadness and loss of interest), age-related cognitive decline, cognitive communication deficit (difficulty with communication), presence of artificial hip joint, constipation (difficulty passing stool) insomnia (sleep disorder) and muscle wasting and atrophy (the wasting or thinning of muscle mass due to disuse or nerve problems). Record review of Resident #14's quarterly MDS assessment, dated 08/07/24, indicated his BIMS score was 11, that indicated Resident #14 had moderately impaired cognition. It reflected Resident #14 requires supervision assistance with most ADLs and transfer. The MDS also indicated resident was receiving antibiotics, antianxiety, antidepressant, and opioid medications as ordered presently. Record review of Resident #14's care plan initiated 12/12/23 revealed Resident #14 was receiving pain medication therapy related to diagnosis of pain. Its goal was to make Resident #14 as comfortable as possible through the next review date. Record Review of Resident #14's Medication Administration Record (MAR) dated August 1 through 31st revealed, he was receiving the following medications: Doxycycline hyclate oral capsule 100 mg. Give 1 capsule my mouth two times a day related to unilateral primary osteoarthritis. Acetaminophen oral tablet 325 mg. Give 2 tablets by mouth every 8 hours as needed. Trazadone HCL oral tablet 50 mg by mouth. Give 1 tablet by mouth every 24 hours as needed for insomnia. Mobic oral tablet 15 mg (meloxicam). Give 1 tablet by mouth one time a day for pain /inflammation related to pain. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Sertraline HCL oral tablet 100 mg by mouth in the morning related to depression. Thiamine HCL oral tablet 100 mg. Give 1 tablet by mouth in the morning for supplement. Buspirone HCL oral tablet 5 mg. Give 1 tablet by mouth two times a day related to generalized anxiety disorder. Dulcolax Oral tablet delayed release 100 mg (bisacodyl). Give 2 tablets by mouth every 8 hours as needed for constipation. Ferrous Sulfate oral tablet 325 mg. Give 1 tablet by mouth two times a day. Observation on 08/07/24 at 6:00 p.m. revealed Resident #14 was in a van transporting him and 12 other residents to a new facility about 3 hours away. On 08/07/24 at 7:40 p.m., this surveyor saw the same van broke down on road about 2 and half hours from their destination. Surveyor stopped and found resident #14 in the van. Resident #14 and 12 other residents was transported to a rest station nearby to get out the high heat. While at the rest area, Resident #14 did not receive his evening medication including antibiotic, anxiety, antidepressant and opioid medications. During an observation on 08/08/2024 at 1:35 AM, the bus was loaded, with residents, including Resident #14, and began the trip to the receiving facility, approximately 3 hours remaining in the trip. The bus arrived at the receiving facility on 08/08/24 at 3:42a.m according to a text from the owner of the facility. An interview, on 08/07/2024 at 2:00 PM, with the Owner, revealed the facility had a van on the way to pick a total of 15 residents up, to transfer to a facility in the Arlington area. He stated all residents would be out of the facility by the end of the day. Facility Owner stated their belongings and medications were being loaded into trucks, that would follow them to the receiving facility. An interview on 08/07/2024 at 3:45 PM, the Owner revealed all control medications and medications requiring temperature control (insulin) will be destroyed and the other facility will be notified to ensure the medications are ordered prior to the residents arriving. During an interview, with the DON, on 08/07/2024 at 6:00 PM, revealed the facility did not have any nursing staff to send on the van with the residents, transferring to the new facility. No staff would be present, during this transport to administer medications or provide care, if needed. Record review of the policy on medication administration effective 07/01/24 reflected the following: Policy: It is the policy of this facility to ensure that Medication Administration and Documentation occurs in a timely and accurate manner. 1. Only Physicians or licensed nurses may administer medications unless the resident is permitted to administer his/her own medications on the written order of the Physician. 2. Medications are to be administered within a two-hour time frame (i.e., one hour before or after the medication order time. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. All medication must be administered by the same person who prepared the dose for administration. 4. The Electronic Medication Administration Record (EMAR) is the form onto which all medication orders are transcribed from physician electronic orders, from which medications are poured and administered and on which medication doses are documented. The EMAR is a permanent part of the resident's medical record. 5. Infection Control protocols must be maintained at all times. 6. The medication cart must be locked when out of nurse's view.

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure meals and snacks are served at times in accordance with resident's needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33198 Based on observation, interview, and record review, the facility failed to provide at least three meals daily, at regular times comparable to normal mealtimes in the community or in accordance with resident needs for 2 of 2 residents reviewed for meals. (Residents #5 and #6). Resident #5 did not receive a normal evening meal on 08/07/24 when he was being transferred to another facility at 6:00p.m. Resident #6 did not receive a normal evening meal on 08/07/24 when he was being transferred to another facility at 6:00p.m. This failure could place the residents, at risk of not receiving adequate therapeutic nutritional status, unplanned weight loss to maintain the highest practicable level of well-being, hunger, and not having their nutritional needs met. Finding included: Resident #5 Record review of Resident #5's face sheet dated 08/07/24 indicated he was a [AGE] year-old male admitted to the facility on [DATE] with a diagnosis of schizoaffective disorder (a chronic mental illness involving symptoms of schizophrenia and characterized by symptoms such as delusions and hallucinations), schizophrenia (a serious mental condition that affects how people think, feel and behave), cognitive communication deficit (difficulty with communication), and generalized anxiety disorder. Record review of Resident #5's admission Minimum Data Set assessment, dated 04//2024, indicated Resident #5 had a BIMS assessment score of 12 indicating he was moderately impaired cognition. Record review of Resident #5's Care Plan dated 11/27/23 revealed a risk for alteration in nutrition related to mechanical soft diet due edentulous (completely toothless). A goal was to maintain adequate nutritional status through next review date. Resident #6 Record review of Resident #6's face sheet indicated he was a [AGE] year-old male admitted to the facility on [DATE] with diagnosis to include acquired absence of left leg below knee, acquired absence of right leg above knee, myocardial infarction (heart attack), ischemic cardiomyopathy (a heart condition caused by low blood flow to the muscles), hyperlipidemia (high fat levels in the blood), generalized anxiety, benign prostatic hyperplasia (enlarged prostate), peripheral vascular disease (a disorder of the blood vessel outside the heart), and diabetes mellitus (a condition that affects blood sugar level and can cause serious complications). (continued on next page)

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	745007	A. Building B. Wing	08/15/2024

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #6's admission Minimum Data Set assessment, dated 04//2024, indicated Resident #6 had a BIMS assessment score of 9 indicating he was moderately impaired cognition. Record review of Resident #6's Care Plan dated 11/27/23 revealed a risk for alteration in nutrition related to diabetes mellitus and edentulous (completely toothless). Its goal was to maintain adequate nutritional status through next review date. Interview on 08/07/2024 at 3:45 PM, the Owner revealed due to staffing concerns the facility was required to conduct an emergency temporary closure. Interview on 08/07/2024 at 5:20 PM the Admissions Staff, who was assisting with loading residents onto the van, revealed residents did not receive an evening meal, but were given a half of a sandwich to take on the van. Observation and interview on 08/07/24 at 6:00p.m revealed Resident #6 and Resident #5 were in a truck transporting him and 1 other resident to a new facility about 3 hours away. There was a van with a total of 13 residents on the van, with the van driver. The DON stated the facility did not have any nursing staff to send on the van with the residents. No staff would be present, during this transport to administer medications or provide care, if needed. Observation on 08/07/24 at 7:40p.m this surveyor saw the same truck parked where another van from the facility broke down on the road about 2 and half hours from their destination. Surveyor stopped and found the residents in the van with 12 other residents. There were 3 police cars and 4 EMT vehicles providing emergency evaluation and treatment for the residents. Resident #5 and 12 other residents was transported to a rest station nearby to get out of the high heat. While at the rest area, Resident #5 stated he did not receive normal evening meal but a small sandwich which did not quench his hunger. He was observed on two separate occasion buying snacks from the vending machine at the rest station. Resident #5 was in this rest station for many hours until a new bus left on 08/8/24 at 1:36a.m the next day. During an observation on 08/07/2024 at 11:28 PM, a bus, rented by the facility, arrived from the metroplex, approximately 3 hours away, to come to complete the transfer of the residents. They began loading residents at that time. Interview on 07/30/24 at 1:22p.m, the owner was asked for the dietary policy regarding food storage. This was not provided to the surveyor. The facility presented policy on emergency disaster menu. Record review of the Emergency disaster policy undated reflected: POLICY - To provide a planned menu with simplified, nutritious meals, using non-perishable items, to be used. during an emergency or disaster. PROCEDURE 1. The 3-day menu is to be used in the event of a (continued on next page)

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	disaster or emergency and has been planned to provide basic nutrients. It has the following limitations: a. Each meal provides one hot item in the expectation that (1) only an electric burner running off emergency power, or (2) a gas camp stove should be available for cooking. b. All residents should be served the regular menu except: 1) Residents with allergies to the regular food. 2) Residents with severe dietary limitations, i.e., brittle diabetics, renal. 3) Residents who cannot chew or swallow regular food.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33198 Based on observation, interview, and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety for 1 of 1 kitchen reviewed for dietary services. 1. The Dietary Aide failed to properly wear hair net while in the kitchen on [DATE]. 2. The exhaust vent filters of the range hood above the range were dirty. 3. Dietary Staff failed to properly label and dispose of leftovers from the refrigerator. 4. Facility failed to maintain 7 days of staple supplies and 2 days of perishable foods on hand for emergencies. 5) The facility was not following a set menu These failures could place residents at risk for food contamination and foodborne illness. Findings: During an observation on [DATE] at 11:15 pm the dietary aide was not wearing a hair-restraint. Observation on [DATE] at 11:32 a.m. in the kitchen revealed in the range hood, the exhaust vent filters above the range had a sticky, brown-colored substance on them. Additionally, the facility did not have a 7 days supply and 2 days of perishable foods on hand for emergencies. During an observation on [DATE] at 11:45 am the refrigerator located in the kitchen had leftovers in 4 plastic containers with unlabeled chicken, chicken patties, cheddar cheese and yogurt. During an interview on [DATE] at 11:52a.m [NAME] G stated she thought she put on her hairnet but realized it was not on when the surveyor brought it to her attention. [NAME] G explained she was supposed to throw away the expired food items and label the leftovers. She said the cooks were responsible for checking and removing items from the refrigerator at least every other day. [NAME] G stated if residents were to consume expired foods it could make them sick. She explained they did not have a set menu but take instructions from the DM on what to prepare on daily basis. [NAME] G stated the residents do not know what was being served until they get their food. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on [DATE] at 1:20pm. the Dietary Manager (DM) stated the facility was having trouble financially, orders from food truck were being cut due to the facility not paying their bills. The DM stated she had been going to the local grocery store several times per day to buy supplies. The DM stated she was only aloud to spend $1000.00 per week. The DM stated they were not following the facilities menu but making up meals each day. The DM stated they did not have emergency supplies at all, all food was purchased day to day. The DM stated there was a sticky, brown-colored substance on the range hood's exhaust vent filters located above the range. She stated the substance was grease and stated the filters has not been cleaned since [DATE] due non-payment by management. During an interview on [DATE] at 2:32 pm the DON said she was aware what dietary was going through, using the local store to buy supplies. The DON stated the residents' weights had been maintained and had no complaints about dietary. The DON stated the facility had been struggling to make ends meet. The DON stated the Owner was aware and told staff to make do with what we can. In an interview with Resident #4 on [DATE] at 12:12p.m, she stated the food was good but did not get extra portions to eat. She stated she did not know what was on the menu until she came to the dining room. During an interview on [DATE] at 1:22p.m, the owner was asked for the dietary policy regarding food storage. The facility presented policy on emergency disaster menu as reflected: POLICY To provide a planned menu with simplified, nutritious meals, using non-perishable items, to be used during an emergency or disaster. PROCEDURE 1. The 3-day menu is to be used in the event of a disaster or emergency and has been planned to provide basic nutrients. It has the following limitations: a. Each meal provides one hot item in the expectation that (1) only an electric burner running off emergency power, or (2) a gas camp stove should be available for cooking. b. All residents should be served the regular menu except: 1) Residents with allergies to the regular food. 2) Residents with severe dietary limitations, i.e., brittle diabetics, renal. 3) Residents who cannot chew or swallow regular food.

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	745007	A. Building B. Wing	08/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vernon Rehabilitation and Nursing Center	4301 Hospital Dr. Vernon, TX 76384

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Administer the facility in a manner that enables it to use its resources effectively and efficiently. 33198 Based on interviews the facility failed to ensure it was administered in a manner that enabled it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being for residents. The facility administration failed to have an Administrator licensed by the state to ensure policy and procedures were being followed regarding notification of facility closing. The Administration knew/should have known that there was a deficient practice, as well as how lack of Administration contributed to this deficient practice. This failure could result in the facility not being managed in a responsible manner, which could affect the health, well-being, and safety of all residents. Findings include: During an interview on 8/7/24 at 3:45pm the Owner stated the facility has been without a licensed Administrator for about 1.5 weeks. He stated he was a licensed Administrator in another state, but not Texas. The Owner stated he has been aware of the severity of staffing for approximately 1.5 weeks. The owner stated he had contacted agency, used sister facility staff, and hired a recruiter to assist with staffing. The Owner stated he did not hire a new Administrator nor looked for new Administrator because the decision was made to close the facility and residents would be transferred to sister facility. The Owner stated he did review the facility policy for Emergency Closure prior to transferring any residents. The Owner stated he was aware there were state and federal regulation related to Transfer, Discharge, and Resident Rights. The Owner stated he did not contact state licensing because he did not know how to contact them. During an interview on 8/7/24 at 4:00pm the DON stated the Administrator quit on 7/26/24, the DON stated the Administrator told her this place was not being run properly and ownership does not have the monetary funds to operate facility like it should. The DON stated she knew vendors were not getting paid and most had stopped providing services, pest control, HVAC services, and dietary was having to go to the local grocery store because the food vendor would cut our order due to nonpayment. The DON stated the Owner arrived at facility on Tuesday 6/30/24. The Owner had an all staff meeting on 6/5/24 at 3:30pm. and stated the facility could possibly close but d do not inform residents or family at that time. The DON stated she was confused and so were other staff, she stated she asked her were we closing or not?. The DON stated she knew residents and families needed to be notified and she started notifying them anyway. The DON stated she was not sure facility was closing until the afternoon of 8/6/24. (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 8/9/24 at 1:29pm, the Former administrator stated she worked for facility from 5/28/24 to 7/26/24. The Former Administrator stated the reason leaving was based on facility not paying bills, dietary menus were not being followed and facility had no emergency food supply due to orders being cut, forcing dietary to use local grocery store to prepare meals. She stated the Pest control was not being provided due to not paying the Pest Control vendor, and facility had a pest problem. The former administrator stated the facility did not have Physical therapy due to lack of funds and the Medical Director was not being paid. The Former Administrator stated she voiced these concerns many times to Owner and the reply was 'we don't have the money'. The Former Administrator stated she should have reported to HHSC the financial problems that was causing the facilities decline. The Former Administrator stated she decided to just separate herself from facility and quit. Interview on 8/9/24 at 4:55pm, the MD stated the facility had not paid him in over 6 months. The MD stated he continued to perform his duties for the residents despite not being paid. The MD stated he notified the Administrator on numerous occasions, and she could not get anything done. He stated he reached out to Owner but did not get any replies.

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F 0836 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the facility is licensed under applicable State and local law and operates and provides services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards. 33198 Based on interview the facility failed to ensure that the governing body failed to operate and provide services in compliance with all applicable Federal, State, and local laws, regulations, and codes for 1 of 1 facility reviewed for Administrator. The facility did not immediately notify Health and Human Services when the Administrator was terminated and there was no licensed nursing Facility administrator appointed as required by state regulation. This failure could place residents at risk of administrative duties not being carried out or maintained at the highest practicable physical, mental, and psychosocial well-being of the residents. Findings Included: During interview on 8/7/24 at 3:45pm the Owner stated the facility has been without a licensed Administrator for about 1.5 weeks. He states he is a licensed Administrator in New York, but not Texas. Owner stated the last Administrator quit without notice on 7/26/24. The Owner was not actively seeking a new Administrator. Owner did not contact HHSC to notify that facility did not have a licensed Administrator. On 8/5/24 the decision was made by Owner that the facility was closing, and residents would be transferred to sister facility. Owner is listed as facility's only governing body contact. Interview on 8/9/24 at 1:29pm, Former administrator stated she worked for facility from 5/28/24 to 7/26/24. Former Administrator stated the reason leaving was based on facility not paying bills. Former Administrator stated she voiced these concerns many times to Owner and the reply was 'we don't have the money'. Former Administrator stated she decided to just separate herself from facility and quit on 7/26/24.

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	745007	A. Building B. Wing	08/15/2024

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F 0837 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Establish a governing body that is legally responsible for establishing and implementing policies for managing and operating the facility and appoints a properly licensed administrator responsible for managing the facility. 33198 Based on interview and record review, the facility failed to ensure that the facility had an Administrator licensed by the state that was responsible for management for 1 of 1 facility's reviewed for governing body. The facility failed to ensure the owner, who was acting as the facility Administrator, had an active Texas Administrator license, and ensure that person designated as being in authority notifies HHSC immediately when the facility does not have an administrator. This deficient practice could result in the facility not being managed in a responsible manner, which could affect the health, well-being, and safety of all residents. The findings include: During interview on 8/7/24 at 3:45pm the Owner stated the facility has been without a licensed Administrator for about 1.5 weeks. He stated he was a licensed Administrator in another state, but not Texas. The Owner stated the last Administrator quit without notice on 7/26/24. The Owner was not actively seeking a new Administrator. The Owner stated he did not contact HHSC to notify that facility did not have a licensed Administrator. The decision was made that the facility was closing and residents would be transferred to sister facility. During interview on 8/7/24 at 4:00pm the DON stated the Administrator quit on 7/26/24. The DON stated she assumed she was the designated Abuse Coordinator if there was not an Administrator. During an interview on 8/9/24 at 1:29pm, the Former administrator stated she worked for facility from 5/28/24 to 7/26/24. The Former Administrator stated she decided to separate herself from facility and quit. Record review 8/7/24 of facility's Active Employee Report revealed Administrator was hired 5/28/24 and had a termination date 7/26/24. Record review of Governing body list undated, indicate the Owner was the only contact on the list.

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F 0845 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Submit a timely, acceptable plan for facility closure, including notification of the appropriate entities and ensuring residents are transferred in a safe and orderly manner. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33198 Based on interview and record review, the facility failed to submit to the residents of the facility and their legal representatives of such residents or other responsible parties, written notification of an impending closure at least 60 days prior to the date of closure for 3 of 3 residents (#1, #8 and #12) reviewed for discharge notice. -The facility failed to provide residents ((#1, #8 and #12) and their representatives a written notice of closure at least 60-days before closure. This failure could affect the residents at the facility by placing them at risk of being discharged and not having access to available advocacy services, continuity of care, the most appropriate facility based on needs and desirable location, and discharge/transfer options. Findings include: Resident #1 Record review of Resident #1's face sheet dated 8/7/24 revealed a [AGE] year-old male, admitted [DATE]. Medical diagnosis; Toxic encephalopathy, Alzheimer's, anemia, hyperlipidemia, Atrial fibrillation, gastro-esophageal reflux disease without esophagitis, muscle wasting, anxiety. Record review of the significant change MDS dated [DATE] revealed Resident #1 with a BIMS score of 5 indicating severe cognitive impairment. Resident #1 required dependent assistance in most ADLs including oral hygiene, toileting, dressing, personal hygiene, bathing and transfers. Observation and Interview on 8/7/24 at 1:05pm, Resident #1 was in room sitting in wheelchair with RP. Resident #1 was visibly upset, stated he did not want to move, Resident #1 stated he wanted to be near family. Resident #1 could not state who told him facility was closing. Interview on 8/7/24 at 1:10pm, Resident #1's RP stated on the afternoon of 8/6/24 she was informed by facility DON that the home was closing, and residents are being moved to their sister facility in [city] tomorrow 8/7/24. Resident #1's RP stated she contacted another facility in her town of [city, state] and could not secure admission there. The RP stated Resident #1 does not have any family nearby. I just here. The RP stated no one from facility contacted her or offered to help find placement. The RP stated Resident #1 will have to go to new facility until she08 can find a place closer. Resident #8 Record review of Resident #8's face sheet dated 8/7/24, revealed a [AGE] year-old male, admitted on [DATE]. Medical diagnosis: Schizoaffective disorder, Bipolar type, mild cognitive impairment, speech disturbances, major depressive disorder, osteoarthritis. (continued on next page)

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	745007	A. Building B. Wing	08/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0845 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 8/7/24 at 1:25pm, Resident #8 stated the staff told him he was being moved but did not know where. Resident #8 stated he heard from another resident the facility was closing, so he contacted his RP and told her. Resident #8 did not know much about the closure and what was going on. Interview on 8/7/24 at 1:30pm, Resident #8's RP stated resident contacted her on 8/6/24 and stated the facility was closing and he was moving someplace else. The RP stated this was the first she heard of it. The RP stated when she arrived at facility on 8/6/24, no staff from facility could give her any answers or what she was supposed to do. The RP stated that evening on 8/6/24 she contacted another facility in town, and they agreed to take Resident #8. The RP stated no one from the facility offered to help her find placement or did the facility give the proper notice of closing or discharging the resident. Resident #12 Record review of Resident #12's face sheet dated 8/7/24 revealed a [AGE] year-old male, admitted on [DATE]. Medical Diagnosis: Sepsis, Alcoholic cirrhosis of liver with ascites, dysphagia, acute hepatitis, alcohol-induced psychotic disorder, chronic kidney disease. Observation on 8/7/24 at 1:50pm, Resident #12 sleeping in bed, boxes in room sealed and ready to move. Interview on 8/7/24 at 1:55pm, Resident #12's RP stated she was informed of facility closing and the plan of moving residents to [city] on 8/6/24. The RP stated she came to visit the resident on 08/07/24 and one of the aides told her. The RP stated she was taking Resident #12 home and stated she had already made arrangement for resident to receive hospice services while at home with her. The RP stated she received no help from facility, did not receive any list of other facilities where she could look for placement. Review of the Facility Policy: Emergency Nursing Home Closure Policy, undated or signed. Emergency Nursing Home Closure Policy 1. Purpose The purpose of this policy is to provide a structured and compassionate approach for the emergency closure of a for-profit nursing home facility in Texas, ensuring the safety and well-being of residents, compliance with state regulations, and clear communication with all stakeholders. 2. Scope This policy applies to all staff, residents, families, and stakeholders of [Facility Name]. 3. Policy Statement [Facility Name] is committed to ensuring a smooth and respectful transition for residents, staff, and families during the emergency closure of the facility. The closure process will comply with all applicable state and federal regulations, including the Texas Health and Human Services Commission (HHSC) requirements. 4. Procedure 4.2. Notification (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	745007	A. Building B. Wing	08/15/2024

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F 0845 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Regulatory Authorities: Notify the Texas Health and Human Services Commission (HHSC) and other relevant state and federal agencies immediately upon the decision to close(Facility Closure 03.22.). Residents and Families: Provide written notice to all residents and their families or legal representatives as soon as possible, ideally within 24 hours. The notice will include the closure date, reasons for closure, and information on the relocation process(Facility Closure 03.22.).

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	745007	A. Building B. Wing	08/15/2024

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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 0846 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have policies and procedures ensuring the administrator's responsibilities for facility closure are completed successfully. 33198 Based on interview and record review, the facility failed to have policies and procedures in place that outline the duties of the Administrator in the event of a facility closure. This includes the provision of the appropriate notices related to the closure. These parties include the State Survey Agency, the State Long-Term Care Ombudsman, all resident in the facility and their legal representatives, the CMS Regional Office, the State Medicaid Agency, and the staff who are responsible for providing care and services for 3 (Resident #1, #8 and #12) 0f 15 residents. The facility failed to notify State Survey Agency, the State Long-Term Care Ombudsman, all resident in the facility and their legal representatives, facility Medical Director of facility closing. This failure could affect the residents at the facility by placing them at risk of being discharged and not having access to available advocacy services, continuity of care, the most appropriate facility based on needs and desirable location, and discharge/transfer options. Findings include: Interview on 8/7/24 1:30pm the Owner stated the facility did not have a Licensed Administrator for facility since 7/26/24. The facility operation was being conducted by facility Owner, who stated he does not hold a state Administrator license, in the state of Texas. Interview on 8/7/24 at 1:30pm, the DON stated the Owner told her and the staff on 8/5/24 at 3:30pm that the facility could possibly close. DON stated on 8/6/24 that the Owner decide that the facility would be closing the next day 8/7/24 and resident will be moved to a sister facility 2.5 hours away. DON stated no notice to residents, families, State agency was given. DON stated that there was no closure plan in place, facility does not have an Administrator, everything was just made up as we went. Interview on 8/7/24 at 3:00pm the Ombudsman stated she was made aware of facility closing on 8/5/24, does not recall time. The Ombudsman stated she spoke with the Owner, and he stated the lack of an Administrator and CNAs was the reason such short notice was given for facility closing and residents being discharged to another facility. Interview on 8/7/24 at 1:10pm, Resident #1's RP stated on the afternoon of 8/6/24 she was informed by the facility DON that the home was closing, and residents are being moved to their sister facility tomorrow 8/7/24. RP stated no one from the facility contacted her or offered to help find placement. Interview on 8/7/24 at 1:25pm, Resident #8 stated he heard from another resident that the facility was closing, so he contacted his RP and told her. (continued on next page)

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	745007	A. Building B. Wing	08/15/2024

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F 0846 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 8/7/24 at 1:30pm, Resident #8's RP stated resident contacted her on 8/6/24 and stated the facility was closing and he was moving was moving someplace else. RP stated that was the first she heard of it. The RP stated when she arrived at facility on 8/6/24, no staff from facility could give her any answers or what she was supposed to do. RP stated that evening on 8/6/24 she contacted another facility in town, and they agreed to take Resident #8. RP stated that no one from the facility gave notice of closing or discharging the resident. Interview on 8/7/24 at 1:55pm, Resident #12's wife (RP) stated she was informed of facility closing and the plan of moving residents to Arlington on 8/6/24. RP stated she came into visit that day and one of the aides told her. RP stated she was taking Resident #12 home and stated she has already made arrangement for resident to receive hospice services while at home with her. RP stated she received no help from facility, did not receive any list of other facilities where she could look for placement. Interview on 8/9/24 at 4:55pm, facility Medical Director stated he was unaware that the facility was closing. Stating he is the primary physician for most of the residents at the facility. Medical Director stated he was informed by the DON on 8/7/24. Observation on 8/7/24 at 4:00pm, residents started being loaded on facility bus. 13 residents were loaded on bus, loading completed at 5:55pm. Bus pulled out of facility parking lot on 6:00pm headed to sister facility. Observation on 8/7/24 at 6:30pm with all residents are out of facility. Facility Closure Policy: Not dated or signed. Emergency Nursing Home Closure Policy 1. Purpose The purpose of this policy is to provide a structured and compassionate approach for the emergency closure of a for-profit nursing home facility in Texas, ensuring the safety and well-being of residents, compliance with state regulations, and clear communication with all stakeholders. 2. Scope This policy applies to all staff, residents, families, and stakeholders of [Facility Name]. 3. Policy Statement [Facility Name] is committed to ensuring a smooth and respectful transition for residents, staff, and families during the emergency closure of the facility. The closure process will comply with all applicable state and federal regulations, including the Texas Health and Human Services Commission (HHSC) requirements. 4. Procedure 4.1. Decision to Close The decision to close the facility will be made by the Board of Directors and/or facility owner(s) after careful consideration of all factors leading to the emergency. Legal and regulatory requirements will be reviewed to ensure compliance. (continued on next page)

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	745007	A. Building B. Wing	08/15/2024

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F 0846 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4.2. Notification Regulatory Authorities: Notify the Texas Health and Human Services Commission (HHSC) and other relevant state and federal agencies immediately upon the decision to close (Facility Closure 03.22.). Residents and Families: Provide written notice to all residents and their families or legal representatives as soon as possible, ideally within 24 hours. The notice will include the closure date, reasons for closure, and information on the relocation process (Facility Closure 03.22.).