STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675326	A. BUILDING _____ B. WING _____	**06/24/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CENTRAL TEXAS NURSING & REHABILITATION	**1800 N BROADWAY ST BALLINGER, TX 76821**

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 0580 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on Interviews, and record reviews the facility failed to notify resident's responsible party/interested family member of the significant changes in the residents physical condition changes and decline for 1 or 5 residents (#1). The facility failed to: a. Notify family of resident holding food in mouth/swallowing issues, change of diet on 5/21/2020 and 5/22/2020, and of order that if resident does not eat 50% of meal to give him a health shake on 06/01/2020. b. Notify family of residents 9.8 pound weight loss on 6/5/2020 and 18 pound weight loss on 06/12/2020. Findings include: Review of Resident #1 clinical record face sheet dated 05/11/2020 revealed he was a [AGE] year old male with BIMS (Brief interview for mental status) of 01, which indicates several cognitive disability. Resident #1 was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. Review of Physician telephone order dated 05/21/2020 Regular diet changed to Pureed texture Review of Physician order [REDACTED]. Speech was working with resident but he still was not eating much. Review of weight records dated 06/05/2020 resident #1 had lost 9.8 pounds, resident #1's weight was 161 pound on admit. Review of phone records did not produce any calls notifying the family. Review of Physician order [REDACTED].#1 had 18 pound weight loss. On this date he weighed 143 pounds. Review of Physician orders [REDACTED]. Lab results Blood urea nitrogen was high 76.8, Creatinine 1.67, Blood glucose 348, [MEDICATION NAME] 2.9 low, White blood cell count was high 18.6, Mercury was normal. Record review from nurse progress notes dated 5/21/20 revealed resident #1 holding food in his mouth and not swallowing, Physician and DON (director of nursing) were informed about diet texture change recommendation from speech therapy, however family was not notified of this change in condition. Interview with Nurse A on 6/19/2020 @ 2:10 PM revealed that resident had begun to decline with eating and the Doctor had added Glucerna if he wasn't eating. Nurse A revealed that the daughter was informed but the daughter had surgery and they had to contact the son in her place and he was calling to check on resident # 1, but she had not called him. Interview with daughter on 6/18/2020 @ 3:30 PM she revealed that the facility did not call and inform them of him not eating enough that it was causing the amount of weight loss that he had over the month he was in the facility. Daughter revealed she had to call every day to get updates but they were never in detail of him holding food in his mouth or the 9.8 pound weight loss. They did not start calling with change of conditions till the last 3 days in the facility, resident was unresponsive and sent to hospital on [DATE] at 1:00 PM. Record review of progress notes on 6/15/2020 was the only note in chart showing notification of family being informed of resident eating less than >50% of his meal. Resident one had started with decline in eating on 5/21/2020. Interview with DON on 6/19/2020 revealed that she could not find a note in progress records that showed where the family had been informed of residents change of condition. Interview with Social Worker on 6/24/2020 at 9:30 am she revealed that they had a care plan meeting with resident #1 family but could not produce the date of meeting or signature page of meeting. Social Worker revealed she did not send email to family as requested. Interview with resident # 1 son on 6/24/2020 @ 10:15 am he revealed he was called about an care plan meeting but he informed Social Worker that they could not all get together could she send him a email with all the changes and update so he could review it with siblings and get back to her, he never received the email. The only phone call he received was about his dentures and dental appointment asking if he had a mouth injury in the past. Interview with DON on 6/19/2020 at 3:30 to ask for weights and policy and procedures for reporting weight loss on resident # 1. Asked DON again on 6/24/2020 for weights and policy she gave weights but said she did not have policy for reporting to family.

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.