STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675925	A. BUILDING _____ B. WING _____	03/12/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
THE MILDRED & SHIRLEY L GARRISON GERIATRIC EDUCATI	3710 4TH ST LUBBOCK, TX 79415

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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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 interview and record review, the facility failed to immediately notify the resident representative(s) when there was a significant change in the resident's physical status for 1 of 5 residents (R #2) reviewed for changes in condition. The facility failed to notify Resident #2's Responsible Party (RP#2) of changes in R#2's skin condition. This failure could place residents at risk for not having their family or legal representative notified when a change of condition occurs. Findings includes: Record Review of Resident #2's Admission Record indicated R#2 was a [AGE] year-old female admitted to the facility on [DATE] and 02/12/19 with [DIAGNOSES REDACTED]. Review R#2's Minimum Date Set ((MDS) dated [DATE] indicated she did not score on her brief interview for mental status, and her functional status for activities of daily living assistance revealed she required extensive assistance with one-person physical assist for bed mobility, transfer, locomotion on and off the unit, dressing, eating, toilet use, and personal hygiene. Observation on 03/10/20 at 3:47 P.M. revealed R#2 had an area beneath her left eye that had a light discoloration measuring approximately 3 inches by 3 inches. Review of Skin Evaluation-PRN/Weekly dated 03/02/20 at 10:41 A.M. and conducted by LVN/ADON#2 indicated R#2 had bruising to left eye orbit on inferior aspect of left eye. No redness or selling to left eye, and full skin assessment performed with no other skin issues. Interview on 03/10/20 at 3:32 p.m. with family member (RP#2) indicated he visits R#2 daily and recalled on 02/27/20 at approximately 2:00 p.m., while visiting R#2, R#2 did not have a black eye (bruise) to the left side of her face. 02/28/20 at approximately 10:00 a.m. to 11 a.m. RP#2 was visiting R#2, when he discovered R#2 had a black eye to her left eye; however, this had not been reported to him prior to coming to facility. RP#2 took pictures of R#2's eye injury and indicated he would share with state investigator. RP#2 indicated he question LVN #1, who was working on 03/02/20, and LVN#1 replied he was unaware of R#2's black eye. Then, RP#2 spoke with facility's Administrator about R#2's black eye. RP#2 added that if R#2 fell she would not be able to lift herself off the floor. RP#2 indicated R#2 was not seen by physician or had x-rays taken of her black eye. Afterwards, RP#2 went through his cell phone and pointed out that he had not received a message or phone call from facility to inform him of his R#2's's injury. RP#2 added that it took facility 4 days to inform him of R#2's injury. Observation of pictures provided by RP#2 revealed the following: Picture #1 taken on 02/29/20 indicated R#2, who was sitting in her wheelchair, had a deep purple color covering her eye, and extended below the eye. The area below R#2's eye was a deep purple color and was approximately 2 inches wide and 1 inch long. Picture #2 taken on 03/02/20 indicated R#2's bruise was the same size as described in picture #1 but was lighter in color. Picture #3 taken on 03/02/20 indicated R#2's bruise was lighter in color but had extended from 2 inches wide by 1 inches long to 2 inches wide by 2 inches long 03/10/20 at 3:47 P.M. RP#2 assisted with interviewing R#2 about her bruise (black eye); however, she was unable to answer the questions asked of her, instead she mumble her responses, which were not understood. 03/10/20 at 4:13 P.M. attempted interview with R#9, who is R#2's roommate; however, she did not respond to questions asked of her. 03/10/20 at 4:20 P.M. LVN#2 indicated she was R#2's, nurse. LVN#2 indicated on 02/28/20 she left on her lunch break from 1:15 P.M. to 3:11 P.M. and upon returning to the unit she was informed by CNA's, 1 and 2, that R#2 had a bruise to her left eye and RP#2 was taking pictures of her. LVN#2 indicated she started her shift at 6 A.M. and received shift report but did not included information about R#2, specifically that she had sustained an injury or fall on the previous shift. LVN#2 indicated she observed R#2 during breakfast and she had no injuries to her face. LVN#2 indicated R#2 is alert some days and other days it's impossible to get her to respond, and in her opinion if she fell on the floor she could try to get up off the floor, if it was on a good day. LVN#2 indicated R#2 has a baby doll that she keeps with her most of the time and has seen her experienced crying spells. During these crying spells she had witnessed R#2 take the baby doll and bounce it back and forth on the dining table. LVN#2 indicated she did not suspect anybody had mistreated R#2. On 03/12/20 at 2:36 P.M. LVN#2 indicated CNAs did report to her that they had witnessed R#8 in R#2 and R#9's room twice but was redirected to leave the room. LVN#2 added that CNA#3 and CNA#4 did not witness R#8 do anything to the residents. In addition, LVN#2 indicated she documented in R#2's progress notes, the information reported to her by the CNAs. Review of facility's Interview Guide included in Provider Investigation Report dated 03/02/20 indicated LVN#2 confirmed she received a report from the CNAs indicating R#2 had and injury but did not report it because she assumed it had been reported. Review of R#2's Progress Notes dated 02/28/20 at 3:35 p.m. revealed the following: Late Entry: R#2 assessed for black eye and cause unknown. Note dated 03/02/30 at 11:15 a.m. R#2 was assessed as soon as aide reported to the nurse. Note dated 03/02/20 at 2:14 p.m. spoke with RP#2 in length regarding recent discovery of discoloration to left lower eye area. Explained to him that we were unable to determined cause of injury to left eye. Explained that we were still investigation the cause and monitoring for and for any latent injuries. Full skin assessment performed with no other injuries to report. Interview on 03/10/20 at 4:30 p.m. LVN/ADON#1 indicated on 02/28/20 she conducted her morning rounds, which included seeing each resident in the unit where resident R#2 resides. LVN/ADON#1 recalled squatting down and speaking face-to-face with R#2, because she was not eating her breakfast, and she did not have a bruise to her face. LVN/ADON#1 indicated she was at the nurses' station when CNA's, 1 and 2, informed her and LVN#2 that R#1 had a black eye and RP#2 was taking pictures of her. LVN/ADON#1 indicated R#2 is to some extent alert some days and other days it's impossible to get her to respond, and in her opinion if R#2 fell on the floor she could try to get up off the floor, if it was on a good day. LVN/ADON#1 indicated R#2 has a baby doll that she keeps with her most of the time, and on 02/28/20, after breakfast, she witnessed R#2 experienced a crying spell. During this crying spell R#2 took her baby doll and bounce it back and forth on the dining table, and LVN/ADON#1 suspects she hit her face with this doll, causing a bruise to her face. LVN/ADON#1 indicated nobody informed her that R#2 had sustained a fall on 02/28/20 nor was it reported to her. LVN/ADON#1 indicated there were no Incident Progress Reports indicating R#2 had a fall. LVN/ADON#1 indicated she did not suspect anybody had mistreated R#2. Interview on 03/12/20 at 11:44 a.m. with CNA#4 indicated on 02/28/20 at approximately 6:30 a.m.she was assisting R#2 up out of bed, when she noticed a bruise to her left eye and under her eye. CNA#4 reported R#2's bruise to CNA#3, and then reported this to LVN#2, and she responded with this glazed look and replied I will look at it. CNA#4 recalled prior to getting R#2 up from bed, R#8 had to be escorted out of R#2 and R#9's room. CNA#4 indicated R#8 has a history of yelling and using his fist to swing at staff, when redirected. In addition, CNA#4 indicated R#2 is unable to walk and if she fell would not be able to lift herself off the floor. CNA#4 added that R#2 is very dependent on staff to transfer her and take care of her. CNA#4 indicated R#9 will make attempts to hit staff that redirect him. Review of facility's Interview Guide included in Provider Investigation Report dated 03/02/20 indicated CNA#4 indicated she reported to the charge nurse (LVN#2); however, she had no knowledge how (R#2) injury was sustained. Interview on 03/12/20 at 11:55 a.m. with CNA#3 indicated on 02/27/20 p.m. she cared for R#2 and recalled that when she left between 2 p.m. and 2:30 p.m. R#2 had no bruising to her face. The following day on 02/28/20, CNA#3 reported to LVN#2 at approximately 6:10 a.m. and again at 6:30

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.

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F 0580 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) a.m., that she had to redirect R#8 to leave residents', R#2 and R#9's, room. CNA#3 indicated between 6:30 a.m. and 7 a.m. she and CNA#4 assisted R#2 out of her bed, when they discovered a red spot under R#2's left eye and immediately reported this to LVN#2 and waited for her to see R#2, but she did not. Afterwards, CNA#3 and CNA#4 took R#2 to conduct her shower, and by this time her red spot had turned into a large bruise. CNA#3 indicated R#8 has a history of yelling and balling up his hand into a fist, which he uses to swing at staff, when redirected. Review of facility's Interview Guide included in Provider Investigation Report dated 03/02/20 indicated CNA#3 indicated she reported to the charge nurse (LVN#2); however, she had no knowledge how (R#2) injury was sustained. Interview on 03/11/10 at 3:10 p.m. ADON#2 indicated on 03/02/20 at 9:06 a.m., via a text, he was notified by LVN#1 that FM#1 was coming to facility today. RP#2 wanted to know why R#1 had a black eye and why no one called him about it, and the night nurse mentioned that R#8 caused it. Review of facility's Interview Guide included in Provider Investigation Report dated 03/02/20 indicated ADON#2 assessed R#2, who had discoloration of left eye area. R#2 was not interviewable due to [DIAGNOSES REDACTED]. ADON#2 asked several of the staff if that they knew how R#2 sustained the injury to her eye, and all staff denied having any knowledge of this injury. ADON#2 questioned if RP#2 had been notified. RP#2 clarify this was shared with CNAs and with LVN #2. ADON#2 questioned LVN#2 who indicated she received reports from the CNAs, but thought it was already reported. Interview on 03/12/20 at 9:10 a.m. LVN#1 indicated he observed R#2 with bruise to her right eye; however, he was informed on 03/01/20 but he was off work. LVN#1 indicated he did not report R#2's injury because he though nurse on shift would handle it. LVN #1 indicated upon his arrival to work on 03/02/20 was unable to locate progress note or incident report specific to R#2's bruise to her face. Afterwards, LVN#1 assessed R#2 and informed ADON#2. LVN#1 indicated R#2, who is wheelchair bound, is not capable of picking herself off the floor if she fell . LVN#1 indicated R#8 has a history of wandering into other residents' rooms, and usually targets and intimidates female residents, CNAs and nurses. LVN#1 indicated there is a hallway monitoring the hallway where R#1, R#8, and R#9 reside, but he is not sure if he can look at recording. Review of facility's video camera recordings for 02/28/20 did not included recording before 9 p.m. Review of this recording from 9 p.m. to 6 a.m. revealed R#8 did get up several times during the night and walked to and from the cabinets located in the unit's dining area. Interview on 03/12/20 at 7:10 p.m. Administrator indicated, his nurses were informed of R#2's injury of unknown origin on 02/28/20 between 6:30 a.m. and 7:00 a.m.; however, the he was not responsible for reporting this injury until he was informed on 03/02/20. Review of facility's policy on Change of Condition Reporting dated revised 07/2018 indicted a licensed nurse will inform family/responsible party of change of condition and document notification.
F 0609 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure all allegations of abuse were reported immediately to the state agency and administrator for 1 of 5 residents reviewed for abuse. (R#2) The facility did not report within 24 hours a suspicious injury of unknown origin to the administrator or the state agency when R#2 had bruising and redness around her eye. The resident was severely impaired cognitively and could not explain what happened. This failure could place residents at risk for abuse due to injuries of unknown origin not reported within 24 hours. Findings included: Review of R#2's Admission Record indicated R#2 was a [AGE] year-old female admitted to the facility on [DATE] and 02/12/19 with [DIAGNOSES REDACTED]. Review R#2's Minimum Date Set ((MDS) dated [DATE] indicated she did not score on her brief interview for mental status, and her functional status for activities of daily living assistance revealed she required extensive assistance with one-person physical assist for bed mobility, transfer, locomotion on and off the unit, dressing, eating, toilet use, and personal hygiene. Observation on 03/10/20 at 3:47 P.M. revealed R#2 had an area beneath her left eye that had a light discoloration measuring approximately 3 inches by 3 inches. Review of Skin Evaluation-PRN/Weekly dated 03/02/20 at 10:41 A.M. and conducted by LVN/ADON#2 indicated R#2 had bruising to left eye orbit on inferior aspect of left eye. No redness or selling to left eye, and full skin assessment performed with no other skin issues. Interview on 03/10/20 at 3:32 p.m. with family member (FM#2) indicated he visits R#2 daily and recalled on 02/27/20 at approximately 2:00 p.m., while visiting R#2, R#2 did not have a black eye (bruise) to the left side of her face. 02/28/20 at approximately 10:00 a.m. to 11 a.m. FM#2 was visiting R#2, when he discovered R#2 had a black eye to her left eye; however, this had not been reported to him prior to coming to facility. FM#2 took pictures of R#2's eye injury and indicated he would share with state investigator. FM#2 indicated he question LVN #1, who was working on 03/02/20, and LVN#1 replied he was unaware of R#2's black eye. Then, FM#2 spoke with facility's Administrator about R#2's black eye. FM#2 added that if R#2 fell she would not be able to lift herself off the floor. FM#2 indicated R#2 was not seen by physician or had x-rays taken of her black eye. Afterwards, FM#2 went through his cell phone and pointed out that he had not received a message or phone call from facility to inform him of his R#2's's injury. FM#2 added that it took facility 4 days to inform him of R#2's injury. Observation of pictures provided by FM#2 revealed the following: Picture #1 taken on 02/29/20 indicated R#2, who was sitting in her wheelchair, had a deep purple color covering her eye, and extended below the eye. The area below R#2's eye was a deep purple color and was approximately 2 inches wide and 1 inch long. Picture #2 taken on 03/02/20 indicated R#2's bruise was the same size as described in picture #1 but was lighter in color. Picture #3 taken on 03/02/20 indicated R#2's bruise was lighter in color but had extended from 2 inches wide by 1 inches long to 2 inches wide by 2 inches long 03/10/20 at 3:47 P.M. FM#2 assisted with interviewing R#2 about her bruise (black eye); however, she was unable to answer the questions asked of her, instead she mumble her responses, which were not understood. 03/10/20 at 4:13 P.M. attempted interview with R#9, who is R#2's roommate; however, she did not respond to questions asked of her. 03/10/20 at 4:20 P.M. LVN#2 indicated she was R#2's, nurse. LVN#2 indicated on 02/28/20 she left on her lunch break from 1:15 P.M. to 3:11 P.M. and upon returning to the unit she was informed by CNA's, 1 and 2, that R#2 had a bruise to her left eye and FM#2 was taking pictures of her. LVN#2 indicated she started her shift at 6 A.M. and received shift report but did not included information about R#2, specifically that she had sustained an injury or fall on the previous shift. LVN#2 indicated she observed R#2 during breakfast and she had no injuries to her face. LVN#2 indicated R#2 is alert some days and other days it's impossible to get her to respond, and in her opinion if she fell on the floor she could try to get up off the floor, if it was on a good day. LVN#2 indicated R#2 has a baby doll that she keeps with her most of the time and has seen her experienced crying spells. During these crying spells she had witnessed R#2 take the baby doll and bounce it back and forth on the dining table. LVN#2 indicated she did not suspect anybody had mistreated R#2. On 03/12/20 at 2:36 P.M. LVN#2 indicated CNAs did report to her that they had witnessed R#8 in R#2 and R#9's room twice but was redirected to leave the room. LVN#2 added that CNA#3 and CNA#4 did not witness R#8 do anything to the residents. In addition, LVN#2 indicated she documented in R#2's progress notes, the information reported to her by the CNAs. Review of facility's Interview Guide included in Provider Investigation Report dated 03/02/20 indicated LVN#2 confirmed she received a report from the CNAs indicating R#2 had and injury but did not report it because she assumed it had been reported. Review of R#2's Progress Notes dated 02/28/20 at 3:35 p.m. revealed the following: Late Entry: R#2 assessed for black eye and cause unknown. Note dated 03/02/30 at 11:15 a.m. R#2 was assessed as soon as aide reported to the nurse. Note dated 03/02/20 at 2:14 p.m. spoke with FM#2 in length regarding recent discovery of discoloration to left lower eye area. Explained to him that we were unable to determined cause of injury to left eye. Explained that we were still investigation the cause and monitoring for and for any latent injuries. Full skin assessment performed with no other injuries to report. Interview on 03/10/20 at 4:30 p.m. LVN/ADON#1 indicated on 02/28/20 she conducted her morning rounds, which included seeing each resident in the unit where resident R#2 resides. LVN/ADON#1 recalled squatting down and speaking face-to-face with R#2, because she was not eating her breakfast, and she did not have a bruise to her face. LVN/ADON#1 indicated she was at the nurses' station when CNA's, 1 and 2, informed her and LVN#2 that R#1 had a black eye and FM#2 was taking pictures of her. LVN/ADON#1 indicated R#2 is to some extent alert some days and other days it's impossible to get her to respond, and in her opinion if R#2 fell on the floor she could try to get up off the floor, if it was on a good day. LVN/ADON#1 indicated R#2 has a baby doll that she keeps with her most of the time, and on 02/28/20, after breakfast, she witnessed R#2 experienced a crying spell. During this crying spell R#2 took her baby doll and bounce it back and forth on the dining table, and LVN/ADON#1 suspects she hit her face with this doll, causing a bruise to her face. LVN/ADON#1 indicated nobody informed her that R#2 had sustained a fall on 02/28/20 nor was it reported to her. LVN/ADON#1 indicated there were no Incident Progress Reports indicating R#2 had a fall. LVN/ADON#1 indicated she did not suspect anybody had mistreated R#2. Interview on 03/12/20 at 11:44 A.M. with CNA#4 indicated on 02/28/20 at approximately 6:30 she was assisting R#2 up out of

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F 0609 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 2) bed, when she noticed a bruise to her left eye and under her eye. CNA#4 reported R#2's bruise to CNA#3, and then reported this to LVN#2, and she responded with this glazed look and replied I will look at it. CNA#4 recalled prior to getting R#2 up from bed, R#8 had to be escorted out of R#2 and R#9's room. CNA#4 indicated R#8 has a history of yelling and using his fist to swing at staff, when redirected. In addition, CNA#4 indicated R#2 is unable to walk and if she fell would not be able to lift herself off the floor. CNA#4 added that R#2 is very dependent on staff to transfer her and take care of her. CNA#4 indicated R#9 will make attempts to hit staff that redirect him. 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CNA#3 indicated R#8 has a history of yelling and balling up his hand into a fist, which he uses to swing at staff, when redirected. Review of facility's Interview Guide included in Provider Investigation Report dated 03/02/20 indicated CNA#3 indicated she reported to the charge nurse (LVN#2); however, she had no knowledge how (R#2) injury was sustained. Interview on 03/11/10 at 3:10 p.m. ADON#2 indicated on 03/02/20 at 9:06 a.m., via a text, he was notified by LVN#1 that FM#1 was coming to facility today. FM#2 wanted to know why R#1 had a black eye and why no one called him about it, and the night nurse mentioned that R#8 caused it. Review of facility's Interview Guide included in Provider Investigation Report dated 03/02/20 indicated ADON#2 assessed R#2, who had discoloration of left eye area. R#2 was not interviewable due to [DIAGNOSES REDACTED]. ADON#2 asked several of the staff if that they knew how R#2 sustained the injury to her eye, and all staff denied having any knowledge of this injury. ADON#2 questioned if FM#2 had been notified. FM#2 clarify this was shared with CNAs and with LVN #2. ADON#2 questioned LVN#2 who indicated she received reports from the CNAs, but thought it was already reported. Interview on 03/12/20 at 9:10 a.m. LVN#1 indicated he observed R#2 with bruise to her right eye; however, he was informed on 03/01/20 but he was off work. LVN#1 indicated he did not report R#2's injury because he though nurse on shift would handle it. LVN #1 indicated upon his arrival to work on 03/02/20 was unable to locate progress note or incident report specific to R#2's bruise to her face. Afterwards, LVN#1 assessed R#2 and informed ADON#2. LVN#1 indicated R#2, who is wheelchair bound, is not capable of picking herself off the floor if she fell . LVN#1 indicated R#8 has a history of wandering into other residents' rooms, and usually targets and intimidates female residents, CNAs and nurses. LVN#1 indicated there is a hallway monitoring the hallway where R#1, R#8, and R#9 reside, but he is not sure if he can look at recording. Review of facility's video camera recordings for 02/28/20 did not included recording before 9 PM. Review of this recording from 9 p.m. to 6 a.m. revealed R#8 did get up several times during the night and walked to and from the cabinets located in the unit's dining area. Interview on 03/12/20 at 10:30 a.m. with Administrator, indicated the facility's video camera stores a few days of video, which causes other recordings to be deleted. In addition, Administrator, indicated he had implemented one-to-one supervision for R#8 due to his history of incidents, his need for psychiatric evaluation, and the need to find him placement in an all-male unit. Record review of Resident #1's facility nurses notes document the facility learned of the incident on 02/28/20 between 6:30 a.m. and 7:00 a.m. The facility did not report the incident to the state as required. Interview on 03/12/20 at 7:10 p.m. Administrator indicated, his nurses were informed of R#2's injury of unknown origin on 02/28/20 between 6:30 a.m. and 7:00 a.m.; however, he was not responsible for reporting this injury until he was informed on 03/02/20. Review of Provider Letter PL 19-17 dated 07/10/19 indicated an injury of unknown source that must be reported: if a resident has bruising determined to be non-serious and no one witnessed the source of the injury, but the injury is suspicious because of the location of the injury. Record review of the facility's Policy/Procedure-Administration dated 11/28/17 indicated all allegation of abuse, neglect misappropriation of resident property, or exploitation should be reported immediately to the administrator. Allegations of abuse and/or neglect will be reported outside the facility, and to the appropriate state or federal agencies in the applicable timeframes, as per this policy and applicable regulations. This report included recognizing signs of abuse, neglect, injuries of unknown sources, and to whom and when staff and other must report their knowledge related to any alleged violation without fear of reprisal.
F 0622 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to notify the resident and/or the resident's representative of the transfer or discharge and the reasons for the move in writing and in a language and manner they understood as soon as was practicable, for one of two residents reviewed for discharge rights and notices. Resident (R#3) R#1's or his family, FM #1 and FM#2, who were listed as his emergency contact, were not notified in writing of the effective date of discharge for R#1, the reason for the transfer/discharge, the location to which the resident would be transferred, or the right of appeal, as soon as was practicable. This failure could place residents at risk for not receiving care and services to meet their needs upon discharge. The findings were: Review of R#3's Admission Record indicated he was a [AGE] year-old male, who was admitted to facility on 01/09/20. This report included R#3's [DIAGNOSES REDACTED]. Review of R#3's Minimum Data Set ((MDS) dated [DATE] indicated he did not score on brief interview for mental status. This MDS included his functional status for activities of daily living assistance indicating he required extensive assistance with two-person physical assist for bed mobility, transfer, locomotion on and off the unit, dressing, eating, toilet use, and personal hygiene. R#3 had not demonstrated walking in room or corridor. 03/10/20 at 1:49 p.m. FM#2 indicated facility was not assisting with potential transfer as needed. In addition, facility was only giving R#3, who requires 24 hour nursing care, 4 days to discharge from current facility or pay 175 dollars a day to continue residing at facilty. Interview on 03/11/20 at 1:19 p.m. family member (FM#1) indicated facility's Social Service staff (SS#1) informed her she had 1 weeks' notice to transfer R#3 to another home. FM#1 indicated another facility informed her information needed was not being shared to determine if R#3 could be accepted at facility. FM#1 indicated she was informed on Thursday to transfer RP#3, and on the following Thursday she took RP#3 home. FM#1 indicated she did not want to be charged family 175 dollars a day and she was getting ping ponging answers for moving R#3. FM#1 indicated she visited R#3 daily, and during that time she was not asked to sign any forms for discharge. FM#1 added that due to R#1's diagnosis, he could not have signed any forms. FM#1 requested APS Caseworker #1 should be contacted for additional information. Interview on 03/11/20 at 2:08 p.m. APS Caseworker (APS#1) indicated R#3 was given 4 days' notice to discharged from facility. R#3 was informed on 02/28/20 he had to move out, but then given a two-day extension until 03/03/20. FM#1 was informed she needed to pay facility for staying 2 - 3 days past the discharge date . APS#1 indicated FM#1 she got tired of facility's ping ponging answers for moving R#3 to another facility and her concern for paying facility, and that's why she took R#3 to their home. Interview on 03/10/20 at 2:12 p.m. with Ombudsman indicated she received a call from FM#2, who was upset, because facility was discharging R#3 from facility. Ombudsman added that she had not received an involuntary discharge specific to R#3. Interview on 03/11/20 at 1 p.m. DON#1 indicated R#3's discharge was handled by SS#1 due to R#3 being discharged for m skilled care services. Interview on 03/11/20 at 1:50 p.m. Social Service staff (SS#1) indicated on 02/26/20 R#3's family member (FM#2) was issued a notice of Medicare Noncoverage because R#3 had plateau and was not showing progress with therapy. SS#1 indicated R#3 was admitted to facility for skilled care on 01/29/20, and on 02/25/20 was discharged from therapy services, which means insurance would no longer pay for R#3 to stay at facility after 48 hours. SS#1 indicated once she was informed therapy has been discontinued, she informs the family and presents the following options: discharge with home health, discharge with hospice, discharge home with no care, or discharge transfer to a LTCF. SS#1 indicated representative (SPR #1) made a visit to facility to evaluate accepting R#3 into their facility. SS#1 added that she was unaware family had requested SPR#1 to evaluate for services. SS#1 indicated on 02/28/20 she informed FM#2 of the NOMNC form for discharged . SS#1 indicated she issued a discharge to R#3 on 02/28/20 but extended it to 03/02/20. The extension was made after FM#2 requested R#3 stay until Monday because SPR#1 could not make decision for admitting R#3 until Monday 03/02/20. FM#2 agreed to pay 175 dollars

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675925	A. BUILDING _____ B. WING _____	03/12/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
THE MILDRED & SHIRLEY L GARRISON GERIATRIC EDUCATI	3710 4TH ST LUBBOCK, TX 79415

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 0622 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 3) per day for the two extra days so R#3 could stay at facility. SS#1 indicated she was informed by SPR#1 that R#3 was denied by his insurance, and insurance representative indicated a peer-to-peer review had not been conducted as requested. SS#1 indicated a peer-to-peer review is usually conducted by resident's current physician because they are more familiar with the resident than the physician taking over care. Once review is conducted it is shared with the resident's insurance to determine if resident could be approved for services, and if approved, resident is eligible to transfer to next facility. SS#1 indicated she had contacted FNP#1 to conduct this peer-to-peer review so R#1 could transferred to next facility. Afterwards, SS#1 contacted Family Nurse Practioner (FNP#1) and asked her if she had completed peer-to-peer review, FNP#1 replied it had been done. SS#1 requested FNP#1 to conduct a second peer-to-peer review, because SPR#1 indicated she was informed by the R#3's insurance a peer-to-peer review had not been conducted. SS#1 denied receiving messages from FNP#1 that she was unable to reach the insurance company to follow up on conducting peer-to-peer review. SS#1 indicated she is the messenger between therapy and resident being discharged . SS#1 indicated 30-day discharge notice is issued by Administrator. In addition, SS#1 indicated a 30-day notice is issued to a resident for reasons other than therapy, such as emergency, negative behaviors, or wanting to relocate to a different home. SS#1 confirmed she informed R#1 and his family they had four days to discharge from facility. Interview on 03/11/20 at 3:13 p.m. SPR#1 indicated R#3's insurance denied him payment because they wanted to talk to someone that was familiar with him through peer-to-peer review. SPR#1 indicated she gave FNP#1 the insurance's phone number, so she could complete a peer-to-peer review to admit R#3 into her facility; however, insurance indicated this review had not been done. SPR#1 indicated she spoke with SS#1 and asked her to notify FNP#1 to complete peer-to-peer review; however, this was not done and that's why R#3 was denied possible admission to her facility. Interview on 03/11/20 at 3:23 p.m. facility's Therapy Director(TD#1) indicated R#3 was admitted to facility for low level therapy, and he met his goals but without changes. At this time, TD#1 indicated R#3 became custodial care, which the insurance will not cover; therefore, he would have to move to another facility to continue rehab. TD#1indicated she informed SS#1 that R#3 had been discharged from therapy, which meant he had 48 hours to discharge. TD#1indicated R#3 was given 5 days, until 03/02/30, instead of two days to discharge. Review of R#3's Progress Notes revealed the following: note dated 02/26/20 indicated Notice of Medicare Non-Coverage (NOMNC) form was issued 02/25/20 indicating discharge date was 02/29/20. Note dated 02/24/20 indicated facility's administration received a call from Ombudsman who had received information from FM#2 that R#3 was being discharged from facility due to issues with the family. Facility's administration clarified that the feedback from TD#1 was that 02/29/20 was already in the works and was a generalized timeframe of when R#3 would not require therapy hours any longer. It was suggested that FM#2 and FM#3 attend a care plan meeting to clarify everything. Afterwards, facility's administration explained therapy information to FM#2, who indicated she was expecting a 30-day discharge to which facility administration clarified it was not needed with this situation. Note dated 02/02/20 indicated a weekly skilled review was held for discharge plan and estimated LOS remaining was 1 week. Note dated 03/05/20 indicated FM#1 and FM#2 requested assistance from therapy in loading R#3 into vehicle before leaving facility. Review of R#3's NOMNC form indicated the effective date coverage of your current services will end 02/28/20 and included discharge date as 02/29/20. A second NOMNC indicated the effective date coverage of your current services will end 03/02/20 and included discharge date as 03/03/20. This form did not include signature of patient or authorized representative. Review of R#3's Skilled Nursing Facility Advance Beneficiary Notice of Non-coverage (SNFABN) indicated beginning 03/03/20, you may have to pay out of pocket for this care if you do not have other insurance that may cover theses costs. This form did not include signature of patient or authorized representative. Review of facility's policy/procedure dated for 11/2016 for Discharge Summary indicated a post-discharge plan of care will be developed with the participation of the resident, and with the resident's consent, the resident representatives, that will include assisting resident to adjust to his or her new living environment. This plan should include should include where the individual plans to reside, any arrangements that have been made for the resident's follow up care, and any post discharge medial and non-medical services. In addition, the resident, and/or his representative must sign a release indicating the information contained on the discharge summary can be provided to the receiving facility. Interview on 03/12/20 at 6:45 a.m. with Administrator indicated facility issues 30-day discharges to resident for reasons other than therapy, such as an emergency, negative behaviors, or wanting to relocate to a different home. And when a resident, who is at facility for skilled care, is discharged from therapy they have 48 hours from discharge before their funds run out.
F 0623 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to provide a written notice of transfer at least 30 days in advance of the discharge for one resident (R #13) of two residents reviewed for transfer/discharge, and failed to notify the Office of the State Long-Term Care Ombudsman of the transfer or discharge and the reasons for the move in writing and in a language and manner they understood for 1 of 2 residents (R#3) reviewed for Discharge Rights in that; The facility informed R#3's family members they had a few days, after R#3 was discharged from therapy services, to move out, not allowing 30-day advance notice. The Office of the State Long-Term Care Ombudsman was not notified in writing of the effective date of transfer or discharge for R#3, the reason for the resident's transfer/discharge, nor the location to which the resident would be transferred. This deficient practice could place residents who were transferred or discharged from the facility at risk of having their discharge rights violated. The findings were: Review of R#3's Admission Record indicated he was a [AGE] year-old male, who was admitted to facility on 01/09/20. This report included R#3's [DIAGNOSES REDACTED]. Review of R#3's Minimum Data Set ((MDS) dated [DATE] indicated he did not score on brief interview for mental status. This MDS included his functional status for activities of daily living assistance indicating he required extensive assistance with two-person physical assist for bed mobility, transfer, locomotion on and off the unit, dressing, eating, toilet use, and personal hygiene. R#3 had not demonstrated walking in room or corridor. 03/10/20 at 1:49 p.m. FM#2 indicated facility was not assisting with potential transfer as needed. In addition, facility was only giving R#3, who requires 24 hour nursing care, 4 days to discharge from current facility or pay 175 dollars a day to continue residing at facilty. Interview on 03/11/20 at 1:19 p.m. family member (FM#1) indicated facility's Social Service staff (SS#1) informed her she had 1 weeks' notice to transfer R#3 to another home. FM#1 indicated another facility informed her information needed was not being shared to determine if R#3 could be accepted at facility. FM#1 indicated she was informed on Thursday to transfer RP#3, and on the following Thursday she took RP#3 home. FM#1 indicated she did not want to be charged family 175 dollars a day and she was getting ping ponging answers for moving R#3. FM#1 indicated she visited R#3 daily, and during that time she was not asked to sign any forms for discharge. FM#1 added that due to R#1's diagnosis, he could not have signed any forms. FM#1 requested APS Caseworker #1 should be contacted for additional information. Interview on 03/11/20 at 2:08 p.m. APS Caseworker (APS#1) indicated R#3 was given 4 days' notice to discharged from facility. R#3 was informed on 02/28/20 he had to move out, but then given a two-day extension until 03/03/20. FM#1 was informed she needed to pay facility for staying 2 - 3 days past the discharge date . APS#1 indicated FM#1 she got tired of facility's ping ponging answers for moving R#3 to another facility and her concern for paying facility, and that's why she took R#3 to their home. Interview on 03/10/20 at 2:12 p.m. with Ombudsman indicated she received a call from FM#2, who was upset, because facility was discharging R#3 from facility. Ombudsman added that she had not received an involuntary discharge specific to R#3. Interview on 03/11/20 at 1 p.m. DON#1 indicated R#3's discharge was handled by SS#1 due to R#3 being discharged for m skilled care services. Interview on 03/11/20 at 1:50 p.m. Social Service staff (SS#1) indicated on 02/26/20 R#3's family member (FM#2) was issued a notice of Medicare Noncoverage because R#3 had plateau and was not showing progress with therapy. SS#1 indicated R#3 was admitted to facility for skilled care on 01/29/20, and on 02/25/20 was discharged from therapy services, which means insurance would no longer pay for R#3 to stay at facility after 48 hours. SS#1 indicated once she was informed therapy has been discontinued, she informs the family and presents the following options: discharge with home health, discharge with hospice, discharge home with no care, or discharge transfer to a LTCF. SS#1 indicated representative (SPR #1) made a visit to facility to evaluate accepting R#3 into their facility. SS#1 added that she was unaware family had requested SPR#1 to evaluate for services. SS#1 indicated on 02/28/20 she informed FM#2 of the NOMNC form for discharged . SS#1 indicated she issued a discharge to R#3 on 02/28/20 but extended it to 03/02/20. The extension was made after FM#2 requested R#3 stay until Monday because SPR#1 could not make decision for admitting R#3 until Monday 03/02/20. FM#2 agreed to pay 175 dollars per day for the two extra days so R#3 could stay at facility. SS#1 indicated she

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F 0623 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 4) was informed by SPR#1 that R#3 was denied by his insurance, and insurance representative indicated a peer-to-peer review had not been conducted as requested. SS#1 indicated a peer-to-peer review is usually conducted by resident's current physician because they are more familiar with the resident than the physician taking over care. Once review is conducted it is shared with the resident's insurance to determine if resident could be approved for services, and if approved, resident is eligible to transfer to next facility. SS#1 indicated she had contacted FNP#1 to conduct this peer-to-peer review so R#1 could transferred to next facility. Afterwards, SS#1 contacted Family Nurse Practioner (FNP#1) and asked her if she had completed peer-to-peer review, FNP#1 replied it had been done. SS#1 requested FNP#1 to conduct a second peer-to-peer review, because SPR#1 indicated she was informed by the R#3's insurance a peer-to-peer review had not been conducted. SS#1 denied receiving messages from FNP#1 that she was unable to reach the insurance company to follow up on conducting peer-to-peer review. SS#1 indicated she is the messenger between therapy and resident being discharged . SS#1 indicated 30-day discharge notice is issued by Administrator. In addition, SS#1 indicated a 30-day notice is issued to a resident for reasons other than therapy, such as emergency, negative behaviors, or wanting to relocate to a different home. SS#1 confirmed she informed R#1 and his family they had four days to discharge from facility. Interview on 03/11/20 at 3:13 p.m. SPR#1 indicated R#3's insurance denied him payment because they wanted to talk to someone that was familiar with him through peer-to-peer review. SPR#1 indicated she gave FNP#1 the insurance's phone number, so she could complete a peer-to-peer review to admit R#3 into her facility; however, insurance indicated this review had not been done. SPR#1 indicated she spoke with SS#1 and asked her to notify FNP#1 to complete peer-to-peer review; however, this was not done and that's why R#3 was denied possible admission to her facility. Interview on 03/11/20 at 3:23 p.m. facility's Therapy Director(TD#1) indicated R#3 was admitted to facility for low level therapy, and he met his goals but without changes. At this time, TD#1 indicated R#3 became custodial care, which the insurance will not cover; therefore, he would have to move to another facility to continue rehab. TD#1indicated she informed SS#1 that R#3 had been discharged from therapy, which meant he had 48 hours to discharge. TD#1indicated R#3 was given 5 days, until 03/02/30, instead of two days to discharge. Review of R#3's Progress Notes revealed the following: note dated 02/26/20 indicated Notice of Medicare Non-Coverage (NOMNC) form was issued 02/25/20 indicating discharge date was 02/29/20. Note dated 02/24/20 indicated facility's administration received a call from Ombudsman who had received information from FM#2 that R#3 was being discharged from facility due to issues with the family. Facility's administration clarified that the feedback from TD#1 was that 02/29/20 was already in the works and was a generalized timeframe of when R#3 would not require therapy hours any longer. It was suggested that FM#2 and FM#3 attend a care plan meeting to clarify everything. Afterwards, facility's administration explained therapy information to FM#2, who indicated she was expecting a 30-day discharge to which facility administration clarified it was not needed with this situation. Note dated 02/02/20 indicated a weekly skilled review was held for discharge plan and estimated LOS remaining was 1 week. Note dated 03/05/20 indicated FM#1 and FM#2 requested assistance from therapy in loading R#3 into vehicle before leaving facility. Review of R#3's NOMNC form indicated the effective date coverage of your current services will end 02/28/20 and included discharge date as 02/29/20. A second NOMNC indicated the effective date coverage of your current services will end 03/02/20 and included discharge date as 03/03/20. This form did not include signature of patient or authorized representative. Review of R#3's Skilled Nursing Facility Advance Beneficiary Notice of Non-coverage (SNFABN) indicated beginning 03/03/20, you may have to pay out of pocket for this care if you do not have other insurance that may cover theses costs. This form did not include signature of patient or authorized representative. Review of facility's policy/procedure dated for 11/2016 for Discharge Summary indicated a post-discharge plan of care will be developed with the participation of the resident, and with the resident's consent, the resident representatives, that will include assisting resident to adjust to his or her new living environment. This plan should include should include where the individual plans to reside, any arrangements that have been made for the resident's follow up care, and any post discharge medial and non-medical services. In addition, the resident, and/or his representative must sign a release indicating the information contained on the discharge summary can be provided to the receiving facility. Interview on 03/12/20 at 6:45 a.m. with Administrator indicated facility issues 30-day discharges to resident for reasons other than therapy, such as an emergency, negative behaviors, or wanting to relocate to a different home. And when a resident, who is at facility for skilled care, is discharged from therapy they have 48 hours from discharge before their funds run out.
F 0644 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to coordinate assessments with the pre-admission screening and resident review (PASRR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort by failing to incorporate the recommendations from the PASRR level II determination and the PASRR evaluation report into a resident's assessment, care planning, and transitions of care for 1 of 2 residents (R#1) reviewed for PASRR. The facility failed to submit a request for the customized manual wheelchair and occupational assessment therapy into the LTC Portal with 20 business days of the PASRR Comprehensive Service Plan (PCSP) meeting held on [DATE]. As of [DATE] this failure has prevented R#1 from obtaining customized manual wheelchair and OT services. In addition, R#1's order for a [MEDICAL CONDITION] sleep apnea machine had not been ordered. This deficient practice has the potential to affect residents by placing them at an increased and unnecessary risk of poor self-esteem and self-worth and poor quality of life. Finding include: Observation on [DATE] at 3:12 PM revealed R#1, who had swollen legs, was in a standard wheelchair that had foam taped to the footrest and legs of the footrest. Interview on [DATE] at 3:12 PM with R#1 recalled attending a care plan meeting (PASRR Comprehensive Service Plan (PCSP) on [DATE]) with PASSR Habilitation Coordinator (PASSR #1), Local Authority-Intellectual or Developmental Disability (LA-IDD #1), family member by phone (RP#1), and facility's staff, Director of Nurses/Registered Nurse (DON #1), Licensed Vocational Nurse/Minimum Data Set Coordinator (LVN/MDS Coordinator #1), Social Worker (SW #1), and Physical Therapist (PT#1). During this care plan meeting, R#1, was approved for a specialized wheelchair and OT services. R#1 indicated OT was to help her regain use of her muscles on her left leg, because of her [MEDICAL CONDITION]. Prior to this meeting, R#1 indicated she had received OT, which helped her regain use of her legs and allowed her to walk a short distance; however, she still must be assisted with showers and getting in and out of bed. In addition, R#1 requested OT so could work on her hand strength. R#1 indicated she has not received her specialized wheelchair and is currently using facility's wheelchair. R#1 indicated her legs and feet are not comfortable in this wheelchair, which has foam taped on the foot pedals and the legs of the foot pedals. R#1 indicated she met with the wheelchair specialist who fitted her for the appropriate specialized wheelchair, but she has not received her new wheelchair. In addition, R#1 indicated her sleep apnea machine was not working correctly because it's [AGE] years old and has an electrical shortage. Review of R#1's Admission Record indicated she was a [AGE] year-old female, whose original admitted was [DATE] and [DATE], and included RP#1 as her financial responsible party. This report included R#1's [DIAGNOSES REDACTED]. Review of Minimum Data Set ((MDS) dated [DATE] indicated she required extensive assistance with one-person physical assist for bed mobility, locomotion off-unit, and dressing; she required extensive assistance with two + person physical assist for transfer, and locomotion on-unit; she required total dependence with one-person physical assist for walking in room, and walking if corridor; she required supervision with setup only, and she was total dependence for bathing. This MDS included R#1's Brief Interview for Mental Status (BIMS) dated [DATE] revealed she scored a score a 15, indicating she was cognitively intact. Review of R#1's Care Plan with review start dated [DATE] indicated she was receiving PASRR services due to being PASRR [DIAGNOSES REDACTED]. The goal for PASRR services was for R#1 to adapt to nursing facility placement by next review. The PASRR interventions included IDT meeting to be completed as required; R#1 has refused all specialized services; notify local authoring of any significant changes, notify physician and responsible party of any changes, PASRR evaluation to be completed by local authority. This plan indicated R#1 focus area as impaired circulation to her right leg due to BLE [MEDICAL CONDITION]. The focus was for R#1 to be free from signs and symptoms of complications due to poor circulation through the review date. The intervention included elevating legs when resting, ensuring proper fitting footwear, inspecting feet for areas of rubbing or injury, and inspecting foot/ankle/calf skin for changes: maceration (white, wrinkly, moist), redness, purple tinge, blue, rust coloring, weeping, [MEDICAL CONDITION], puffiness, tenderness, and areas with no sensation. This plan included focus as sleep apnea/[MEDICAL CONDITION]. The goal was to maintain normal breathing pattern as evidenced by normal respirations, normal skin color, and regular respiratory

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NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
THE MILDRED & SHIRLEY L GARRISON GERIATRIC EDUCATI	**3710 4TH ST LUBBOCK, TX 79415**

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F 0644 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 5) rate/pattern through the review dated and will have no complications related to SOB through the review date. The interventions included elevate head of bed as tolerated, encourage sustained deep breaths by: using demonstration (emphasizing slow inhalation, holding end inspiration for a few seconds, and passive exhalation); using incentive spirometer (place close for convenient resident use); asking resident to yawn, etc. Interview on [DATE] at 1:42 PM with PASRR Habilitation Coordinator PASSR #1, indicated she attended R#1's PCSP meeting on [DATE], at which time the team agreed on recommendations to pursue a customized wheel chair and specialized assessment for occupational therapy. [DATE] PASSR #1 followed up on these recommendations and discovered recommendations had not been implemented, because the LTC Portal was not checked daily by MDS Coordinator to determined eligibility, as required. PASRR #1 indicated facility has 20 days from the time recommendations are made by the PSP to implement recommendations, specifically wheelchair and OT; however, this was not done. PASSR #1 added that if these recommendations had been pursued after [DATE] meeting, R#1 would have her wheelchair and OT, but as of [DATE] the wheelchair has not been purchased, because R#1's Medicaid had expired and needed to be renewed. PASRR #1 indicated at the [DATE] PSP meeting R#1's RP #1 relinquished her financial responsibility to facility. In addition, PASRR #1 indicated she questioned why R#1's OT services had been discontinued, and facility staff replied that it was due to R#1 declining services for two days. PASSR #1 indicated the facility is not allowed to discontinue services without going through the proper protocols. PASSR #1 indicated she was sent alerts from TMHP on [DATE] denying R#1's OT, and on [DATE] denying R#1's customized wheelchair, because these items were entered into the system 30 days after the IDT meetings. PASSR indicated Interview on [DATE] at 3:42 PM with RP#1 revealed R#1 should not have had her equipment and services delayed, because at the [DATE] PSP meeting she relinquished financial responsibility to the facility. However, 2 weeks ago, she received a call requesting she pursue renewing R#1's Medicaid, and she informed facility staff she had relinquished that right to facility at PSP meeting. On [DATE] at 11:02 AM, RP #1 sent facility bank statements on [DATE], as requested. Review of R#1's PASRR Comprehensive Service Plan (PSP) Forms revealed the following: PCSP dated [DATE] for LA Updated meeting indicated R#1 needed specialized assessment for OT. PCSP form dated [DATE] for LA Updated meeting indicated specialized assessment for OT was completed, and specialized OT was new (needed). PCSP dated [DATE] for Quarterly meeting indicated customized manual wheelchair was new (needed), and specialized assessment for OT was new (meaning a need for continuance). PCSP dated [DATE] for Quarterly meeting indicated customized manual wheelchair had been completed, specialized assessment for OT was ongoing, specialized OT was needed. PCSP dated [DATE] for LA Updated indicated customized manual wheelchair was pending, and specialized assessment for OT was pending. PCSP dated [DATE] R#1's customized manual wheelchair, specialized assessment occupational therapy, and specialized physical therapy were pending due to inactive Medicaid. Review of R#1's Client Contact reports revealed the following: On [DATE] LVN/MDS Coordinator #1 was informed alerts from TMHP on [DATE] indicated R#1's customized wheelchair was denied due to being entered into the system 30 days after the IDT met. On [DATE] LVN/MDS Coordinator #1 was informed she entered wrong information into SIMPLE under the NFSS tab for R#1's customized manual wheelchair, and once she entered the correct information it was approved. On [DATE] indicated R#1s [MEDICAL CONDITION] sleep apnea machine was not working correctly and causing her not to breath well. LVN/MDS Coordinator #1 indicated she was not aware of any new orders. This report indicated R#1 had been asking for help with new machine since [DATE], and had 1 of 2 sleep studies and there was an order for [REDACTED].#1 reported R#1's customized manual wheelchair could not be completed because her Medicaid was inactive. In addition, LVN/MDS Coordinator #1 indicated she had followed up on R#1's sleep apnea ([MEDICAL CONDITION]) machine; however, no one at the facility had information specific to this machine. Review of R#1's Telephone Encounter report dated [DATE] indicated to start [MEDICAL CONDITION] machine due to [DIAGNOSES REDACTED].#1's Telephone Encounter report dated [DATE] indicated a fax with physician's signed order for [MEDICAL CONDITION] supplies was sent to agency. Interview [DATE] at 2:19 PM LVN/MDS Coordinator #1 indicated their mistakes made in pursuing R#1's customized manual wheelchair and OT services, when signatures on reports were not obtained correctly and information was not entered correctly into the LTC portal system. In addition, this system was not checked daily as required to find if items were approved or denied.