STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676380	A. BUILDING _____ B. WING _____	**09/09/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
BIG SPRING CENTER FOR SKILLED CARE	**3701 WASSON RD BIG SPRING, TX 79720**

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 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** Interview and record review indicated the facility failed to permit the resident to remain in the facility and not transfer or discharge from the facility unless, the transfer or discharge was necessary for the resident's welfare and the resident's needs cannot be met in the facility for one (R #1) of two residents reviewed for discharge. The facility failed to provide sufficient evidence they could not meet R#1's needs or that R#1 was a danger to herself of others. R#1 was discharged after a resident to resident incident of aggression. This failure placed residents at risk of not getting the necessary care and services to meet their physical and psychological needs. Findings included: R#1's Admission Record indicated he was a [AGE] year-year-old male, who was admitted to facility on 09/09/19. This report indicated R#1's responsible party, next of kin, substitute decision maker, care conference person, and emergency contact were designated to Responsible Party (RP#1). This report included R#1's [DIAGNOSES REDACTED]. Record Review of R#1's annual Minimum (MDS) data set [DATE] indicated his Brief Interview for Mental Status score was a 9, revealing he was moderately impaired. This report indicated R#1 did not display behaviors that included physical, verbal, or other behaviors directed at others. And R#1 required extensive assistance with one-person physical assist for bed mobility, and transfer, and supervision with one-person physical assist for walking in his room and corridor, and locomotion on and off unit, etc. In addition, this report indicated R#1 did not use mobility devices (cane/crutch, walker, wheelchair, limb prosthesis). This MDS did not trigger behavioral symptoms that needed to be addressed in his care plan. Record Review of R#1's Care Plan dated 06/21/20 indicated R#1's care performance deficit included the following; he required 1 staff for setup/supervision assistance for bed mobility, dressing, eating, toilet use, transferring, and walking; he required using a walker at times, and encourage him to discuss feelings about self-care deficit. This plan addressed R#1's Alzheimer disease, and pain medication that could lead to him being aggressive. This plan did not indicate R#1 had behaviors of aggression that were addressed. Record review of R#1's Incident Report dated 08/19/20 included nursing description indicating R#2 was using R#1's cane to push R#1 into the hallway, as R#1 tried to kick and hit him with his cane but was unsuccessful. Charge Nurse #1 (CN #1) and Certified Nurse Aide #1 (CNA #1) separated the residents. R#1 reported that R#2 always ___ with me and won't leave me alone and messes with my A/C and messes with my curtains. Afterwards, R#1 requested to have another roommate. This report indicated intervention occurred when staff intervened with resident to resident, physician was notified of situation, who issued immediate discharge for R#1, and R#1 was moved to a different room. This report revealed R#1 did not sustain any injuries during this incident. Record review of Order Entry dated 08/19/20 indicated Medical Director (MD) ordered R#1 be immediately discharged home because he was an endangerment to residents. Record review of R#2's Admission Record indicated he was a [AGE] year-old male, who was admitted to facility on 05/23/20. This report included R#2's [DIAGNOSES REDACTED]. Record Review of R#2's quarterly Minimum (MDS) data set [DATE] indicated his Brief Interview for Mental Status score was a 6, revealing he was severely impaired. This report indicated R#2 did not display behaviors that included physical, verbal, or other behaviors directed at others. Review of R#2's Care Plan reviewed on 08/27/20 addressed his [DIAGNOSES REDACTED]. Record review of R#2's Incident Report dated 08/19/20 included nursing description indicating R#2 was trying to watch tv, when R#1 became aggressive verbally and abusive with his cane. R#2 added that this incident started when R#1 entered their room and accused him of being in his room and told him to leave because R#1 wanted to watch tv. This report indicated immediate action was taken to remove R#2 from the room and to assess him. The assessment revealed R#2 did not sustain any injuries during this incident. Record review of Social Service Note dated 08/19/20 at 2:05 pm indicated R#2 reported his roommate (R#1) had attached him with a cane and tried to hit him in the face/head but he blocked it with his arm. He reported he then grabbed the cane with both hands as the roommate attempted to hit him, and that's when he walked R#1 into the hallway from the room so staff could see what was happening. R#2 reported he did not sustain any injuries and he did not strike R#1 because he is elderly and did not want to hurt him. Interview on 09/11/20 at 7 pm with R#1's Responsible Party (RP-A) indicated R#1 had lived at facility approximately 1 year and in that year R#1 did not have an incident of aggression with another resident until 08/19/20. On this dated facility's charge nurse informed her R#1 was involved in a resident to resident incident of aggression with his roommate R#2. RP-A indicated for the past year R#1 did not have a roommate until 2 weeks before he was discharge. RP-A indicated if she had been informed R#1, who has [MEDICAL CONDITION], was going to have a roommate she would have talked him in attempt to assure him it would be ok. RP-A indicated on 08/19/20 she was informed by charge nurse through her husband that R#1 hit his roommate; therefore, he was issued a 30-day discharge. On 08/19/20 at 5:40 pm RP-A went to the facility to talk to R#1, when she was informed by SW-A that R#1 had 24 hours to leave facility and was handed a discharge letter dated 08/20/20. Afterwards, RP-A indicated she asked SW-A to assist her with referrals, so she could find R#1 a facility to move to and she agreed. RP-A indicated while at the facility on 08/19/20 she was informed by charge nurse (unknown name) that R#1's personal items were being packed in preparation for discharge. RP-A indicated ten minutes later R#1's packed boxes were placed outside of the facility's main entrance and R#1, who was in his wheelchair, was pushed outside of facility's main entrance. RP-A indicated she was not prepared to take R#1 home, because he has to wear briefs and he has Alzheimer. RP-A added that as of 09/11/20 she has been unable to find R#1 another facility that will admit him. Record review of CNA-A's Witness Statement dated 08/20/20 indicated she was at nurses' station when a resident informed her and the charge nurse that someone was fighting. That's when CNA-A witnessed both R#1 and R#2 were holding onto the cane as they exited their room into the hallway, and R#2 said please help his trying to hit me. R#1 tried to kick R#2, but that's when CNA-1 and LVN-A separated the residents. Interview on 09/09/20 at 1:09 pm with LVN-A indicated she was at the nurses' station when she witnessed R#1 hit his roommate, R#2, with his cane. This was the first incident of aggression between R#1 and R#2. Afterwards, LVN-A assessed R#2 and found no marks, he indicated he had no pain; nor did he report being afraid of R#1. LVN-A assessed R#1 and he had no injuries but did informed her he did not like having a roommate. R#1 was moved out later that day because he was an endangerment to other. LVN-A indicated R#1 did not apologized to R#2 nor did he try to hit anybody else. Interview on 09/09/20 at 11:15 am with LVN-B indicated R#1 was discharged he hit his roommate, R#2, with his cane. I though the discharge was inappropriate because she had not heard of any conflict between R#1 and R#2. LVN-B indicated R#2 is interview able and alert and had not complained to her that he was afraid of his R#1. As far as she knowns, R#1 and R#2, were roommates for approximately 2-3 weeks, and were getting along well. Interview on 09/09/20 at 12:43 pm with CNA-B indicated she was informed R#1 was discharged because he had hit R#2. CNA-B was surprised by this discharge because this was the first time she had heard of R#1 hitting his roommate, R#2. CNA-B indicated that to her knowledge neither resident was aggressive

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 0622 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) with each other or other residents. Interview on 09/09/20 at 2:04 pm with CNA-C indicated R#1 was discharged because he used his cane to hit his roommate, R#2. CNA-C indicated she was not working on this day when the altercation occurred between the two residents but was not aware of incidents of aggression between R#1 and R#2. Interview on 09/09/20 at 2:38 pm with CNA-D indicated R#1 had always been in a room by himself, then approximately 2 weeks ago R#2 became his roommate. CNA-D she was not aware of any problems between R#1 and R#2. CNA-D was coming onto her shift when she heard R#1 becoming became about the TV and that's when he hit R#2 with his cane. CNA-D indicated R#1 normally used a wheelchair instead of his cane. Later that day, CNA-D gathered R#1's belongings and gave it to his family, who left facility with R#1. CNA-D was informed by R#1 that he did not want to move from the facility and reported to her and the Social Worker he might as well die if he had to move. Interview on 09/09/04 at 4:07 pm with Social Worker (SW-A), indicated she was informed by Administrator and DON that R#1 had had 24 hours to discharge from the facility. LSW-A indicated she informed RP #1, while she was visiting R#1 that he had 24 hours to discharge. LSW-A indicated R #1's family complained daily that facility was not meeting his needs, which was discussed during the facility's morning meetings; however, R#1's incident of aggression was the deciding factor to discharge. Record review of the facility's letter, Notice of discharge date d 08/20/20, addressed to R#1's responsible party (RP-A) indicated This letter is written notification that R#1 will be immediately discharged for m facility. The discharged is based on the facility's inability to meet his care needs due to the aggressive and abusive behavior toward other residents. This type of behavior is unacceptable, and the facility can no longer meet his needs. In addition, this report indicted R#1 was being discharged into RP #1s care due to abusing another resident. Interview on 09/09/20 at 4:43 pm with the Agency Staff (AS-A) indicated she received an email dated 08/20/20 from the facility's Administrator indicating a letter of discharge was issued on 08/19/20 to RP-A on behalf of R#1. This email included an attachment revealing R#1 was being discharged immediately due to facility's inability to meet his care needs due to the aggressive and abusive behavior toward other residents. This report indicated he would be discharged to RP-A's care due to his abuse of another resident. In addition, the AS-A indicated she was not informed by facility that they were discharging R#1, but she was informed the day after he was discharged . Interview on 09/16/20 at 9:19 am with the facility's Medical Director (MD) indicated he was informed by facility R#1 was an immediate danger to other residents; therefore, he needed to be discharged immediately and that's when he signed the order to discharge. MD indicated to his knowledge there were no previous incidents of aggression involving R#1. MD indicted the facility should have requested a psychiatric evaluation after R#1 became aggressive towards a resident, because he has a [DIAGNOSES REDACTED]. Interview on 09/09/20 at 6:45 pm with Administrator indicated she had no additional information to confirmed R#1 had a history of [REDACTED]. Review of facility's policy and procedure for Resident's Rights dated 2003 included Except in an emergency cases, the resident is, next of kin, attending physician, guardian, or representative payee shall be consulted at least thirty days in advance of any resident transfer or discharge. And each resident is transferred or discharged on ly for medical reason, or for his/her welfare or that of other resident, or for the nonpayment for his/her stay. Review of facility's policy and procedure for Discharge of Transfer to another Facility (ADO3-1.0) not dated indicated The facility will permit each resident to remain in the facility, and not transfer or discharge the resident from the facility. In the following limited circumstances, this facility may initiate transfer or discharges: The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility. If the facility is unable to meet the needs of the resident, the documentation made by the resident's physician must include: The specific needs not met by the facility; the facility's efforts to meet those needs; and the specific services the receiving facility will provide to meet the needs of the resident which cannot be met at the current facility. The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident. The reason for discharge must be provided by a physician, not necessarily the attending physician.
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 interview and record review the facility failed to provide 30 day notice to responsible party and the Ombudsman before the resident was discharge for 1 of 2 Resident's (R#1) reviewed for Discharge Rights. 1. The facility failed to provide 30 day notice to Responsible Party and the Ombudsman before Resident R#1's was discharge from facility. This deficient practice could affect all residents who are transferred or discharged from the facility and could place them at risk of having their discharge rights violated. The findings included: R#1's Admission Record indicated he was a [AGE] year-year-old male, who was admitted to facility on 09/09/19. This report indicated R#1's responsible party, next of kin, substitute decision maker, care conference person, and emergency contact were designated to Responsible Party (RP#1). This report included R#1's [DIAGNOSES REDACTED]. Record Review of R#1's annual Minimum (MDS) data set [DATE] indicated his Brief Interview for Mental Status score was a 9, revealing he was moderately impaired. This report indicated R#1 did not display behaviors that included physical, verbal, or other behaviors directed at others. And R#1 required extensive assistance with one-person physical assist for bed mobility, and transfer, and supervision with one-person physical assist for walking in his room and corridor, and locomotion on and off unit, etc. In addition, this report indicated R#1 did not use mobility devices (cane/crutch, walker, wheelchair, limb prosthesis). This MDS did not trigger behavioral symptoms that needed to be addressed in his care plan. Record Review of R#1's Care Plan dated 06/21/20 indicated R#1's care performance deficit included the following; he required 1 staff for setup/supervision assistance for bed mobility, dressing, eating, toilet use, transferring, and walking; he required using a walker at times, and encourage him to discuss feelings about self-care deficit. This plan addressed R#1's Alzheimer disease, and pain medication that could lead to him being aggressive. This plan did not indicate R#1 had behaviors of aggression that were addressed. Record review of R#1's Incident Report dated 08/19/20 included nursing description indicating R#2 was using R#1's cane to push R#1 into the hallway, as R#1 tried to kick and hit him with his cane but was unsuccessful. Charge Nurse #1 (CN #1) and Certified Nurse Aide #1 (CNA #1) separated the residents. R#1 reported that R#2 always ___ with me and won't leave me alone and messes with my A/C and messes with my curtains. Afterwards, R#1 requested to have another roommate. This report indicated intervention occurred when staff intervened with resident to resident, physician was notified of situation, who issued immediate discharge for R#1, and R#1 was moved to a different room. This report revealed R#1 did not sustain any injuries during this incident. Record review of Order Entry dated 08/19/20 indicated Medical Director (MD) ordered R#1 be immediately discharged home because he was an endangerment to residents. Record review of R#2's Admission Record indicated he was a [AGE] year-old male, who was admitted to facility on 05/23/20. This report included R#2's [DIAGNOSES REDACTED]. Record Review of R#2's quarterly Minimum (MDS) data set [DATE] indicated his Brief Interview for Mental Status score was a 6, revealing he was severely impaired. This report indicated R#2 did not display behaviors that included physical, verbal, or other behaviors directed at others. Review of R#2's Care Plan reviewed on 08/27/20 addressed his [DIAGNOSES REDACTED]. Record review of R#2's Incident Report dated 08/19/20 included nursing description indicating R#2 was trying to watch tv, when R#1 became aggressive verbally and abusive with his cane. R#2 added that this incident started when R#1 entered their room and accused him of being in his room and told him to leave because R#1 wanted to watch tv. This report indicated immediate action was taken to remove R#2 from the room and to assess him. The assessment revealed R#2 did not sustain any injuries during this incident. Record review of Social Service Note dated 08/19/20 at 2:05 pm indicated R#2 reported his roommate (R#1) had attached him with a cane and tried to hit him in the face/head but he blocked it with his arm. He reported he then grabbed the cane with both hands as the roommate attempted to hit him, and that's when he walked R#1 into the hallway from the room so staff could see what was happening. R#2 reported he did not sustain any injuries and he did not strike R#1 because he is elderly and did not want to hurt him. Interview on 09/11/20 at 7 pm with R#1's Responsible Party (RP-A) indicated R#1 had lived at facility approximately 1 year and in that year R#1 did not have an incident of aggression with another resident until 08/19/20. On this dated facility's charge nurse informed her R#1 was involved in a resident to resident incident of aggression with his roommate R#2. RP-A indicated for the past year R#1 did not have a roommate until 2 weeks before he was discharge. RP-A indicated if she had been informed R#1, who has Alzheimer, was going to have a roommate she would have talked him in attempt to assure him it would be ok. RP-A indicated on 08/19/20 she was informed by charge nurse through her husband that R#1 hit his roommate; therefore, he was issued a 30-day discharge. On 08/19/20 at 5:40 pm RP-A went to the facility to talk to R#1, when she was informed by SW-A that R#1 had 24 hours to leave facility and was handed a discharge letter dated 08/20/20. Afterwards, RP-A indicated she asked SW-A to assist her with referrals, so she could find R#1 a facility to move

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MD indicated to his knowledge there were no previous incidents of aggression involving R#1. MD indicted the facility should have requested a psychiatric evaluation after R#1 became aggressive towards a resident, because he has a [DIAGNOSES REDACTED]. Interview on 09/09/20 at 6:45 pm with Administrator indicated she had no additional information to confirmed R#1 had a history of [REDACTED]. Review of facility's policy and procedure for Resident's Rights dated 2003 included Except in an emergency cases, the resident is, next of kin, attending physician, guardian, or representative payee shall be consulted at least thirty days in advance of any resident transfer or discharge. And each resident is transferred or discharged on ly for medical reason, or for his/her welfare or that of other resident, or for the nonpayment for his/her stay. Notification of Discharge: Which are facility-initiated transfer or discharge of a resident, the facility will notify the resident and the resident's representative of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. Additionally, the facility will send a copy of the notice of transfer or discharge to the representative of the Office of the state Long-Term Care Ombudsman. Emergency Transfer: When a resident is temporarily transferred on an emergency basis to an acute care facility, this type of transfer is considered to be a facility-initiated transfer and a notice of transfer will be provided to the resident and resident representative as soon as practicable.