MARYLAND
Health Care
Commission

Randolph S. Sergent, Esq, Chairman
Ben Steffen, Executive Director

Updated: February 2025

APPLICATION FOR NURSING HOME ACQUISITION

Before acquiring a nursing home, a person must obtain approval from the Maryland Health Care Commission in accordance with Health-General § 19-120.2, COMAR 10.24.01.21 and COMAR 10.24.20.06 unless the acquisition only involves changes of ownership among existing owners of the nursing home.

An acquisition means any transfer of stock or assets that results in a change of the person or persons who control a health care facility; or the transfer of any stock or ownership interest in excess of 25 percent.

The definition of "acquisition" includes:

1. Transfers of stock or assets of the owner of the real property and improvements, bed rights[1], or operation of the nursing home or any combination thereof.
2. An affiliation agreement between non-profit entities that change the person who controls a nursing homes operation or assets; and
3. A lease agreement that changes the person who controls the nursing homes operation.

The application pages must be consecutively numbered at the bottom of each page. Exhibits attached to subsequent correspondence during the review process shall use a consecutive numbering scheme, continuing the sequencing from the original application.

SUBMISSION FORMATS:

This application, attachments or exhibits and the applicant's responses to any follow up questions shall be submitted to mhcc.confilings@maryland.gov in both searchable PDF and WORD at least sixty (60) days prior to the desired closing date. Also 60 days before the closing date, a notice of the acquisition must be provided to the facility staff and residents.

Note that an affirmation regarding the accuracy of the information provided must be signed by an authorized individual.

[1] **"Bed rights" means the legal rights associated with the Commission's approval of nursing home beds, including the right to sell the beds to another person, but does not include approvals required by other State or federal entities**

PART I – GENERAL INFORMATION FACILITY INFORMATION

1. Facility Name and Address:	Laurelwood Healthcare Center 100 Laurel Drive Elkton, MD 21921
Tax ID:	[redacted]
Medicare / Medicaid Certification #:	Medicare – 215111 Medicaid – 424086300
Applicant:	Laurelwood Nursing and Rehab Center, LLC

Please provide a narrative summarizing the proposed acquisition:

Laurelwood Nursing and Rehab Center LLC will acquire the assets of the current operator Laurel Leasing Co., LLC.

Laurelwood Nursing and Rehab Center LLC will acquire the bed rights for 110 beds from CSE Elkton LLC.

100 Laurel Drive LLC will acquire the real estate from CSE Elkton LLC.

There will be a lease between Laurelwood Nursing and Rehab Center LLC and 100 Laurel Drive LLC.

2. OWNERSHIP

Identify each person with a 5% or more ownership interest[2] in the acquiring entity or a related or affiliated entity[3]; the percentage of ownership interest of each such person; and the history of each such person's experience in ownership or operation of health care facilities. This information should be included in Attachment A.

Attach a chart that completely delineates the ownership structure, including the relationship between the owners of:

- **A. The real property and improvements;**
- **B. Bed rights; and**
- **C. Operator**

Please see page 18 for charts delineating the ownership structure, including the listed owner relationships.

Ownership: current and post-transaction

The name and address of the owner of the real property and improvements.[4]

Current:	**Post-transaction:**
CSE Elkton LLC 10123 Alliance Road Blue Ash, OH 45242	100 Laurel Drive LLC [redacted]

The name and address of the owner of the bed rights (i.e., the person/entity that could sell the beds to a third party).

Current:	**Post-transaction:**
CSE Elkton LLC 10123 Alliance Road Blue Ash, OH 45242	Laurelwood Nursing and Rehab Center LLC 100 Laurel Drive Elkton, MD 21921

The name and address of the operator of the facility.

Current:	**Post-transaction:**
Laurel Leasing Co., LLC 10123 Alliance Road Blue Ash, OH 45242	Laurelwood Nursing and Rehab Center LLC 100 Laurel Drive Elkton, MD 21921

[2] "Ownership interest" means an owner, former owner, member of senior management or management organization, or current or former owner or senior manager of any related or affiliated entity during the past three years.

[3] "Related or affiliated entity" means any parent or subsidiary, or affiliate and includes any business, corporation, partnership, limited liability company or other entity.

[4] If the transaction involves only changes to the real property ownership and the owner of the real property will not exercise any ownership or control in the operations of the facility, the acquiring entity may request an exemption from the acquisition approval process by completing FORM plus AFFIDAVIT.

3. ADDITIONAL INFORMATION ABOUT THE ACQUIRING ENTITY

Is the entity acquiring the nursing home a private equity company?[5]

No, the acquiring entity is not a private equity company.

Identify any persons not identified above that does or will do any of the following:

(1)

(i) Exercise operational, financial, or managerial control over the facility or a part thereof;
Eugene Amanahu will be the facility administrator.

(ii) Provides policies or procedures for any of the operations of the facility; or
The administrative services company, Hallmark Health Consulting Services, will provide all policies and procedures for operation of the facility.

(iii) Provides financial or cash management services to the facility
All financial management for the facility will be provided by Apex Global Solutions, LLC.

(2)

(i) Leases or subleases real property to the facility; or
100 Laurel Drive LLC is the only entity that will lease the real property to the facility.

(ii) Owns a whole or part interest equal to or exceeding 5 percent of the total value of such real property.
100 Laurel Drive LLC is the only entity that will own an interest equal to or exceeding 5 percent of the total value of such real property.

(3) Provides:

(i) Management or administrative services;
Hallmark Health Consulting Services will provide administrative services.

(ii) Management of clinical consulting services; or
Narender Bharaj will be the medical director.

(iii) Accounting or financial services to the facility.
All financial management for the facility will be provided by Apex Global Solutions, LLC. Judy Chaves will prepare cost reports.

[5] **Private equity company (for Medicare purposes): A publicly traded or non-publicly traded company that collects capital investments from individuals or entities (like investors) and purchases a direct or indirect ownership share of a provider. CMS Form 855-A.**

4. BEDS BY JURISDICTION AND REGION

Number and percentage of nursing home beds in the jurisdiction and health planning region (HPR) controlled by the acquiring entity (or by an entity in which a person in the ownership structure of the acquiring entity has an interest, specifying each person, facility, and interest) before and after the proposed acquisition.

Jurisdiction Before: 0	**Jurisdiction After:** 121 beds, 20.6%
HPR Before: 0	**HPR After:** 247 beds, 8%

5. FINANCIAL CAPACITY

Submit documentation that demonstrates the acquiring entity's ability to operate the newly acquired facility for 90 days. Include either audited financial statements or a letter from a certified CPA demonstrating working capital.

Please see **Attachment E** for a letter from Benjamin Berger, CPA, demonstrating that the applicant has sufficient resources to operate the facility for 90 days. The available funds will cover operations and facility improvements.

6. NOTICE TO RESIDENTS, RESIDENT REPRESENTATIVES AND EMPLOYEES

Provide a copy of the notice that has or will be provided to residents, resident representatives, and employees of the nursing home to be acquired. Specify the manner in which and date the notice has been provided.

Please see below for a copy of the notice that will be provided to residents, resident representatives, and employees of Laurelwood Healthcare Center. The notices will be posted in prominent locations throughout the facility, hand delivered to residents and mailed to resident representatives by December 3, 2025. The applicant will provide an update to MHCC via email once the notices have been distributed.

PART II – TRANSACTION INFORMATION

7. **Anticipated date of closing or transfer:**
   The anticipated date of transfer is February 1, 2026.

8. **Purchase price:**
   The purchase price is $22,504,020.

9. **Source of funds:**
   The Applicant proposes to fund the acquisition using cash reserves. A letter confirming the availability of adequate funds is included in **Attachment E.**

10. **Will the acquiring entity be taking automatic assignment of the existing Medicare provider number?**
    Yes, Laurelwood Nursing and Rehab Center, LLC will take automatic assignment of the existing Medicare provider number for the proposed facility.

PART III– FACILITY INFORMATION

11. Describe the health care services provided by the facility:

The facility provides licensed Comprehensive Care Facility services.

12. Bed capacity:

The licensed bed capacity of the facility is 110 beds.

13. Number of admissions for the prior calendar year:

The number of admissions for the prior calendar year was 177 admissions.

14. Gross operating revenue generated during the last fiscal year:

The facility generated a gross operating revenue of $12,280,476 during the last fiscal year.

15. Detail any management contracts at the facility:

Hallmark Health Consulting Services will provide administrative services.

PART IV-CONSISTENCY WITH ACQUISITION APPROVAL STANDARDS AT COMAR 10.24.20.06(B)

INSTRUCTION: Each applicant must respond to all standards included in COMAR 10.24.20.06 listed below.

Please provide a direct, concise response explaining the project's consistency with each standard. In cases where demonstrating compliance with a standard requires the provision of specific documentation, please include the documentation as a part of the application.

10.24.20.06 SHP Nursing Homes Services: Acquisitions of Nursing Homes

A person seeking to acquire a nursing home shall meet the following acquisition approval standards.

(1) Quality.

An applicant shall meet the quality standard outlined in Regulation COMAR 10.24.20.05(A)(8): The applicant shall demonstrate that it will provide high quality of care, as determined by an assessment of the following information requested in(a)-(g). Please complete Attachment B and provide any additional narrative response required.

(a) An applicant shall report on its overall CMS Five Star Rating for all the nursing homes owned or operated by the applicant or a related or affiliated entity for three years or more, for the five quarterly refreshes for which CMS data is reported preceding the date of the applicant's letter of intent submission, or submission date for other Commission approval.

(i) If the applicant or a related or affiliated entity owns or operates one or more nursing homes in Maryland, the CMS star ratings for Maryland facilities shall be used.

(ii) If the applicant or a related or affiliated entity does not own or operate nursing homes in Maryland, the applicant shall select the state or states in which it owns the most facilities and the CMS star ratings for such facilities shall be used.

The Applicant, Laurelwood Nursing and Rehab Center, LLC, does not own any other nursing homes in Maryland. Jack Shelby, the trustee, owns 9 facilities in Texas. CMS Five Star Ratings for each of these facilities is included in **Attachment B**.

(b) If any facilities identified under paragraph (a) has an average star rating below 3 stars, the applicant shall provide a detailed quality rating analysis demonstrating good cause for not meeting the CMS star rating threshold and that the applicant is likely to provide adequate quality of care in the nursing home subject to the request.

Of the 9 Texas facilities listed under paragraph (a) that are owned by the trustee, Jack Shelby, 6 have an average star rating above three stars. An additional facility has an average rating below three stars but shows improvement, with the most recent three quarters meeting the 3 star standard, indicating an upward trend in quality. Overall, the average CMS star rating across all Texas facilities owned by the trustee is 3.73—considerably higher than the current average rating of 1.8 for Laurelwood Healthcare Center.

Laurelwood Healthcare Center Average CMS Star Rating

Facility	Q1 Sept. 2024	Q2 Nov. 2024	Q3 Mar. 2025	Q4 June 2025	Q5 Sept. 2025	5 Quarter Avg.
Laurelwood Healthcare Center	3	2	2	1	1	**1.8**

Among the Texas facilities, three currently fall below the three-star average rating threshold: Palo Pinto Nursing Center (1.6), Whitehall Rehab & Nursing (2.2), and Park View Care Center (2.4). Each has identified the underlying causes of its lower rating and implemented corrective measures to ensure continued improvement and adequate quality of care.

At Palo Pinto Nursing Center, the low rating stemmed from a lack of qualified staff, oversight, and survey management. The facility has launched a comprehensive improvement effort that includes weekly quality measure meetings, weekly on-site monitoring and staff training, and ongoing leadership oversight to support sustained progress and adequate quality of care. **Attachment D** includes the Performance Improvement Project (PIP) worksheet outlining these improvement initiatives in detail.

Whitehall Rehab & Nursing's rating reflected earlier lapses in clinical oversight and care coordination that affected resident outcomes. In response, the facility has implemented a detailed improvement plan emphasizing fall prevention, timely wound care, medication review, and staffing stability through active oversight and recruitment. These measures are intended to drive consistent improvement and ensure adequate quality of care. **Attachment D** includes the PIP charter and report detailing these efforts.

The low star rating at Park View Care Center was due to the lack of established systems, limited oversight, and deferred capital improvements under prior management. Since then, leadership has carried out extensive corrective actions, including replacing much of the staff and key department heads, implementing consistent training and monitoring processes, and completing critical facility upgrades to ensure regulatory compliance. The regional team continues to provide regular on-site support and oversight to maintain stable operations and ensure adequate quality of care in the nursing home. **Attachment D** includes details on Park View's corrective actions and ongoing performance improvements.

(c) The applicant shall address whether any nursing home currently or previously owned by the applicant or a related or affiliated entity, within or outside the State, for the period of 3 years immediately preceding the submission of the letter of intent or request for other Commission approval was the subject of an enforcement action, a special focus facility designation, or a deficiency involving serious or immediate threat, actual harm, or immediate jeopardy to a resident. The applicant shall describe what measurable efforts it has taken to address the deficiencies.

Four facilities owned by the trustee, Jack Shelby, were the subject of an enforcement action, a special focus facility designation, or a deficiency involving serious or immediate threat, actual harm, or immediate jeopardy to a resident. **Attachment C** identifies each facility, the deficiencies, and the corrective actions taken to address them.

No facilities owned by the grantors of the trusts were the subject of an enforcement action, a special focus facility designation, or a deficiency involving serious or immediate threat, actual harm, or immediate jeopardy to a resident.

Affiliates of Jack Shelby own 83 additional facilities in which the trustee holds no ownership or control. Of these, 55 facilities were the subject of an enforcement action, a special focus facility designation, or a deficiency involving serious or immediate threat, actual harm, or immediate jeopardy to a resident. **Attachment C** identifies these facilities, their deficiencies, and actions taken to address them.

(d) The applicant shall address whether any nursing home currently or previously owned by the applicant or a related or affiliated entity, within or outside the State, for the period of 3 years immediately preceding the submission of the letter of intent or request for other Commission approval was the subject of a lawsuit judgment or an arbitration finding, following a complaint filed by a resident, resident representative, or a government agency. The applicant shall provide an explanation of the circumstances surrounding the judgment or finding and subsequent actions taken.

No facilities owned by the trustee, Jack Shelby, or by the grantors of the trusts have been the subject of a lawsuit judgment or an arbitration finding, following a complaint filed by a resident, resident representative, or a government agency.

Based on publicly available information, only one of the 83 additional facilities owned by Jack Shelby's affiliated entities was the subject of a lawsuit judgment following a resident complaint: Landmark of Plano Rehabilitation and Nursing Center. Court records indicate that a default judgment was entered on May 28, 2025, after the defendants failed to respond to the complaint. The trustee holds no ownership interest in, nor operational involvement with, that facility and therefore is not in a position to provide further information regarding any subsequent actions taken.

The applicant is not aware of any other lawsuit judgments or arbitration findings involving facilities owned by trustee or affiliated entities.

(e) An applicant shall demonstrate appropriate infection prevention and control by providing the percent of residents receiving COVID, flu and pneumonia vaccinations, and the percent of staff receiving COVID, flu and pneumonia vaccinations at the nursing homes identified under (a).

Attachment B includes the percentage of residents and staff receiving COVID, flu, and pneumonia vaccinations at each of the facilities listed under paragraph (a).

(f) If the applicant or a related or affiliated entity owns or operates or previously owned Maryland nursing homes, it shall report its rating of overall care and percent satisfied for the most recent three years on the MHCC Family Experience of Care Survey, reporting on any trends in the results. If the facility's average rating of overall care is below 7.0, the applicant shall document efforts to improve the facility's rating. If the facility's average percent satisfied overall rating is below 70 percent, the applicant shall document efforts to improve the facility's rating.

This question is not applicable. Neither the applicant nor any affiliated entity of the trustee owns or operates Maryland nursing homes; therefore, there is no MHCC rating to report.

(g) Quality Assurance.

(i) An applicant shall demonstrate that it has an effective quality assurance program in each nursing home facility that is owned or operated by the applicant or a related or affiliated entity for the period of 3 years immediately preceding the submission of the request for other Commission approval

(ii) An applicant that has never owned or operated a nursing home shall provide documentation that demonstrates a thorough understanding of assessing quality assurance in a long-term care facility or related facility/program. Include any documentation of a prior assessment that reviewed quality metrics, a review of operations, and regulatory compliance and include any subsequent follow up in the form of actions taken, results, or improvement plans

After acquisition of this facility the applicant will enter an administrative services agreement with Hallmark Health Consulting Services. They will oversee the implementation of all quality policies at this facility. Hallmark Health Consulting Services has not previously managed or owned any other Nursing Home facility. For that reason, they will be utilizing the same quality policies of Health Consulting Services, a similar entity, so that the applicant will have the same type of agreement with at facilities to be acquired congruent with this one. **Attachment F** includes sample policies and procedures for quality programs at facilities owned or managed by Health Consulting Services. A similar program will be implemented at Laurelwood Nursing and Rehab Center.

(2) Multi-bedded Rooms.

If the nursing home to be acquired contains any resident rooms with more than two beds, submit a detailed plan outlining how the applicant intends to eliminate the resident rooms containing more than two beds within 3 years of the acquisition approval.

This question is not applicable. The facility does not contain any resident rooms with more than two beds; therefore, no corrective action or plan is necessary.

(3) Medicaid Participation.

Except for nursing home beds contained in a continuing care requirement community exempt from CON regulation under § 19-114(d)(2)(ii) of the Health-General Article, an applicant for acquisition approval shall agree to serve and maintain a proportion of Medicaid days at the acquired facility that is at least equal to the proportion of Medicaid days in all other nursing homes in the jurisdiction or region, whichever is lower, calculated in accordance with COMAR 10.24.20.05A(2)(b).
The link to this information is: https://mhcc.maryland.gov/mhcc/pages/hcfs/hcfs_ltc/hcfs_ltc.aspx

Laurelwood Healthcare Center currently maintains a Medicaid percentage rate of **77.0 percent**. Located in Cecil County, its Medicaid day threshold is 49.8 percent. The Applicant agrees to serve at least 49.8 percent once the acquisition is complete.

(4) Public Interest.[6]

An applicant shall demonstrate the proposed acquisition is in the public interest and will benefit residents, employees and the community.

Overview

This acquisition is profoundly in the public's best interest and will benefit residents, employees, and the community it serves because it represents a necessary upgrade and overhaul of a vital community healthcare asset. The Applicant aims to prevent quality deterioration, as recently (September 2025) this facility has maintained a very concerning CMS 5-Star rating of 1.0. Additionally, the Applicant intends to ensure the long-term, high-quality availability of this asset's service, which currently operates at 79.9% occupancy. The following sections detail how the Applicant will ensure upgrades to this service to better serve the residents, employees, and community.

Competition

The Applicant does not expect this project to affect the volume of service provided by other existing nursing homes in the jurisdiction of Cecil County. Additionally, this acquisition does not increase the total number of licensed beds in the jurisdiction as reported by the MHCC.

[6] **"Public interest" means the interests of the public in protecting competitive and accessible health care markets for prices, quality, choice, accessibility, and availability of all health care services for local communities, regions, or the State as a whole.**

Upon successful acquisition, the Applicant plans to make necessary renovations and additions to the facility. These changes include enhanced amenities aimed at providing higher quality, accessible care in comparison to what was previously offered. The changes made to the acquired facility do not intend to harm viable competitors or destabilize the existing healthcare market but look to attract new residents to fill existing vacancies within the acquired facility, that could not be accommodated at competing well-occupied homes.

Health Equity

According to Claritas Spotlight Pop-Facts by Age Race Sex, Cecil County population is racially and ethnically diverse.

Table 1: Cecil County Population Demographics, 2025

Demographic	% of Total Cecil County Population
American Indian/Alaskan Native Alone	0.34%
Asian Alone	1.25%
Black/African American Alone	9.28%
Native Hawaiian/Pac. Islander Alone	0.03%
Some Other Race Alone	2.33%
Two or More Races Alone	7.86%
White Alone	78.92%
Hispanic/Latino	6.31%

Source: Claritas Spotlight Pop-Facts by Age Race Sex, Accessed October 2025

The current residents of this facility represent this diversity, and once acquired by the Applicant, the residents will continue to reflect the diversity of the jurisdiction.

The Applicant aims to provide the highest level of care for all people, where everyone has a fair and just opportunity to attain their optimal health regardless of race, ethnicity, disability, sexual orientation, gender identity, socioeconomic status, geography, preferred language, and other factors that affect access to care and health outcomes.

Quality of Care

After this acquisition, the applicant will enter an administrative services agreement with Hallmark Health Consulting Services, a corporate entity that will oversee all quality policies. Once acquired, this facility will follow the standards and quality policies of Hallmark Health Consulting Services. Hallmark Health Consulting Services has not previously managed or owned any other Nursing Home facility. For that reason, they will be utilizing the same quality policies of Health Consulting Services. Please see Attachment F for a set of quality policies from existing nursing homes owned or managed by Health Consulting Services.

Employee Benefit and Stability

Through this acquisition, this facility will receive a more stable, supportive, and rewarding work environment for all employees, ensuring the retention of high-quality staff crucial for resident care. The Applicant intends to retain 100% of non-management, frontline staff. Retention of these crucial high-quality staff are necessary to maintain the employee-resident relationship. This relationship is an integral, non-quantifiable asset that directly translates into better resident outcomes and a more stable higher-performing facility. The depth and breadth of resident knowledge held by these essential caregivers allows for highly personalized and proactive care that a new employee would take months to acquire.

Additionally, continuous professional development and specialized training programs will be offered and encouraged for both new and established employees in order to continually foster growth in their position while uplifting and educating new employees.

Community Engagement and Resident Cultural Needs

The Applicant understands the importance of effective community engagement and ensuring the well-being of the communities we serve. The Applicant will continue to maintain the level of community engagement that these facilities already participate in. This can include needs assessments to identify specific health care needs and challenges faced by the target population, as well as collaboration with local organizations, community leaders, and local hospitals to gain insight into the needs and preferences of the community.

ATTACHMENTS:

AFFIRMATION:

The undersigned is the owner(s), or Board-designated official of the proposed or existing facility.

If the owner(s), or Board-designated official of the proposed or existing facility. is unable to sign, one or more persons shall be officially authorized in writing to sign for and act for the owner(s), or Board-designated official of the proposed or existing facility for the project which is the subject of this application. Copies of this authorization shall be attached to the application.

I hereby declare and affirm under the penalties of perjury that:

1. The services at the acquired facility will not change as a result of this acquisition;
2. Within the last ten years:[7]

   (a) No current or former owner or senior manager of the facility, of the operator, of the management organization, if any, or of any related or affiliated entity:

   (i) Has been convicted of a felony or pleaded guilty, nolo contendere, entered a best interest plea of guilty, or received a diversionary disposition regarding a felony; or

   (ii) Has received a determination of exclusion from participation in Medicare or State health care programs, with respect to a criminal conviction or civil finding of Medicare or Medicaid fraud or abuse; and

   (b) Neither the facility, the operator, the management organization, if any, nor a current or former related or affiliated entity:

   (i) Has been convicted of a felony or pleaded guilty, nolo contendere, entered a best interest plea of guilty, or received a diversionary disposition regarding a felony;

   (ii) Has received a determination of exclusion from participation in Medicare or State health care programs, with respect to a criminal conviction or civil finding of Medicare or Medicaid fraud or abuse; or

   (iii) Has paid fines or penalties in excess of $10,000,000 with or without an admission or finding of guilt with respect to any criminal or civil charges relating to Medicare or Medicaid fraud or abuse;
3. The facts stated in this application and its attachments are true and correct to the best of my knowledge, information, and belief.
4. The acquiring entity agrees to serve and maintain a proportion of Medicaid days at the acquired facility that is at least equal to the proportion of Medicaid days in all other nursing homes in the jurisdiction or region, whichever is lower.

[7] If the applicant is unable to satisfy this affirmation, the applicant may show evidence as to why this rule should not be applied if all of the individuals involved in the fraud or abuse are no longer associated with the entity (or any of the related or affiliated entities) and each entity has fully complied with each applicable plan of correction and, if applicable, with each condition of the imposition of a civil penalty or agreed disposition.

Date: Nov 12, 2025

Signature: Jack Shelby (Nov 12, 2025 20:19:39 EST)

Name & Title: Jack Shelby, Authorized Official

Company: Laurelwood Nursing and Rehab Center, LLC

Address: 100 Laurel Drive, Elkton, MD 21921

Phone: [redacted]

Email: [redacted]

Signature Pages Precision Acquisition

Final Audit Report 2025-11-13

Created:	2025-11-12
By:	Kelly Ivey (kivey@pda-inc.net)
Status:	Signed
Transaction ID:	CBJCHBCAABAAMD_CL09tyASKgAs4JLKoZzpaTGhUGOWt

"Signature Pages Precision Acquisition" History

Document created by Kelly Ivey (kivey@pda-inc.net)
2025-11-12 - 9:56:48 PM GMT

Document emailed to Jack Shelby [redacted] for signature
2025-11-12 - 9:56:53 PM GMT

Email viewed by Jack Shelby [redacted]
2025-11-13 - 1:13:51 AM GMT

Document e-signed by Jack Shelby [redacted]
Signature Date: 2025-11-13 - 1:19:39 AM GMT - Time Source: server

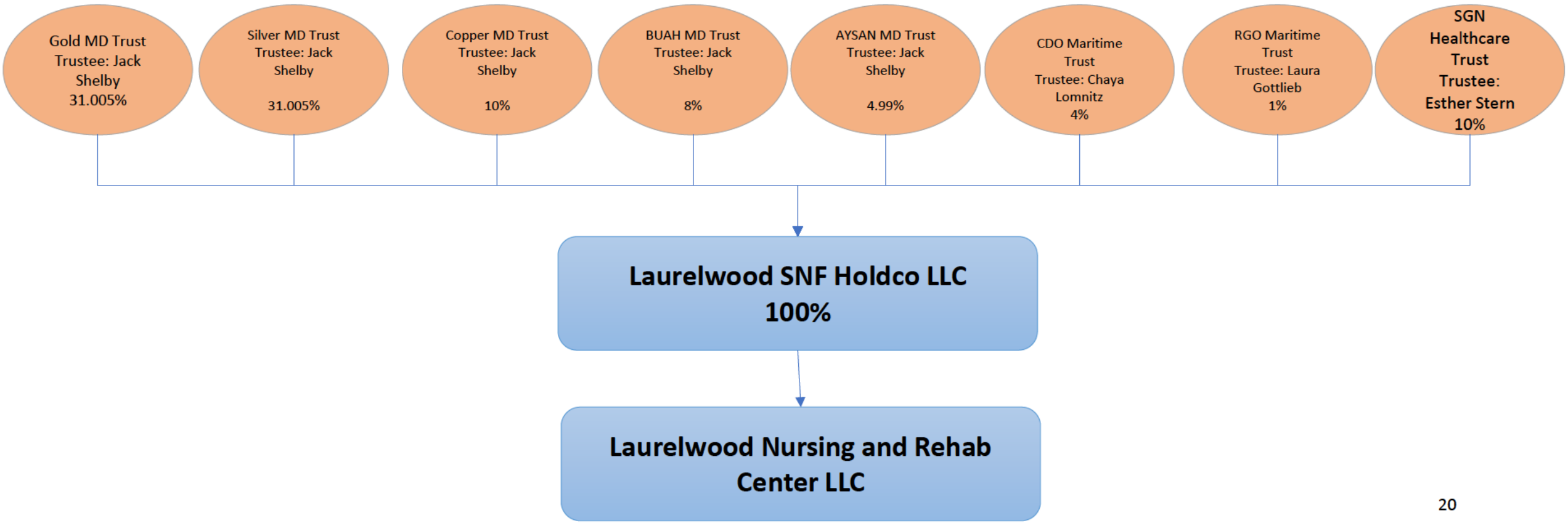
Agreement completed.
2025-11-13 - 1:19:39 AM GMT

OWNERSHIP ORGANIZATION CHART

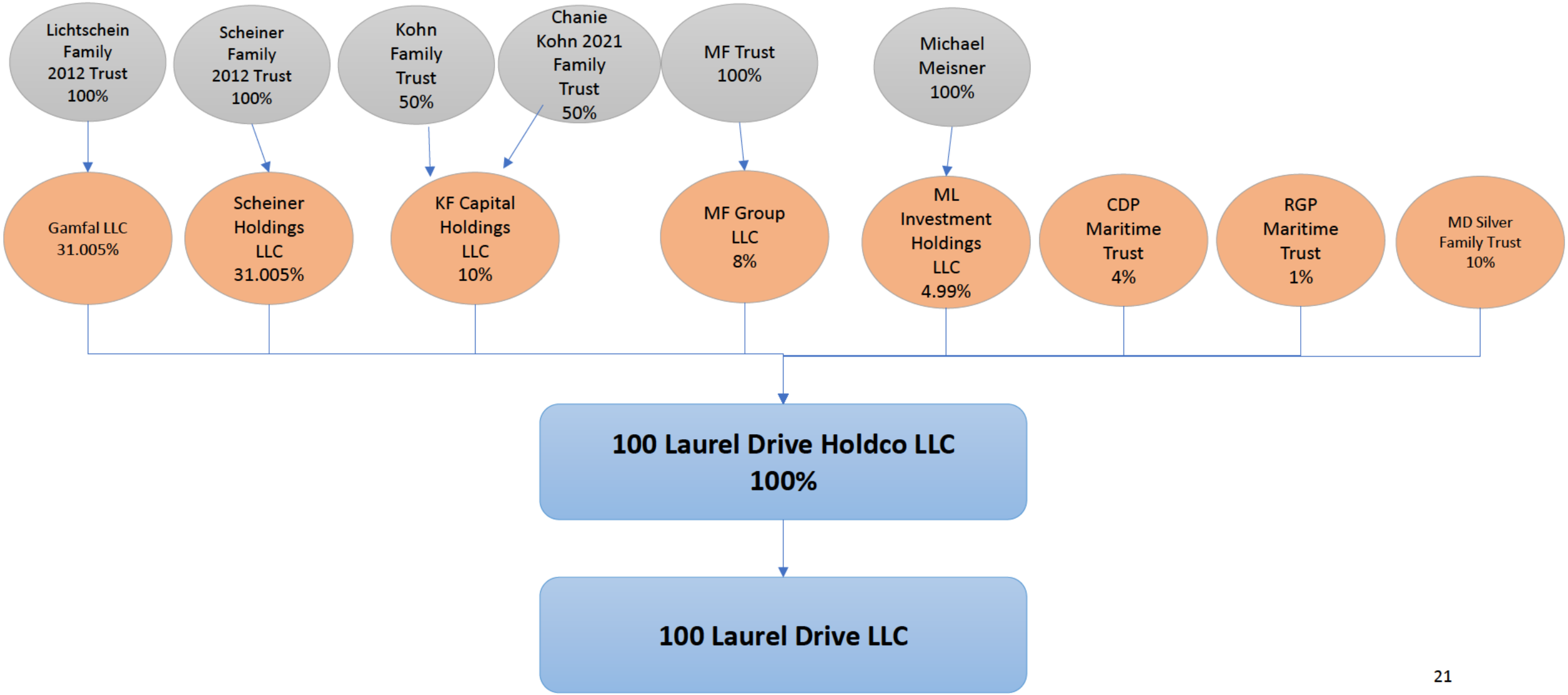
Attach a chart that completely delineates the ownership structure. Include the relationship between the owners (real property, bed rights, and operator).

Please see the following page for a chart that completely delineates the ownership structure.

Laurelwood Nursing and Rehab Center LLC



100 Laurel Drive LLC



NOTICE TO EMPLOYEES, RESIDENTS AND RESIDENT REPRESENTATIVES

Date: **December 3, 2025**

Dear Employees and Residents of Laurelwood Healthcare Center:

This notice is to inform you that 100 Laurel Drive LLC plans to become an owner of the land and building of this nursing home. Laurelwood Nursing and Rehab Center LLC plans to become an owner of the operations and beds rights of this nursing home. This change is scheduled to happen on February 1, 2026.

100 Laurel Drive LLC and Laurelwood Nursing and Rehab Center LLC asked the Maryland Health Care Commission, https://mhcc.maryland.gov/, to approve this change of ownership.

You have the right to submit comments about this planned change to the Commission.

Your comments must be received by January 2, 2026.

Send all comments to:
Maryland Health Care Commission
mhcc.confilings@maryland.gov
4160 Patterson Ave
Baltimore, MD 21215
410-764-3460

Please post this notice in a location where it is available to both Employees and Residents. Additionally, hand deliver to each resident and mail to resident representatives.

ATTACHMENT A

Identify each person with an ownership interest in the acquiring entity or a related or affiliated entity; the percentage of ownership interest of each such person; and the history of each such person's experience in ownership or operation of health care facilities. Include the names and addresses of all healthcare facilities owned or operated by each individual within the last three years. (*This form is designed in WORD so that those completing it can expand the number of rows, as necessary.)*

Please see the following page for the required table.

Attachment A: Persons With Ownership Interest in Acquiring Entity and/or Related or Affiliated Entity

Source: CMS Skilled Nursing Facility - all owners data

Person with ownership interest in the acquiring entity or a related/affiliated entity	Ownership Type	% Ownership in the acquiring entity	Name of affiliated Entity	Location of affiliated entity	% Ownership of affiliated entity	Describe each person's experience in ownership or operation of health care facilities (Years of ownership/association)
Jack Shelby	Trustee	85%	ADVANCED REHABILITATION AND HEALTHCARE OF BOWIE	Bowie, TX	21.0%	4.35
			CLYDE NURSING CENTER	Clyde, TX	21.0%	4.35
			CROWELL NURSING CENTER	Crowell, TX	21.0%	4.35
			PALO PINTO NURSING CENTER	Mineral wells, TX	21.0%	4.35
			PARK VIEW CARE CENTER	Fort worth, TX	21.0%	4.35
			PRAIRIE HOUSE LIVING CENTER	Plainview, TX	21.0%	4.35
			SANTA FE HEALTH & REHABILITATION CENTER	Weatherford, TX	21.0%	4.35
			SEYMOUR REHABILITATION AND HEALTHCARE	Seymour, TX	21.0%	4.35
			THE BRISTOL CARE CENTER	Tampa, FL	35.0%	4.74
			WHITEHALL REHAB & NURSING	Crockett, TX	21.0%	4.35
Heather Scheiner	Indirect Ownership	31%	THE SANDS AT SOUTH BEACH FACILITY INC	Miami Beach, FL	17.8%	7.75
Julie Lichtschein	Indirect Ownership	31%	MEADOW PARK REHABILITATION & HEALTH CARE CENTER, LLC	Fresh Meadows, NY	25.0%	26.25
Chanie Kohn	Indirect Ownership	10%	N/A	N/A	-	No Prior Ownership Experience
Michal Rodkin	Indirect Ownership	8%	N/A	N/A	-	No Prior Ownership Experience
Esther Stern	Trustee	10%	N/A	N/A	-	No Prior Ownership Experience
Meir Silberberg	Indirect Ownership	10%	N/A	N/A	-	No Prior Ownership Experience

Attachment A: Persons With Ownership Interest in Acquiring Entity and/or Related or Affiliated Entity

Source: CMS Skilled Nursing Facility - all owners data

Person with ownership interest in the acquiring entity or a related/affiliated entity	Ownership Type	% Ownership in the acquiring entity	Name of affiliated Entity	Location of affiliated entity	% Ownership of affiliated entity	Describe each person's experience in ownership or operation of health care facilities (Years of ownership/association)
Teddy Lichtschein			ADVANCED REHABILITATION AND HEALTHCARE OF ATHENS	Athens, TX	39.5%	4.41
			ADVANCED REHABILITATION AND HEALTHCARE OF BOWIE	Bowie, TX	39.5%	4.41
			ADVANCED REHABILITATION AND HEALTHCARE OF VERNON	Vernon, TX	39.5%	4.41
			BROOKHAVEN REHAB & HEALTH CARE CENTER L L C	Far rockaway, NY	7.5%	14.79
			CLYDE NURSING CENTER	Clyde, TX	39.5%	4.41
			COLONIAL MANOR NURSING CENTER	Cleburne, TX	39.5%	4.41
			CROWELL NURSING CENTER	Crowell, TX	39.5%	4.41
			GRANBURY REHAB & NURSING	Granbury, TX	39.5%	4.41
			HERITAGE HOUSE AT KELLER REHAB & NURSING	Keller, TX	39.5%	4.41
			PALO PINTO NURSING CENTER	Mineral wells, TX	39.5%	4.41
			PARK VIEW CARE CENTER	Fort worth, TX	39.5%	4.41
			PRAIRIE HOUSE LIVING CENTER	Plainview, TX	39.5%	4.41
			ROCKVILLE SKILLED NURSING & REHAB CENTER, L L C	Rockville centre, NY	50.0%	27.24
			SANTA FE HEALTH & REHABILITATION CENTER	Weatherford, TX	39.5%	4.41
			SEYMOUR REHABILITATION AND HEALTHCARE	Seymour, TX	39.5%	4.41
			WEDGEWOOD NURSING HOME	Fort worth, TX	39.5%	4.41
			WHITE SETTLEMENT NURSING CENTER	White settlement, TX	39.5%	4.41
			WHITEHALL REHAB & NURSING	Crockett, TX	39.5%	4.41
			WINDCREST HEALTH & REHABILITATION	Abilene, TX	39.5%	4.41
			WINFIELD REHAB & NURSING	Crockett, TX	39.5%	4.41

Attachment A: Persons With Ownership Interest in Acquiring Entity and/or Related or Affiliated Entity

Source: CMS Skilled Nursing Facility - all owners data

Person with ownership interest in the acquiring entity or a related/affiliated entity	Ownership Type	% Ownership in the acquiring entity	Name of affiliated Entity	Location of affiliated entity	% Ownership of affiliated entity	Describe each person's experience in ownership or operation of health care facilities (Years of ownership/association)
Eliezer Scheiner			BEACON REHABILITATION AND NURSING CENTER	Rockaway park, NY	65.0%	9.32
			ACHIEVE REHAB AND NURSING FACILITY	Liberty, NY	45.0%	18.28
			PARK VIEW CARE CENTER	Fort worth, TX	39.5%	4.35
			ADVANCED REHABILITATION AND HEALTHCARE OF VERNON	Vernon, TX	39.5%	4.35
			SEYMOUR REHABILITATION AND HEALTHCARE	Seymour, TX	39.5%	4.35
			PRAIRIE HOUSE LIVING CENTER	Plainview, TX	39.5%	4.35
			COLONIAL MANOR NURSING CENTER	Cleburne, TX	39.5%	4.35
			GRANBURY REHAB & NURSING	Granbury, TX	39.5%	4.35
			ADVANCED REHABILITATION AND HEALTHCARE OF BOWIE	Bowie, TX	39.5%	4.35
			WHITE SETTLEMENT NURSING CENTER	White settlement, TX	39.5%	4.35
			WEDGEWOOD NURSING HOME	Fort worth, TX	39.5%	4.35
			SANTA FE HEALTH & REHABILITATION CENTER	Weatherford, TX	39.5%	4.35
			PALO PINTO NURSING CENTER	Mineral wells, TX	39.5%	4.35
			CLYDE NURSING CENTER	Clyde, TX	39.5%	4.35
			HERITAGE HOUSE AT KELLER REHAB & NURSING	Keller, TX	39.5%	4.35
			WINDCREST HEALTH & REHABILITATION	Abilene, TX	39.5%	4.35
			ADVANCED REHABILITATION AND HEALTHCARE OF ATHENS	Athens, TX	0.0%	4.35
			WINFIELD REHAB & NURSING	Crockett, TX	0.0%	4.35
			WHITEHALL REHAB & NURSING	Crockett, TX	0.0%	4.35
			CROWELL NURSING CENTER	Crowell, TX	39.5%	4.35

Attachment A: Persons With Ownership Interest in Acquiring Entity and/or Related or Affiliated Entity

Source: CMS Skilled Nursing Facility - all owners data

Person with ownership interest in the acquiring entity or a related/affiliated entity	Ownership Type	% Ownership in the acquiring entity	Name of affiliated Entity	Location of affiliated entity	% Ownership of affiliated entity	Describe each person's experience in ownership or operation of health care facilities (Years of ownership/association)
Advanced HCS LLC			ADVANCED REHABILITATION AND HEALTHCARE OF ATHENS	Athens, TX	0.0%	8.61
			ADVANCED REHABILITATION AND HEALTHCARE OF BOWIE	Bowie, TX	0.0%	4.35
			ADVANCED REHABILITATION AND HEALTHCARE OF VERNON	Vernon, TX	0.0%	4.35
			CLYDE NURSING CENTER	Clyde, TX	0.0%	11.11
			COLONIAL MANOR NURSING CENTER	Cleburne, TX	0.0%	11.19
			CROWELL NURSING CENTER	Crowell, TX	0.0%	4.35
			GRANBURY REHAB & NURSING	Granbury, TX	0.0%	11.11
			HERITAGE HOUSE AT KELLER REHAB & NURSING	Keller, TX	0.0%	11.11
			PALO PINTO NURSING CENTER	Mineral wells, TX	0.0%	11.11
			PARK VIEW CARE CENTER	Fort worth, TX	0.0%	4.35
			PRAIRIE HOUSE LIVING CENTER	Plainview, TX	0.0%	4.35
			SANTA FE HEALTH & REHABILITATION CENTER	Weatherford, TX	0.0%	11.11
			SEYMOUR REHABILITATION AND HEALTHCARE	Seymour, TX	0.0%	4.35
			WEDGEWOOD NURSING HOME	Fort worth, TX	0.0%	11.11
			WHITE SETTLEMENT NURSING CENTER	White settlement, TX	0.0%	11.11
			WHITEHALL REHAB & NURSING	Crockett, TX	0.0%	8.61
			WINDCREST HEALTH & REHABILITATION	Abilene, TX	0.0%	11.11
			WINFIELD REHAB & NURSING	Crockett, TX	0.0%	8.61
Baylor County Hospital District			ADVANCED REHABILITATION AND HEALTHCARE OF VERNON	Vernon, TX	0.0%	11.11
			CHEROKEE TRAILS NURSING HOME	Rusk, TX	100.0%	2.44
			SEYMOUR REHABILITATION AND HEALTHCARE	Seymour, TX	0.0%	11.11
			TOMBALL REHAB & NURSING	Tomball, TX	100.0%	2.44
Bristol Holdco llc			THE BRISTOL CARE CENTER	Tampa, FL	100.0%	4.74
Childress County Hospital District			APEX SECURE CARE BROWNFIELD	Brownfield, TX	0.0%	10.94
			CHILDRESS HEALTHCARE CENTER	Childress, TX	100.0%	11.11
			CROWELL NURSING CENTER	Crowell, TX	0.0%	8.61
			LANDMARK OF AMARILLO REHABILITATION AND NURSING CE	Amarillo, TX	100.0%	8.19
			MATADOR HEALTH AND REHABILITATION CENTER	Matador, TX	100.0%	7.61
			MEMPHIS CONVALESCENT CENTER	Memphis, TX	100.0%	1.60
			PRAIRIE HOUSE LIVING CENTER	Plainview, TX	0.0%	11.19
			RALLS NURSING HOME	Ralls, TX	0.0%	10.94
			VILLA HAVEN HEALTH AND REHABILITATION CENTER	Breckenridge, TX	100.0%	8.61
			WELLINGTON CARE CENTER	Wellington, TX	100.0%	1.60
			WILLOWCREEK REHAB AND NURSING	Abilene, TX	100.0%	8.61

Attachment A: Persons With Ownership Interest in Acquiring Entity and/or Related or Affiliated Entity

Source: CMS Skilled Nursing Facility - all owners data

Person with ownership interest in the acquiring entity or a related/affiliated entity	Ownership Type	% Ownership in the acquiring entity	Name of affiliated Entity	Location of affiliated entity	% Ownership of affiliated entity	Describe each person's experience in ownership or operation of health care facilities (Years of ownership/association)
Coryell County Memorial Hospital			ADVANCED REHABILITATION AND HEALTHCARE OF ATHENS	Athens, TX	0.0%	8.61
			AUSTIN WELLNESS & REHABILITATION	Austin, TX	100.0%	7.23
			BEDFORD WELLNESS & REHABILITATION	Bedford, TX	100.0%	7.23
			BLUEBONNET REHAB AT ENNIS	Ennis, TX	100.0%	6.65
			BRENTWOOD PLACE ONE	Dallas, TX	100.0%	3.93
			BRENTWOOD PLACE THREE	Dallas, TX	100.0%	3.93
			BRENTWOOD PLACE TWO	Dallas, TX	100.0%	3.93
			COLONIAL MANOR NURSING CENTER	Cleburne, TX	0.0%	11.19
			COPPERAS HOLLOW NURSING & REHABILITATION CENTER	Caldwell, TX	0.0%	11.85
			CORYELL HEALTH REHABLIVING AT THE MEADOWS	Gatesville, TX	0.0%	0.79
			CRESTVIEW HEALTHCARE RESIDENCE	Waco, TX	0.0%	11.11
			FAIRVIEW HEALTHCARE RESIDENCE	Fairfield, TX	0.0%	11.11
			FORT WORTH WELLNESS & REHABILITATION	Ft worth, TX	100.0%	7.23
			FT WORTH SOUTHWEST NURSING CENTER	Fort worth, TX	100.0%	3.93
			GLENVIEW WELLNESS & REHABILITATION	Richard hills, TX	100.0%	7.23
			GRACY WOODS II LIVING CENTER	Austin, TX	0.0%	8.61
			GRANBURY REHAB & NURSING	Granbury, TX	0.0%	11.19
			HICO NURSING AND REHABILITATION	Hico, TX	0.0%	3.60
			NEW HOPE MANOR	Cedar park, TX	0.0%	8.61
			THE HEIGHTS NURSING AND REHABILITATION	Waco, TX	100.0%	1.85
			THE MANOR HEALTHCARE RESIDENCE	Mexia, TX	0.0%	11.11
			WESLEY WOODS HEALTH & REHABILITATION	Waco, TX	0.0%	6.94
			WEST SIDE CAMPUS OF CARE	White settlement, TX	0.0%	10.69
			WESTERN HILLS HEALTHCARE RESIDENCE	Comanche, TX	0.0%	6.10
			WHITEHALL REHAB & NURSING	Crockett, TX	0.0%	8.61
			WINDSOR HEALTHCARE RESIDENCE	Groesbeck, TX	0.0%	11.11
			WINFIELD REHAB & NURSING	Crockett, TX	0.0%	8.61
			WOODWAY REHABILITATION AND HEALTHCARE CENTER	Waco, TX	100.0%	5.60
Jack County Hospital District			AVIR AT JACKSBORO	Jacksboro, TX	100.0%	11.11
			PARK VIEW CARE CENTER	Fort worth, TX	0.0%	11.11

Attachment A: Persons With Ownership Interest in Acquiring Entity and/or Related or Affiliated Entity

Source: CMS Skilled Nursing Facility - all owners data

Person with ownership interest in the acquiring entity or a related/affiliated entity	Ownership Type	% Ownership in the acquiring entity	Name of affiliated Entity	Location of affiliated entity	% Ownership of affiliated entity	Describe each person's experience in ownership or operation of health care facilities (Years of ownership/association)
Nocona Hospital District			ADVANCED REHABILITATION AND HEALTHCARE OF BOWIE	Bowie, TX	0.0%	11.11
			EVERGREEN HEALTHCARE CENTER	Burkburnett, TX	100.0%	10.94
			FARMERSVILLE HEALTH AND REHABILITATION	Farmersville, TX	100.0%	8.61
			GRACE CARE CENTER OF HENRIETTA	Henrietta, TX	0.0%	11.19
			GRACE CARE CENTER OF NOCONA	Nocona, TX	0.0%	1.10
			GREENVILLE GARDENS	Greenville, TX	100.0%	10.69
			LANDMARK OF PLANO REHABILITATION AND NURSING CENTE	Plano, TX	100.0%	6.61
			LEXINGTON MEDICAL LODGE	Farmersville, TX	100.0%	10.44
			MIDLAND MEDICAL LODGE	Midland, TX	100.0%	4.10
			OAK MANOR OF COMMERCE NURSING AND REHABILITATION	Commerce, TX	100.0%	4.74
			OAKMONT GUEST CARE CENTER	Hurst, TX	100.0%	1.85
			PRINCETON MEDICAL LODGE	Princeton, TX	100.0%	1.85
			SENIOR CARE HEALTH & REHABILITATION CENTER - WICHI	Wichita falls, TX	100.0%	10.70
			SHERIDAN MEDICAL LODGE	Burkburnett, TX	100.0%	1.76
			SKYLINE NURSING CENTER	Dallas, TX	100.0%	9.94
			SUNNY SPRINGS NURSING & REHAB	Sulphur springs, TX	100.0%	10.69
			THE HIGHLANDS GUEST CARE CENTER	Dallas, TX	100.0%	7.61
			TRAYMORE NURSING CENTER	Dallas, TX	100.0%	8.61
			WHITNEY NURSING AND REHABILITATION CENTER	Whitney, TX	100.0%	0.85
Palo Pinto Hospital District			BENBROOK NURSING & REHABILITATION CENTER	Benbrook, TX	0.0%	11.11
			CLYDE NURSING CENTER	Clyde, TX	0.0%	11.11
			HERITAGE HOUSE AT KELLER REHAB & NURSING	Keller, TX	0.0%	11.11
			PALO PINTO NURSING CENTER	Mineral wells, TX	0.0%	11.11
			SANTA FE HEALTH & REHABILITATION CENTER	Weatherford, TX	0.0%	11.11
			WEDGEWOOD NURSING HOME	Fort worth, TX	0.0%	11.11
			WHITE SETTLEMENT NURSING CENTER	White settlement, TX	0.0%	11.11
			WINDCREST HEALTH & REHABILITATION	Abilene, TX	0.0%	8.61

ATTACHMENT B

(If the acquiring entity owns facilities in Maryland, use only Maryland facilities in the analysis. If the acquiring entity does not own Maryland facilities, choose the State or states with the largest number of facilities for the analysis).

Please see the following page for the required table.

Attachment B: Jack Shelby > 5% Ownership Interest Facilities

CCN	List facilities that are required for review under 10.24.20.05(8)	a. Each facility's overall rating based on the most recent CMS 5-star quality rating system*						b. Has the facility maintained quarterly QA? Provide the quarterly QA meeting schedule
		Q1 Sept. 2024	*Q2* Nov. 2024	*Q3* Mar. 2025	*Q4* June 2025	*Q5* Sept. 2025	*5 Quart. Avg.*	
Jack Shelby Owned Facilities (Texas)								
455849	ADVANCED REHABILITATION AND HEALTHCARE OF BOWIE	5	4	5	5	5	4.8	Yes, 3rd week of every month
675038	CLYDE NURSING CENTER	5	5	5	5	5	5	Yes, 3rd Tuesday of every month
675013	CROWELL NURSING CENTER	5	5	5	5	5	5	Yes, 2nd Tuesday of every month
455961	PALO PINTO NURSING CENTER	3	1	2	1	1	1.6	Yes, 2nd Friday of every month
455606	PARK VIEW CARE CENTER	2	1	3	3	3	2.4	Yes, 3rd Tuesday of every month
675478	PRAIRIE HOUSE LIVING CENTER	5	5	4	4	5	4.6	Yes, 2nd Thursday of every month
455957	SANTA FE HEALTH & REHABILITATION CENTER	3	3	4	5	5	4	Yes, 2nd Tuesday of every month
675042	SEYMOUR REHABILITATION AND HEALTHCARE	2	4	4	5	5	4	Yes, 2nd Tuesday of every month
675624	WHITEHALL REHAB & NURSING	3	2	2	2	2	2.2	Yes, 2nd Thursday of every month

Source:

a. *CMS NH Quality Compare, Sept. 2024 - Sept. 2025*

b. *Trustee Internal Data*

c. *CMS NH Quality Compare, MD Facilities, Sept 2025*

Note(s):

* *Quarterly data is from the CMS NH Quality Compare Snapshot data closest to the end of the quarter*

** *Please note that Resident Vacincation Rates were most recently collected by CMS 12/8/2024*

Attachment B: Jack Shelby > 5% Ownership Interest Facili

CCN	List facilities that are required for review under 10.24.20.05(8)	c. % of residents and staff receiving Flu, COVID and Pneumonia vaccines						d. Family Satisfaction Ratings			e. Percent Satisfied		
		Flu		COVID-19**		Pneumonia		*2022*	*2023*	*2024*	*2022*	*2023*	*2024*
		Residents	*Staff*	*Residents*	*Staff*	*Residents*	*Staff*						
Jack Shelby Owned Facilities (Texas)													
455849	ADVANCED REHABILITATION AND HEALTHCARE OF BOWIE	100.0	36.8	30.5	3.0	100.0	N/A						
675038	CLYDE NURSING CENTER	100.0	43.9	62.5	3.5	100.0	N/A						
675013	CROWELL NURSING CENTER	100.0	14.0	98.0	0.0	100.0	N/A						
455961	PALO PINTO NURSING CENTER	100.0	N/A	44.2	3.8	100.0	N/A						
455606	PARK VIEW CARE CENTER	96.6	53.6	0.0	0.0	99.4	N/A						
675478	PRAIRIE HOUSE LIVING CENTER	100.0	44.6	66.3	0.0	100.0	N/A						
455957	SANTA FE HEALTH & REHABILITATION CENTER	100.0	44.7	32.9	1.1	100.0	N/A						
675042	SEYMOUR REHABILITATION AND HEALTHCARE	100.0	51.1	52.9	0.0	99.4	N/A						
675624	WHITEHALL REHAB & NURSING	100.0	43.4	32.9	0.0	100.0	N/A						

Source:

a. CMS NH Quality Compare, Sept. 2024 - Sept. 2025

b. Trustee Internal Data

c. CMS NH Quality Compare, MD Facilities, Sept 2025

Note(s):

** Quarterly data is from the CMS NH Quality Compare Snapshot data closest*

*** Please note that Resident Vacincation Rates were most recently collected b*

ATTACHMENT C

Attachment C: Jack Shelby Owned Facilities Deficiencies and Survey Results

Source: ProPublica Nursing Home Inspection/Survey Results

List facilities that are required for review under 10.24.20.05(8)	SFF	Date of the Survey	Deficiencies	Deficiencies (Cont.)	Description	Seriousness
Jack Shelby Owned Facilities (Texas)						
ADVANCED REHABILITATION AND HEALTHCARE OF BOWIE	-	-	-	-	-	-
THE BRISTOL CARE CENTER	**SFF: Met survey criteria during most recent inspection**	12/1/2023	Quality of Life and Care Deficiency — F0689	Failure to: Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.	Facility failed to prevent accidents and hazards related to smoking safety precautions, for 14 residents (#114, #96, #102, #198, #131, #188, #324, #162, #184, #191, #113, #57, #68, and #61) out of 14 residents sampled for smoking safety out of a 44 residents on the facility residents who smoke list. The facility failed to ensure the safety of all 229 residents in the facility as a result of the failure.	L
			Administration Deficiency — F0867	Failure to: Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action.	Facility failed to utilize the Quality Assessment and Performance Improvement (QAPI) process to investigate, develop, and implement an effective Performance Improvement Plan (PIP) to prevent continued accidents and hazards related to smoking safety precautions, for 14 residents (#114, #96, #102, #198, #131, #188, #324, #162, #184, #191, #113, #57, #68, and #61) out of 14 residents sampled for smoking safety out of 44 residents on the facility residents who smoke list. The facility failed to ensure the safety of all 229 residents in the facility as a result of the failure.	L
			Environmental Deficiency — F0926	Failure to: Have policies on smoking.	Based on observations, record review, and interview, the facility failed to develop and implement an effective policy and procedure to address smoking safety and fire hazards for 14 residents (#114, #96, #102, #198, #131, #188, #324, #162, #184, #191, #113, #57, #68, and #61) out of 14 residents sampled for smoking safety out of 44 residents on the facility residents who smoke list. On 9/22/23 at 5:11 p.m. Resident #61 was found by the Nursing Home Administrator smoking (alleged) marijuana in an unauthorized smoking area of the facility. On 10/21/23 at 4:03 a.m. Resident #102, who was on oxygen, was permitted to keep smoking materials at the bedside and as a result Resident #102 was harmed when she smoked in bed on 10/21/23 and started a fire inside the facility. Resident #102 burned herself on her left arm and suffered shortness of breath due to smoke inhalation and was transferred to the hospital for evaluation and treatment. The event endangered all residents in the facility. On 10/24/23 at 4:59 p.m. Resident #61 was found by the Nursing Home Administrator smoking in a non-smoking area with his oxygen tank on his wheelchair. Observations conducted on 11/27/23, 11/28/23, and 11/29/23 revealed residents had unsecured smoking materials on their persons, were seen lighting other resident's cigarettes on the smoking patio in front of the facility staff and were smoking in non-smoking areas on the facility property.	L
			Freedom from Abuse, Neglect, and Exploitation Deficiency — F0600	Failure to: Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.	Facility failed to protect the resident's right to be free from abuse by not ensuring one resident (#30) out of two residents reviewed was free from restraints which caused physical harm (bruising and skin tear).	L
			Freedom from Abuse, Neglect, and Exploitation Deficiency — F0609	Failure to: Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.	Facility failed to ensure all allegations of abuse and injuries of unknown source were reported within the required two hour time frame for two residents (#30 and #137) out of two residents reviewed for reporting allegations of abuse.	L

Attachment C: Jack Shelby Owned Facilities Deficiencies and Survey Re

Source: ProPublica Nursing Home Inspection/Survey Results

		Medicare			
List facilities that are required for review under 10.24.20.05(8)	**Action Taken**	**Penalty Date**	**Payment Denial Length in Days**	**Payment Denial Start Date**	**Payment Denial End Date**
Jack Shelby Owned Facilities (Texas)					
ADVANCED REHABILITATION AND HEALTHCARE OF BOWIE	-	-	-	-	-
THE BRISTOL CARE CENTER	a QAPI was put in place by the facility's leadership team to prevent recurrence. The facility stopped admitting new residents from December until the beginning of February to give the team time to put new processes in place. A change in Administrator and Director of Nursing was made, and an outside consulting group by the name of RB Health Partners was brought in. The consulting group provides ongoing regulatory and risk support, as well as education and training for multiple departments, including Nursing, Social Services, and Dietary among others. The facility cleared all survey deficiencies from the annual survey on the first revisit and has not received any further citations since November. Bristol Care Center is currently in substantial compliance with CMS regulations and has met all requirements for removal from the Special Focus Facility (SFF) listing. Formal removal is pending due to the current government shutdown. Since the last update in May 2024, the center successfully completed its recertification survey conducted from June 23 to June 26, 2025, which identified only low scope and severity concerns that were fully cleared as of August 20, 2025. The center continues to demonstrate strong performance through its robust Quality Assurance and Performance Improvement (QAPI) program and ongoing consultation with RB Health Partners. Bristol Care Center maintains a dedicated Risk Manager, Nurse Consultant and a strong, stable interdisciplinary team with no leadership vacancies. Additionally, the center achieved and has sustained its goal of becoming agency-free, reflecting enhanced staff stability, team growth, and improved morale.	-	-	-	-
	No action was taken.				
	The RM stated Staff V, RN had been suspended as of today pending investigation.				

Attachment C: Jack Shelby Owned Facilities Deficiencies and Survey Results

Source: ProPublica Nursing Home Inspection/Survey Results

List facilities that are required for review under 10.24.20.05(8)	SFF	Date of the Survey	Deficiencies	Deficiencies (Cont.)	Description	Seriousness
THE BRISTOL CARE CENTER	**SFF: Met survey criteria during most recent inspection**	5/5/2023	Quality of Life and Care Deficiency — F0678	Failure to: Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident's advance directives.	Facility failed to accurately identify a resident, follow facility policy, and accurately identify a code status of one resident (#1) out of six residents reviewed for advance directives. Resident #1, had physician orders and care plan showing her wishes were for a Full Code (meaning all resuscitation procedures will be provided to keep her alive if found without a pulse and/or respirations). On [DATE] when Resident #1 was found to be unresponsive without pulse and respirations, resuscitation efforts were begun, and then stopped due to a mistake in identifying the correct medical record. Resuscitation efforts were started again after Resident #1's actual medical record was found and a nurse realized the error. The resident was not successfully revived and was pronounced dead by Emergency Medical Service (EMS) staff.	J
CLYDE NURSING CENTER	-	-	-	-	-	-
CROWELL NURSING CENTER	-	-	-	-	-	-
PALO PINTO NURSING CENTER	-	8/25/2024	Resident Assessment and Care Planning Deficiency — F0656	Failure to: Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.	Failed to develop and implement a comprehensive care plan to meet the highest practicable physical, mental, and psychosocial wellbeing for 2 (Resident #9 and #24) of 24 residents reviewed for care plans. 1. The facility failed to develop and implement a comprehensive care plan for Resident #24 to address the left femur fracture sustained on [DATE] and current transfer status. 2. The facility failed to update Resident #24's Kardex (a brief digital overview of the resident's needs) to reflect she required 2 people to transfer her. As a result, the resident was transferred on [DATE] by a hospitality aide. Resident #24 was sent to the hospital and sustained a femur fracture. 3. The facility failed to develop a comprehensive care plan for Resident #9 to address her non-compliance with asking for assistance with transfers and failed to follow Resident #9 transfer status. As a result, staff were not aware of the transfer status of Resident #9 and she experienced an unwitnessed fall on [DATE], [DATE], and [DATE]. 4. The facility failed to update Resident #9's care plan to address the nasal bone fracture on [DATE].	K
			Quality of Life and Care Deficiency — F0689	Failure to: Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.	Facility failed to ensure each resident received adequate supervision/assistance to prevent accidents for one (Resident #24) of four residents reviewed for accidents. The facility failed to ensure Resident #24 was free of accident hazard when HA (non-certified) C transferred Resident #24, without any assistance, for toileting.	J

Attachment C: Jack Shelby Owned Facilities Deficiencies and Survey Re

Source: ProPublica Nursing Home Inspection/Survey Results

		Medicare			
List facilities that are required for review under 10.24.20.05(8)	**Action Taken**	**Penalty Date**	**Payment Denial Length in Days**	**Payment Denial Start Date**	**Payment Denial End Date**
THE BRISTOL CARE CENTER	The Center has taken the following steps to ensure the safety of our residents who are at risk for Advance directive related to CPR and Code status compliance. Resident family was notified of outcome of CPR attempt at approximately 1:15 am on [DATE]th 2023 Physician notified of incident - At approximately 1:15 am on [DATE]th 2023 Administrator, DON, Nurse manager notified of incident and reported to facility on [DATE]th 2023 All residents in facility were audited for advance directives preferences to ensure accuracy, 100% on [DATE]th 2023 Facility-initiated code blue drill on [DATE]th 2023 All chart locations were audited to ensure in proper location on [DATE]th 2023 100% complete. CPR competency plus competency quiz and proper identification of code status for resident via chart, and EHR (Electronic Health Record) and resident photo in EHR for all staff initiated on [DATE]. [DATE] - 75% complete [DATE] - 90% complete [DATE] - 95% complete [DATE] -100% complete No employee will be permitted to work until they have completed in-services and competencies(nursing). Staff contacted via phone on [DATE] to contact facility for training prior to returning to work. DON or designee will be completing work on completion of training with competencies.This issue was taken to Quality Assurance Performance Improvement (QAPI) at an ad-hoc (when necessary) meeting on [DATE] to discuss the event and necessary adequate follow up. QAPI meeting discussed CPR Policy & Procedures, Education, Chart locations and disaster drills. Daily review of new admissions for code status and any code status change request will be completed by Nurse Management and Social Services for any concerns so that corrective actions can be identified/implemented as appropriate. CPR Drills completed at facility on [DATE] and will be on-going weekly for 1 month and biweekly for 1 month, then quarterly on all shifts. This Administrator is responsible for oversight of this plan. Verification of the facility's removal plan was conducted by the survey team on [DATE]. The Regional Nurse and the Administrator provided the State Survey team with documentation showing records of the facility actions to remove the immediacy: Bristol CPR Incident [DATE] Timeline included witness statements and five-day follow-up Audit conducted of all Resident code statuses, matching care plan and charts. Nurse CPR Certification Audit with all active CPR cards available CPR Policy QAPI Ad Hoc Meeting Minutes with CPR Policy In-Service Attendance Record with CPR Competency Quizzes Interviews were conducted with 47 Staff, 16 licensed nurses, 23 CNAs and 8 other staff. The staff members were able to state that they had been trained and were knowledgeable about the facility CPR policy.	-	-	-	-
CLYDE NURSING CENTER	-	-	-	-	-
CROWELL NURSING CENTER	-	-	-	-	-
PALO PINTO NURSING CENTER	The facility's plan of removal was accepted on [DATE] at 6:05 PM and included:1.On [DATE] resident # 24 was immediately sent the emergency room .2.On [DATE] the hospitality aide involved in this incident was suspended until further notice 3.On [DATE] the DON/Designee completed the investigation on incident involving resident # 24. 4. On [DATE] at 12:30 pm, the Regional Nurse Consultant provided in-service education with the DON on Job descriptions to include Hospitality Aides job duties, and Certified Aide job duties This was completed on [DATE]. The Regional Nurse Consultant will provide oversight on this process weekly x 4 weeks. 5. On [DATE] at 1:00 pm, the DON/Designee began in-service education with all clinical staff on Job descriptions to include Hospitality Aides job duties, and Certified Aide job duties to validate that each Aide had clear understanding of what was in their scope and practice. This was completed on [DATE] and no clinical staff will be allowed to work until this education has been completed. 6. On [DATE] the DON/Designee began in-service education with individual hospitality aides on their specific job duties and had the individual sign a new job description. This was completed on [DATE] either directly or by phone. This education included that at any time, a hospitality aide is performing care that is not in their job description, the DON/Administrator will be notified immediately, and staff will be asked to leave facility. This was completed on [DATE]. 7. On [DATE] at 12:30 pm, the Regional Nurse Consultant provided in-service education with the DON/Designee on transfers which guides staff on how to properly and safely transfer residents according to their plan of care and type of device if needed. This was completed on [DATE] at 1:00 pm. The Regional Nurse Consultant will provide oversight on this process weekly x 4 weeks. 8. On [DATE] at 2:00 pm the DON/Designee began in-service education with all clinical staff on transfers which guides staff on how to properly and safely transfer residents according to their plan of care and type of device if needed this included skills competency on Transfers (Hoyer and gait belts). This was completed on [DATE] and no staff will be allowed to work until this education has been completed. DON/Designee will complete weekly hoyer skills validations and gait belt skills validation on 5 C.N.A. weekly, rotation shifts x 90 days. The Regional Nurse consultant will provide oversight for this process and will review monthly. 9. On [DATE] at 12:30 pm, the Regional Nurse Consultant provided in-service education with the DON/Designee On use of PCC Kardex to determine type and amount care residents require, including reporting to Charge Nurse if ADLS are not present and or accurate on Kardex. This was completed at completed on [DATE]. The Regional Nurse Consultant will provide oversight on this process weekly x 4 weeks. 10. On [DATE] at 1:00 pm the DON/Designee began in-service education with all clinical staff on use of PCC Kardex to determine type and amount care residents require, including reporting to Charge Nurse if ADLS are not present and or accurate on Kardex. This was completed on [DATE], and no clinical staff will be allowed to work until this education has been completed. 11. On [DATE] the Regional Nurse Consultant provided 1:1 education to the Center's DON and two ADONS on care plans that they are responsible to review all incident reports including falls, updating care plan with appropriate interventions for each fall and make sure interventions are appropriate, ensuring timely completion and that interventions are reflective on Kardex. This was completed on [DATE]. 12. On [DATE] the facility conducted and Ad Hoc QAPI meeting to discuss Incidents/Accidents and Hazards and on sustaining compliance.	-	-	-	-

Attachment C: Jack Shelby Owned Facilities Deficiencies and Survey Results

Source: ProPublica Nursing Home Inspection/Survey Results

List facilities that are required for review under 10.24.20.05(8)	SFF	Date of the Survey	Deficiencies	Deficiencies (Cont.)	Description	Seriousness
PARK VIEW CARE CENTER	-	2/20/2025	Freedom from Abuse, Neglect, and Exploitation Deficiency — F0600	Failure to: Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.	The facility failed to ensure Resident #1 had the right to be free from abuse when Resident #2 struck him in the face on 02/18/25.	G
		9/19/2024	Freedom from Abuse, Neglect, and Exploitation Deficiency — F0600	Failure to: Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.	The facility failed to ensure the Administrator did not verbally abuse Resident #1 when he cursed at him during a conversation.	G
			Freedom from Abuse, Neglect, and Exploitation Deficiency — F0607	Failure to: Develop and implement policies and procedures to prevent abuse, neglect, and theft.	The facility failed to ensure Resident #1 was free from abuse per the policy when the Administrator verbally abused Resident #1 when he cursed at him during a conversation.	G
		2/1/2024	Freedom from Abuse, Neglect, and Exploitation Deficiency — F0600	Failure to: Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.	The facility failed to ensure Housekeeping Supervisor did not verbally abuse Resident #3 on 12/10/23.	G
		9/7/2023	Quality of Life and Care Deficiency — F0689	Failure to: Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.	The facility failed to ensure Housekeeping Supervisor did not verbally abuse Resident #3 on 12/10/23.	G
PRAIRIE HOUSE LIVING CENTER	-	-	-	-	-	-
SANTA FE HEALTH & REHABILITATION CENTER	-	-	-	-	-	-
SEYMOUR REHABILITATION AND HEALTHCARE	-	-	-	-	-	-
WHITEHALL REHAB & NURSING	-	11/13/2024	Quality of Life and Care Deficiency — F0689	Failure to: Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.	Facility failed to provide adequate supervision to prevent Resident #42 from eloping from the facility and being located in an empty lot with multiple fall and environment hazards approximately 550 feet behind facility and approximately 300 feet from highway on 10/13/24 at 1:30 am. The facility failed to keep Resident #42 in a safe environment to prevent an elopement on 10/13/24 at 1:30 am.	J
		8/20/2024	Quality of Life and Care Deficiency — F0689	Failure to: Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.	The facility failed to properly secure Resident #1 in the facility van on [DATE] and Resident #1 fell forward while in transport striking his head on the side of the van causing a laceration and emergency room care.	J
		3/27/2024	Freedom from Abuse, Neglect, and Exploitation Deficiency — F0600	Failure to: Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.	Facility failed to prevent physical abuse for Resident #1 witnessed by HA to have been hit on the head by CNA A on 02/27/2024 at approximately 3:00 a.m. during incontinence care.	J
			Freedom from Abuse, Neglect, and Exploitation Deficiency — F0607	Failure to: Develop and implement policies and procedures to prevent abuse, neglect, and theft.	1. The facility failed to prevent physical abuse of Resident #1 who was hit on the head by CNA A on 02/27/2024. 2. The facility failed to ensure CNA A was not allowed to work after the allegation of abuse had been reported	J
			Freedom from Abuse, Neglect, and Exploitation Deficiency — F0609	Failure to: Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.	1. The facility failed to report physical abuse of Resident #1 to the Administrator immediately following HA witnessing CNA A hit Resident #1 on the head on 02/27/2024 at approximately 3:00 a.m. during incontinent care. 2. HA notified CNA C of a witnessed abuse incident on 02/27/2024 at 6:30 p.m. and CNA C did not report the allegation of abuse to the administrator/abuse prohibition coordinator until 02/28/2024 at approximately 3:00 p.m.	J

Attachment C: Jack Shelby Owned Facilities Deficiencies and Survey Re

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		Medicare			
List facilities that are required for review under 10.24.20.05(8)	**Action Taken**	**Penalty Date**	**Payment Denial Length in Days**	**Payment Denial Start Date**	**Payment Denial End Date**
PARK VIEW CARE CENTER	The DON contacted corporate administration and they agreed the resident was a risk to other residents. An emergency discharge was initiated. The DON stated there had been no physical violence with Resident #2, he was only verbally 'grumpy with staff. Interview on 09/18/24 at 3:00 PM with the Administrator and the DON revealed the Administrator said he never intended to abuse Resident #1. The Administrator said there was an allegation that Resident #1 was abused by him, so he was suspending himself and leaving the DON to complete the investigation. The Administrator said he was leaving the facility due to the suspension. Record review of an undated letter with the third party company's logo and name on the top reflected: To Whom it my Concern- This letter is to state that [the Housekeeping Supervisor] has been terminated from [company name] since December 15, 2023, with a prior suspension. Interview on 09/07/23 at 3:20 PM with the ADON revealed she had been made aware of Resident #1's fall and stated staff should not have provided care alone and needed two staff members. She said a second person was required to keep the resident safe or to keep her from rolling off the bed. The ADON said if a staff member was not sure if a resident required one or two staff members, they could look in the computer system or as the charge need of the resident's needs.	-	-	-	-
PRAIRIE HOUSE LIVING CENTER	-	-	-	-	-
SANTA FE HEALTH & REHABILITATION CENTER	-	-	-	-	-
SEYMOUR REHABILITATION AND HEALTHCARE	-	-	-	-	-
WHITEHALL REHAB & NURSING	Record review of Elopement/Wandering Risk assessment history indicated all residents were reassessed for elopement risk by 10/13/24. The facility identified seven residents to be at risk and to require additional supervision. Record review of 15-minute check documentation forms dated 10/13/24 through 11/11/24 indicated that staff document Resident #42's location every 15 minutes throughout the day. Record review of invoices from [business name], a private sitting company indicate that facility paid for a private sitter for Resident #42 from the night of 10/14/24 through 11/11/24. Record review of facility form for elopement drill indicated that facility held elopement drills on 10/13/24 for day shift attended by 8 staff members; 10/13/24 for night shift attended by 5 staff members; 10/14/24 day shift attended by 10 staff members; and 10/14/24 night shift attended by 7 staff members. Record review of facility log sheets dated 10/13/24 through 10/19/24 indicated that documentation of daily door checks were done for front door, dining room door, 100-hall exit door, exit door by DON office, therapy exit door, 400-hall exit door and 500-hall exit door. Record review of Resident #42's physician orders indicated that a new order was put into place to check function of wanderguard every shift for wandering dated 10/13/24. 1. Immediate Action Taken A. Resident # 1 expired in the facility on [DATE] . B. The facility's van immediately stopped all van transport on [DATE] at 4:30 pm C. The facility's van is scheduled for replacement / installation of shoulder harness this Thursday [DATE]. D. The Administrator or designee completed the following with the one facility designated van driver: o In-service education on the Transportation Policy which provides direction on duties and responsibilities of driver, van safety, and forms required was completed on [DATE] at 7:00pm. Skills check off on driving of the van, how to operate the wheelchair lift and the wheelchair securement system, use of seat and shoulder harness, and how to transport more than 1 wheelchair was completed on [DATE] at 8:00am at neighboring facility with a similar van. Van driver performed return demonstration on noted skills. This process will be redone once our van has the shoulder harness installed. o In-service education provided to van driver by administrator/designee on weekly maintenance log which includes checking Operable seatbelt straps, wheelchair tie down, shoulder strap, floor W/C tie down straps that van driver will complete and provide to administrator/designee weekly. This was completed on [DATE] at 7:00 pm. o The Administrator reviewed with van driver, a new signed job description. This was completed on [DATE] at 7:00 pm. The surveyor confirmed PNC had been implemented sufficiently to remove the Immediate Jeopardy by: - Facility implementation of monitoring resident daily for three days for psychosocial harm.- Facility notification of abuse incident to responsible parties, MD, police, Ombudsman, and HHSC.- Completion of head-to-toe skin assessment on resident/victim.- Completion of in-services on abuse, reporting, dementia and approaching combative residents.- Completion of safe surveys on residents.- Suspension of involved staff pending outcome.- Completion of formal disciplinary actions for involved staff.- Termination of confirmed perpetrator. The noncompliance was identified as PNC. The IJ began on 02/27/2024 and ended on 03/05/2024. The facility had corrected the noncompliance before the survey began.	-	-	-	-

Attachment C: Jack Shelby Affiliated Entities Owned Facilities Deficiencies and Survey Results

Source: ProPublica Nursing Home Inspection/Survey Results

List facilities that are required for review under 10.24.20.05(8)	SFF	Date of the Survey	Deficiencies	Deficiencies (Cont.)	Description	Seriousness
Other Affiliated Facilities						
ACHIEVE REHAB AND NURSING FACILITY	-	-	-	-	-	-
Advanced Health & Rehab Center Of Garland	-	12/2/2024	Quality of Life and Care Deficiency — F0695	Failure to: Provide safe and appropriate respiratory care for a resident when needed.	Facility failed to ensure that each resident received necessary respiratory care and services that is in accordance with professional standards of practice, the resident's care plan and the residents' choice for 3 (Resident #1, Resident #2, and Resident #3) of 8 residents reviewed for respiratory care.	K
ADVANCED REHABILITATION AND HEALTHCARE OF ATHENS	-	7/14/2023	Quality of Life and Care Deficiency — F0697	Failure to: Provide safe, appropriate pain management for a resident who requires such services.	Facility failed to ensure that pain management was provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences for 1 of 5 reviewed for pain. The facility failed to contact the physician in a timely manner regarding Resident #1's pain medication.	J
ADVANCED REHABILITATION AND HEALTHCARE OF VERNON	-	-	-	-	-	-
APEX SECURE CARE BROWNFIELD	-	-	-	-	-	-
AUSTIN WELLNESS & REHABILITATION	-	9/19/2024	Quality of Life and Care Deficiency — F0689	Failure to: Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.	The facility failed to address or put in place new interventions when Residents #1 and #2 had a change-in-condition and began experiencing more frequent falls in a short time-frame. Facility failed to implement the new intervention of a helmet that was documented in a nursing noted for Resident #2 after a fall on 07/27/24.	K
		6/4/2024	Resident Assessment and Care Planning Deficiency — F0656	Failure to: Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.	The facility failed to include frequent falls as a focus area to provide possible preventive interventions despite the resident having serious injuries from falls in his recent history, prior to admission and multiple falls since his admission.	J
		6/4/2024	Quality of Life and Care Deficiency — F0689	Failure to: Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.	Facility failed to ensure a resident's environment remained free of accident hazards and residents received adequate supervision and assistance devices to prevent accidents for one (Resident #1) of three residents reviewed for accidents and hazards. The facility failed to ensure Resident #1 did not have repeated falls without attempts to decrease the severity and frequency of falls that continued to occur despite the same two interventions used each time a fall occurred.	J
		3/27/2024	Quality of Life and Care Deficiency — F0689	Failure to: Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.	Facility failed to ensure each resident received adequate supervision and assistance devices to prevent accidents for 1 of 3 residents (Resident #1) reviewed for elopement. Resident #1 walked out of the facility unattended on 03/15/2024 at about 9:00PM until the police found him at about 10:00 PM from a place approximately 1.5 miles away from the facility. EMS organized by the police to take him to the hospital and at the hospital it was confirmed that resident had hairline fracture above the left eye and cheek with lacerations on left eye lid, left wrist, and lower and upper lips, and abrasions on hands. The facility staff was not aware the resident was missing until the family called the facility.	J
AVIR AT JACKSBORO	-	8/26/2023	Quality of Life and Care Deficiency — F0684	Failure to: Provide appropriate treatment and care according to orders, resident's preferences and goals.	The facility failed to ensure Resident #40 had physician orders regarding care of the surgery site, post hip replacement surgery, on 07/30/2023. The 8 surgical staples were not removed until 08/13/2023, 14 days after surgery which resulted in a superficial infection	H

Attachment C: Jack Shelby Affiliated Entities C

Source: ProPublica Nursing Home Inspection/Survey

		Medicare			
List facilities that are required for review under 10.24.20.05(8)	**Action Taken**	**Penalty Date**	**Payment Denial Length in Days**	**Payment Denial Start Date**	**Payment Denial End Date**
Other Affiliated Facilities					
ACHIEVE REHAB AND NURSING FACILITY	-	-	-	-	-
Advanced Health & Rehab Center Of Garland	The IJ template was provided to the facility on [DATE] at 4:45 PM. While the IJ was removed on [DATE]. No IJ removal plan provided in the survey.	7/20/2022	88	8/18/2022	11/14/2022
ADVANCED REHABILITATION AND HEALTHCARE OF ATHENS	DON/Designee will Provide all nurses with education on Pain Management Policy, Change of Condition, and Medication Administration Guidelines. DON/Designee started education with all license nurses on Control Substance Prescriptions Guidelines (which includes back up procedures for new admissions, including notifying physician and telehealth physician after hours for orders.). DON or designee will monitor daily the 24hr sheets to identify any residents with unrelieved pain with physician notified of any identified.	-	-	-	-
ADVANCED REHABILITATION AND HEALTHCARE OF VERNON	-	-	-	-	-
APEX SECURE CARE BROWNFIELD	-	-	-	-	-
AUSTIN WELLNESS & REHABILITATION	DON and ADON in-serviced by CNO on Inservice on Fall Documentation and interventions, Assessments and interventions, on Fall policy and procedure, and on Abuse and Neglect. Audit all residents with fall risk to ensure interventions are in place and documented A Fall reassessment for Resident #1 was completed by DON on 6/1/24 and the Care Plan was updated on 6/1/24 for Resident #1 to reflect the appropriate interventions to try to help prevent injury from further falls. All staff were re-educated on the regulatory guidelines and facility policy and procedures regarding Abuse, Neglect and Exploitation. A full house fall risk reassessment was implemented and completed by DON for all residents to ensure no additional residents are at risk, and Care Plans will be updated to reflect appropriate fall interventions. New system implementation of tracking resident falls and interventions in a fall tracking binder for daily review by charge nurses which will help identify residents with multiple falls and appropriate interventions. DON will audit binder for updates and completeness. DON will audit the binders daily for a week, biweekly for a month, monthly for QAPI. Audit results will be reviewed and shared with QAPI team. An All-Clinical Staff in-service by DON to include FT/PT/PRN/New Hires (No Agency in Use) on the fall management program policy and procedure along with communicating updated interventions and staff responsibilities, prior to them working the floor. All residents re-evaluated for risk of elopement via assessment on 3/25/2024. No additional residents were identified based on evaluation. Elopement Binder up to date and remains at reception desk. DON ensured all residents who are imminent risk for elopement are donning a wander guard for safety. Physician orders related to residents on wander guard placement reviewed and updated for all residents. In-services completed with all staff (facility does not use agency, all staff to include PRN staff) related to Elopement, if resident has more than one request to leave then elopment/wandering risk assessment must be completed	-	-	-	-
AVIR AT JACKSBORO	No actions in report. Facility policy states that the admitting nurse must document the following information (as each may apply) in the nurses' notes, admission form, and other appropriate place as designated by facility protocol: - the time the physician's orders were received and verified; - the presence of a catheter, dressings, etc	-	-	-	-

Attachment C: Jack Shelby Affiliated Entities Owned Facilities Deficiencies and Survey Results

Source: ProPublica Nursing Home Inspection/Survey Results

List facilities that are required for review under 10.24.20.05(8)	SFF	Date of the Survey	Deficiencies	Deficiencies (Cont.)	Description	Seriousness
BALCH SPRINGS NURSING HOME	-	-	-	-	-	-
BEACON REHABILITATION AND NURSING CENTER	-	3/14/2024	Freedom from Abuse, Neglect, and Exploitation Deficiency — F0600	Failure to: Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.	facility failed to protect a resident from physical abuse by nursing home staff. This was evident in 1 out of 3 residents sampled for abuse (Resident #1). Specifically, on 02/28/24 at approximately 7:00 pm, Resident #1 reported to Nursing Supervisor #1 that they were kicked in the scrotal area by Certified Nursing Assistant #2. Resident #1 reported that when they were kicked in the groin, they screamed out in pain. Certified Nursing Assistant #1 also reported to Nursing Supervisor #1 they witnessed Certified Nursing Assistant #2 kick Resident #1 in their private area and that Resident #1 screamed out in pain. A nursing note, by Nursing Supervisor #1, dated 02/28/24 at 6:33 pm documented that a head-to-toe assessment was done immediately and revealed no visible injuries.	G
BEDFORD WELLNESS & REHABILITATION	-	9/13/2024	Freedom from Abuse, Neglect, and Exploitation Deficiency — F0600	Failure to: Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.	facility failed to ensure residents were free from neglect for two of three residents (Resident #127 and Resident #56) reviewed for abuse, neglect, and exploitation. 1. The facility failed to provide timely transportation for Resident #127 when he was finished with his medical appointment, being wheelchair bound, offsite from the facility. On 9-10-2024 Resident #127 was not picked up by a transportation driver for over 4 hours causing him to miss his lunch meal, pain medication time for Tramadol PRN every 4 hours (which the resident could have received at 11:00 AM but did not), causing psychosocial harm (resident was crying and felt abandoned which was exacerbated due to the resident's post-traumatic stress disorder). 2. The facility failed to provide timely transportation for Resident #56 on 09-09-2024 due to the van lift malfunction and required his appointment to be rescheduled. The facility failed to provide timely transportation for Resident #56 on 09-10-2024 and was approximately an hour late for his appointment.	J
		6/23/2023	Quality of Life and Care Deficiency — F0693	Failure to: Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube.	The facility failed to ensure a resident who received nutrition by enteral means received the appropriate treatment and services to prevent complications of enteral nutrition including metabolic abnormalities for 1 (Resident #1) of 3 residents who were reviewed for enteral nutrition (a form of nutrition that is delivered into the digestive system as a liquid in the form of a tube feeding). The facility failed to ensure Resident #1's physician order enteral nutrition (a form of nutrition that is delivered into the digestive system as a liquid in the form of a tube feeding) was changed, per the physician's order, to treat high blood sugars.	G

Attachment C: Jack Shelby Affiliated Entities C

Source: ProPublica Nursing Home Inspection/Survey

		Medicare			
List facilities that are required for review under 10.24.20.05(8)	**Action Taken**	**Penalty Date**	**Payment Denial Length in Days**	**Payment Denial Start Date**	**Payment Denial End Date**
BALCH SPRINGS NURSING HOME	-	-	-	-	-
BEACON REHABILITATION AND NURSING CENTER	On 02/29/24 the Quality Assurance Committee held a meeting where the incident was discussed. Attendees included the Administrator, Director of Nursing, Assistant Director of Nursing, and other departmental heads. On 02/29/24, Policy/Procedure on Abuse, Neglect, Mistreatment, and Reporting was reviewed. No revisions were done to the policy. On 02/29/24, Certified Nursing Assistant #2 was suspended and subsequently terminated. On 02/29/24 Nursing Supervisor #1 and Nursing Supervisor #2 were both re-educated on abuse, reporting of abuse immediately to the Administrator, Director of Nursing, and Assistant Director of Nursing. The topic also covered removing staff from resident care pending investigation outcome. On 03/01/24 the facility's Social Worker interviewed multiple residents on Certified Nursing Assistant #2's assignment and there were no abuse, neglect, or mistreatment issues identified.	-	-	-	-
BEDFORD WELLNESS & REHABILITATION	Facility driver to immediately notify transportation coordinator if unable to pick up resident/patient from appointment within an hour. The coordinator will immediately schedule with alternate vendor for immediate pick up/drop off. The Transportation coordinator will immediately notify Administrator/Director of Nursing/ Assistant Director of Nursing of the status of patient. All licensed nurses RN and LVN, DON/ADON's, educated on Abuse/neglect, resident rights, change in condition, and procedure for patients out on appointments which includes follow up if resident is out of facility on MD appointment greater than 3 hours, Nurse is to call MD office to follow up to ascertain patient status. All licensed staff RN/LVN in serviced on use of transportation log, which will be at every nursing station. All staff in-serviced on abuse/neglect, resident rights by administrator/DON.	-	-	-	-
	No actions taken. The facility's Tube Feeding policy dated [DATE] indicated to ensure that the facility met the nutritional guidelines and resident's nutritional requirements per the physician's orders.				

Attachment C: Jack Shelby Affiliated Entities Owned Facilities Deficiencies and Survey Results
Source: ProPublica Nursing Home Inspection/Survey Results

List facilities that are required for review under 10.24.20.05(8)	SFF	Date of the Survey	Deficiencies	Deficiencies (Cont.)	Description	Seriousness
BEDFORD WELLNESS & REHABILITATION	-	6/23/2023	Pharmacy Service Deficiency — F0755	Failure to: Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.	The facility failed to provide pharmaceutical services, including procedures that assure the accurate dispensing and administering of all drugs and biologicals, to meet the needs of each resident for 1 (Resident #1) of 7 residents reviewed for medication administration. The facility failed to ensure Resident #1's blood sugars were monitored and insulin administered as ordered by his physician.	G
BENBROOK NURSING & REHABILITATION CENTER	-	12/7/2023	Quality of Life and Care Deficiency — F0689	Failure to: Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.	The facility failed to provide adequate supervision for 1 of 10 residents (Resident #1) reviewed for wandering and elopement risk. The facility failed to implement effective interventions for Resident #1 identified as at-risk for elopement and had a history of elopement. On 12/03/23 at approximately 1:15 PM, Resident #1 was demonstrating exit-seeking (actively trying to leave the boundaries of a particular area) behaviors by attempting to go out the exit door when the alarm sounded off. LVN A verbally redirected Resident #1 to come to the nurse's station. On 12/03/23, Resident #1 eloped (an unauthorized departure of a resident from an around-the-clock care setting) from the secured unit unnoticed by facility staff. On 12/03/23 at 1:43 PM, Resident #1 was struck by a vehicle while crossing a major intersection 1.4 miles from the facility, sustaining an injury to his right arm.	J
		12/11/2022	Quality of Life and Care Deficiency — F0695	Failure to: Provide safe and appropriate respiratory care for a resident when needed.	The facility failed to provide timely emergency respiratory care consistent with professional standards of practice, including maintaining training for nursing staff regarding expectations for suctioning residents in the on-site dialysis center, for a resident in respiratory distress in the facility's in-house, contracted dialysis center for one (Resident #1) of one resident reviewed for tracheostomy care. 1. Facility staff failed to respond immediately to a request by contract dialysis staff to provide suction for Resident #1 when she had respiratory distress on 10/25/22, at which time Resident #1's distress increased, and she stopped breathing and became unresponsive for an estimated 45 seconds. At this time facility staff began to provide trach suctioning, approximately 12 minutes after dialysis staff initially started attempting to get help from facility staff. 2. A nurse (thought to be LVN J by dialysis staff), refused to provide immediate trach suctioning for Resident #1 on 11/11/22, as requested by contract dialysis staff, when Resident #1 was having gurgling and wet rattling during breathing, and felt she was having increased trouble breathing, and anxiety. This required dialysis staff to attempt to find other nursing facility staff to suction Resident #1's trach, causing a delay in making her comfortable, and a delay in their ability to begin her dialysis treatment timely, and deliver the full treatment.	G

Attachment C: Jack Shelby Affiliated Entities C

Source: ProPublica Nursing Home Inspection/Survey

		Medicare			
List facilities that are required for review under 10.24.20.05(8)	**Action Taken**	**Penalty Date**	**Payment Denial Length in Days**	**Payment Denial Start Date**	**Payment Denial End Date**
BEDFORD WELLNESS & REHABILITATION	No actions taken. The facility's Telephone Orders for Medication policy dated [DATE] indicated the receiver documents the order immediately to reduce errors misinterpreted verbal or telephone communication of physician orders.	-	-	-	-
BENBROOK NURSING & REHABILITATION CENTER	COO in-serviced DON and NFA on Code Silver Policy and Procedure, updating wandering assessments, changing door codes, and checking all door exits and windows. All windows on locked unit have been permanently secured by DOM to ensure they do not open fully, and no resident was able to exit via the window. All non-permanent furniture has been removed from the secure unit courtyard. All staff have been in-serviced by the DON, ADON, and Administrator on the prohibition of non-permanent furniture in the secure unit courtyard. Aall residents have updated wandering assessments completed by DON, ADON, and MDS. Any resident who was designated at risk - which will be determined by the IDT (DON, ADON, and MDS) was placed on the secure unit with an order from the physician. All residents who are determined to be at risk of wandering will have a personalized care plan updated by DON, ADON, and MDS. no plan of action in report	-	-	-	-

Attachment C: Jack Shelby Affiliated Entities Owned Facilities Deficiencies and Survey Results

Source: ProPublica Nursing Home Inspection/Survey Results

List facilities that are required for review under 10.24.20.05(8)	SFF	Date of the Survey	Deficiencies	Deficiencies (Cont.)	Description	Seriousness
BLUEBONNET REHAB AT ENNIS	-	-	-	-	-	-
BRENTWOOD PLACE ONE	-	7/21/2023	Freedom from Abuse, Neglect, and Exploitation Deficiency — F0600	Failure to: Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.	the facility failed to protect the resident's right to be free from neglect for one (Resident #1) of twenty residents reviewed for neglect. 1) On 07/15/23, LVN A unlocked and opened an exit door to allow Resident #1 to leave a secured unit without supervision. Resident #1 had not been located was not located as of 07/21/23. 2) LVN A failed to evaluate Resident #1's mental status, pertinent medical conditions, mental health diagnoses, risk of harm to self or tried to prevent the departure when Resident #1 stated wanting to leave the facility. 3) LVN A failed to notify the attending physician, on call physician, or medical director of Resident #1's departure from the facility after opening an access-controlled locked door to allow Resident #1 to exit the secured facility. 4) LVN A failed to follow the Abuse Prevention and Prohibition Program policy and failed to follow the policy for Discharge Against Medical Advice.	J
BRENTWOOD PLACE THREE	-	-	-	-	-	-
BRENTWOOD PLACE TWO	-	2/29/2024	Freedom from Abuse, Neglect, and Exploitation Deficiency — F0600	Failure to: Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.	The facility failed to protect Resident #1 from neglect when they failed to conduct adequate therapeutic drug monitoring of Resident #1's lab levels who was receiving lithium. This led to Resident #1 being admitted to acute care hospital on 06/30/23 and was diagnosed with acute toxic encephalopathy secondary to lithium toxicity. Lab records revealed Resident #1's lithium level was 5.3 mmol/L (critical level) when he arrived at the hospital.	J
			Pharmacy Service Deficiency — F0757	Failure to: Ensure each resident's drug regimen must be free from unnecessary drugs.	The facility failed to conduct adequate therapeutic drug monitoring of Resident #1's lab levels who was receiving lithium. This led to Resident #1 being admitted to acute care hospital on 06/30/23 and was diagnosed with acute toxic encephalopathy secondary to lithium toxicity. Lab records revealed Resident #1's lithium level was 5.3 mmol/L (critical level) when he arrived at the hospital.	J

Attachment C: Jack Shelby Affiliated Entities C

Source: ProPublica Nursing Home Inspection/Survey

		Medicare			
List facilities that are required for review under 10.24.20.05(8)	**Action Taken**	**Penalty Date**	**Payment Denial Length in Days**	**Payment Denial Start Date**	**Payment Denial End Date**
BLUEBONNET REHAB AT ENNIS	-	-	-	-	-
BRENTWOOD PLACE ONE	1. Training for all staff in response to resident AMA was initiated on 7/15/23 and completed by the RDO. a. The Facility Staff member who finds that a resident wishes to leave the facility will alert the charge Nurse. The charge nurse will verbalize and document any verbal and/or physical exit seeking behaviors to the oncoming shift and 24hrs report. 2. A licensed nurse will notify the attending physician, on call physician, or medical director of the resident's desire to leave the Facility AMA Training for all licensed nursing staff on completion of accurate elopement assessments initiated on 7/17/23 and will be ongoing until all staff have completed the training. 3. The Facility and/or physician will discuss with the resident and/or the resident's personal representative, if applicable, the reason for the AMA decision and will advise them of the potential consequences of the AMA decision. 4. A licensed nurse will have the resident or the residents' personal representative sign Discharge AMA, or similar form located in the Facility's EHR. 5. Nursing staff will document in the progress notes all pertinent information concerning the residents' actions, including the resident's stated reasons for his/her desire to leave the Facility. Nursing staff will document in the progress notes all pertinent information concerning the resident's actions, including the resident's stated reasons for his/her desire to leave the Facility. Residents with a history of wandering or who IDT have assessed to be at risk for wandering or elopement will have a photograph maintained in their medical record and Elopement/Wandering Risk Binder	-	-	-	-
BRENTWOOD PLACE THREE	-	-	-	-	-
BRENTWOOD PLACE TWO	The facility implemented the following interventions: Review of a neglect/abuse in-service dated 09/25/23 was provided by the Adm to all staff Record review of order listing report reflect Resident #2 on lithium. Interviews and record review reflected serum level for lithium was done routinely and reflected no concerns. Record review of the inservice dated 10/02/23 revealed the RNC in-serviced ADONs and nurses on timely report labs, notify physician on time, review admission orders. Notify physician if monitoring order for psych medication was missing. Further review of the inservice dated 10/02/23 revealed charge nurse would review all new admission orders and verify with the physician on all new lithium and required lab orders, ADONs would be responsible for reviewing the admission orders in the interval of 24 hours for lithium have the appropriate monitoring orders. The DON would review the admission orders in 72 hours, and the RNC would do a weekly review. Record review of the inservice dated 10/02/23 revealed the RNC in-serviced the DON, ADON B, ADON C and LVN A on Lab/Radiology/Physician orders: transcribing physician orders and clarification of physician order relater to medication monitoring. An impromptu Quality Assurance and Performance Improvement was completed on 10/09/23with the MD, Administrator, DON, ADONs, and Social Worker. Record review revealed on 02/28/23, the facility reviewed of all residents in the facility and identified no other resident on lithium or any other psychotropic medication requiring therapeutic monitoring. Interview on 02/28/23 were conducted from 2:23 PM to 5:29 PM with the following staff who represented all shifts: ADON B, ADON C, LVN D, LVN E, LVN A, LVN F, LVN G, and MA I. Individual interviews revealed they had received in-service training on abuse and neglect. All staff were able to verbalize understanding of in-service training regarding abuse and neglect. Interviews on 02/29/23 were completed from 11:48 AM to 12:12 PM with the DON, ADON B, and ADON C which revealed they were in-serviced on abuse and neglect. Review of the facility's policy titled Abuse Prevention and Prohibition Program, revised August 2020 reflected, .Each resident has the right to be free from mistreatment, neglect, abuse, involuntary seclusion and misappropriation of property. The Facility has zero-tolerance for abuse, neglect, mistreatment, and/or misappropriation of resident property.	-	-	-	-

Attachment C: Jack Shelby Affiliated Entities Owned Facilities Deficiencies and Survey Results

Source: ProPublica Nursing Home Inspection/Survey Results

List facilities that are required for review under 10.24.20.05(8)	SFF	Date of the Survey	Deficiencies	Deficiencies (Cont.)	Description	Seriousness
BRENTWOOD PLACE TWO	-	7/13/2023	Resident Assessment and Care Planning Deficiency — F0656	Failure to: Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.	The facility failed to implement a care plan which included monitoring and interventions to prevent Resident #1 (who was identified with severe cognitive impairment and being at moderate risk for elopement) from eloping from the facility, unsupervised on 06/24/23 and his whereabouts remained unknown.	J
			Quality of Life and Care Deficiency — F0689	Failure to: Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.	The facility failed to implement procedures, monitoring and interventions to prevent Resident #1 (who was identified with severe cognitive impairment and being at moderate risk for elopement) from eloping from the facility unsupervised on 06/24/23 and his whereabouts remained unknown.	J
BROOKHAVEN REHAB & HEALTH CARE CENTER L L C	-	-	-	-	-	-

Attachment C: Jack Shelby Affiliated Entities C

Source: ProPublica Nursing Home Inspection/Survey

		Medicare			
List facilities that are required for review under 10.24.20.05(8)	**Action Taken**	**Penalty Date**	**Payment Denial Length in Days**	**Payment Denial Start Date**	**Payment Denial End Date**
BRENTWOOD PLACE TWO	Identify responsible staff/ what action taken. 1. Training for all licensed nursing staff on completion of accurate elopement assessments was initiated on 6/27/2023 by Regional Nurse consultant. 2. Training for all licensed nursing staff was initiated on 6/27/23, on notification of elopement assessments that trigger for moderate or higher will require DON, ADON and/or MDS notification. Training was conducted by the RNC . 3. Training for DON/ADON/MDS was initiated on 6/27/23 on care plan completion and interventions regarding elopement assessment for those that trigger as moderate or higher risk by Regional Nurse Consultant. 4. DON/ADON/MDS/weekend supervisor retraining was initiated on 6/27/23 by the Regional Nurse Consultant of overview of reviewing elopement risk assessment for accuracy, completion, interventions and updating care plans to reflect elopement risk. 5. DON/ADON/MDS completed audit of all resident elopement assessments on 6/27/23. 6. All residents with moderate risk score were care planned by DON/ADON/MDS on 6/27/23, with no residents at imminent risk identified. 7. All staff retraining has been initiated 6/24/2023 on response to resident elopement. No staff will be allowed to return to work without completion of required training. The DON initiated training. In-Service conducted. 1. Training for all staff on response to resident elopement initiated on 6/24/23. a. The Facility Staff member who finds that a resident is missing will alert the charge Nurse. b. The Charge Nurse will call CODE PINK and organize a search. Facility Staff will search areas of the Facility, including communal areas, bathrooms, showers, outside areas, etc. c. If the resident cannot be located, the Charge Nurse will notify Administrator/designee ii. Director of Nursing Services/designee, Attending Physician iv. Responsible Party. 2. Training for all licensed nursing staff on completion of accurate elopement assessments initiated on 6/27/23. 3. Training for all licensed nursing staff was initiated on 6/27/23, on notification of accurate elopement assessments that trigger for moderate or higher to notify DON/ADON/MDS. 4. Training for DON/ADON/MDS/weekend supervisor was initiated on 6/27/23 on care plan completion and interventions regarding elopement assessment for those that trigger as moderate or higher. 5. Retraining was initiated on 6/27/23 with DON/ADON/weekend supervisor for oversight of reviewing elopement risk assessment for accuracy, completion, interventions and updating care plans to reflect elopement risk. Implementation of Changes Training for DON/ADON/MDS/weekend supervisor was initiated on 6/27/23 on care plan completion and interventions regarding elopement assessment for those that trigger as moderate or higher. The Regional Nurse Consultant started the changes. The changes were implemented effective on 6/27/2023 and training was completed on 6/28/2023. Staff will not be allowed to work until they have been fully re-educated. All new hires will be educated on elopement protocol/response prior to working the floor. The Director of Nursing will ensure competency through signing of in service, verbalization of understanding and completion of returned questionnaire. All licensed nurses will notify DON/ADON/MDS if elopement risk is moderate or higher. The DON/ADON/MDS will review all elopement assessments daily in morning clinical meeting and care plan if necessary. Weekend supervisor/ designee will review all elopement assessments over the weekend for accuracy and care plan if necessary. Regional Nurse Consultant will complete audit of elopement assessments daily x 30 days then weekly thereafter. Monitoring The Administrator/Director of Nursing/Assistant Director of Nursing/Regional Nurse Consultant will be responsible for monitoring the implementation and effectiveness of in-service on 6/28/2023. o The Administrator/Director of Nursing/Assistant Director of Nursing/Regional Nurse Consultant will monitor/review all elopement assessments daily x4 weeks, then weekly thereafter and report any adverse finding during QAPI . o Director of Nursing/Assistant Director of Nursing will conduct a daily audit of Elopement assessment x4 weeks, then weekly thereafter and report any adverse findings during QAPI.	-	-	-	-
BROOKHAVEN REHAB & HEALTH CARE CENTER L L C	-	-	-	-	-

Attachment C: Jack Shelby Affiliated Entities Owned Facilities Deficiencies and Survey Results

Source: ProPublica Nursing Home Inspection/Survey Results

List facilities that are required for review under 10.24.20.05(8)	SFF	Date of the Survey	Deficiencies	Deficiencies (Cont.)	Description	Seriousness
CHEROKEE TRAILS NURSING HOME	-	9/25/2024	Quality of Life and Care Deficiency — F0689	Failure to: Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.	The facility failed to put interventions in place to prevent Resident #1 from sliding out of the wheelchair during transport on 2/19/24 and ensure that she was secured by the shoulder and lap belt harness, resulting in Resident #1 sliding out of her wheelchair during transport. The facility failed to ensure the transport staff were aware of how to properly position the shoulder and lap belt harness to ensure Resident #1 did not have forward bodily movement in the event of the driver had to quickly stop the van.	J
		7/27/2023	Resident Rights Deficiency — F0584	Failure to: Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.	The facility air conditioning system had not been working adequately for at least 4 days. The temperature of a common area (dining room) used by the residents was above 81 F. The temperature of a common area of the secured unit (dining area/TV room) used by the residents was above 81 F. The temperature of a common area (lobby/TV room) used by the residents was above 81 F.	K

Attachment C: Jack Shelby Affiliated Entities C

Source: ProPublica Nursing Home Inspection/Survey

		Medicare			
List facilities that are required for review under 10.24.20.05(8)	**Action Taken**	**Penalty Date**	**Payment Denial Length in Days**	**Payment Denial Start Date**	**Payment Denial End Date**
CHEROKEE TRAILS NURSING HOME	1. Immediate Action Taken A. Resident #1 remains in the facility on 9/24/24. B. The facility's van immediately stopped all van transport on 9/24/2024 at 4:00 pm. C. The Administrator or designee completed the following with the two facilities designated van drivers: In-service education on the Transportation Policy which provides direction on duties of driver, driving of the van, how to operate the wheelchair lift and the wheelchair securement system, use of seat and shoulder harness, and how to transport more than 1 wheelchair. This was completed on 9/24/2024 at 7:00 pm. In-service education on Q'Straint QRT-1 Series User Instructions which provides direction on wheelchair securement, passenger securement and passenger release. This was completed on 9/25/24 at 12:00 pm. In-service education provided to van driver by administrator/designee on weekly maintenance log which includes checking operable seatbelt straps, W/C/ tie down, shoulder strap, floor W/C tie down straps that van driver will complete and provide to administrator/designee weekly. This was completed on 9/24/2024 at 7:00 pm. Sister facility maintenance director completed a skills validation check list on van driver to acknowledge skills competence on how to operate the wheelchair lift and the wheelchair securement system, seatbelts including shoulder harness. The van driver completed a return demonstration. This will be completed on 9/25/2024 at 2:00 pm. The Maintenance Director completed training with sister facility maintenance director on wheelchair securement, passenger securement and passenger release. A skills validation check list was completed on maintenance director to acknowledge skills competence on how to operate the wheelchair lift and the wheelchair securement system, seatbelts including shoulder harness. This will be completed on 9/25/2024 at 2:00 pm. The Maintenance Director completed In-service education on Q'Straint QRT-1 Series User Instructions which provides direction on wheelchair securement, passenger securement and passenger release. This was completed on 9/25/24 at 12:00 pm. The Administrator and/or designee reviewed with van driver, a new signed job description. This was completed on 9/24/2024 at 7:00 pm. 2. Identification of Residents Affected or Likely to be Affected: A. No other residents identified, all scheduled van transports for the remainder of the week will be transported by an outside vendor. This will allow the facility time for training all van drivers, complete skills competencies and return demonstration, with all van drivers. 3.Actions to Prevent Occurrence/Recurrence: A. As of 9/24/2024, any staff member hired for van transports will be provided the following by the facility maintenance supervisor. In-service education on the Transportation Policy which provides direction on duties of driver, driving of the van, how to operate the wheelchair lift and the wheelchair securement system, use of seat and shoulder harness, and how to transport more than 1 wheelchair prior to driving the van. In-service education on Q'Straint QRT-1 Series User Instructions which provides direction on wheelchair securement, passenger securement and passenger release. In-service education on weekly maintenance log which includes checking Operable seatbelt straps, W/C/ tie down, shoulder strap, floor W/C tie down straps that van driver will complete and provides to administrator/designee weekly. Completed a skills validation check list on van driver to acknowledge skills competence on how to operate the wheelchair lift and the wheelchair securement system, seatbelts including shoulder harness, and will complete a return demonstration. Have van driver sign job description duties. B. The weekly maintenance log will be reviewed in the morning meeting by the Administrator or designee. On 9/24/2024 the facility's Administrator notified the Medical Director regarding the Immediate Jeopardy the facility received related to Accidents/Hazards/Supervision and reviewed plan to sustain compliance Immediate action taken: On 7/24/2023 the 10 residents on the Secure Unit were move to other beds throughout the facility at 6:15 pm. All windows were checked by maintenance director, and all were locked. On 7/25/2023 facility will increase staff back to 7 staff members on this unit from 3:00 pm until wireless audible window alarms can be placed on windows on this unit. On 7/24/2023 there were 7 staff members (6 nurse assistants and 1 licensed nurse) assigned to the unit that housed these 10 residents. On 07/25/2023 there would be 2 staff members that would be assigned to door monitor for both doors that leave the unit. These 2 staff will sit inside the unit monitoring the closed door that exits out into the facility, and the end door that exits out of the facility 24 hours a day ensuring that no residents leave the unit, until residents can be moved back to the secure unit. These 2 monitors will have no other duties but monitor the door and ensure the safety of the residents. During break periods, these 2 monitors will be relieved by staff from other areas of the building. Each monitor will document times of duties/responsibilities for each shift covered. This went into effect 7/25/2023 at 6:30 pm. On 7/25/2023 there will be 1 licensed nurse, and 2 nurse assistants assigned to provide direct care to the 10 residents on this unit. This went into effect 7/25/2023 at 6:30 pm. On 7/24/2023 the DON/Designee completed an assessment on the 10 residents on the secure unit for signs/symptoms of dehydration, heat exhaustion and heat stroke. The physician will be notified if any resident has any symptoms of dehydration, heat exhaustion, or heat stroke. This was completed 7/24/2023. On 7/24/2023 An air conditioner company was notified of the need for air conditioning repair in the facility. On 7/25/2023 Regional Nurse consultant provided 1:1 education to the facility/maintenance director related to scheduling repairs when any system malfunctions. On 7/25/2023 the air conditioner company is in the center working on the air conditioner units that are not working. The air conditioner in the kitchen has been repaired. The air conditioner for the lobby and the secured unit will be repaired by 5:00 pm 7/25/2023. The air conditioner for the lobby and for the secure unit has been repaired, operating, and working. 2. Identification of Residents Affected or Likely to be Affected: Maintenance Director/Designee completed rounds on 7/24/2023 to validate that all other air conditioners were operational. On 7/25/2023, air conditioner in the kitchen has been repaired. The air conditioner for the lobby and the secured unit will be repaired by 5:00 pm 7/25/2023. The air conditioner for the lobby and for the secure unit has been repaired, operating, and working. On 7/26/2023 the air conditioner unit in the Dining room went down about an hour ago. The Maintenance Director will place two refrigerated window units in the Dining Room today 7/26/2023 to ensure that the temperature in the Dining Rooms remains at 80 degrees or cooler until the Air Conditioner Unit can be repaired. The lobby air conditioner is operational. On 7/26/2023 the air conditioner in the lobby is not maintaining temperatures at a comfortable level. All residents were removed from the lobby area at this time, and the center will place Evaporated units in the lobby areas to maintain the temperature at or below 80 degrees. Laundry Supervisor will be taking temperatures in the lobby and Dining area this evening and tonight to validate temperature is at 80 or below. Resident will be encouraged to not sit in these areas and will be removed from lobby and Dining Rooms if temperature is not maintained. 3. Actions to Prevent Occurrence/Recurrence: On 7/24/2023 the Regional Nurse Consultant provided education to the Director of Nurses, and the Maintenance Director on the center's Extreme Weather Policy including assessing resident for any signs/symptoms of distress or discomfort, re-locating resident to a cooler part of the facility if temperature go above 81 degrees, providing cool cloths and fan for circulation, encourage hydration and notification to the Regional Nurse Consultant or Regional Director of Operations if applicable. This was completed at 8:00 pm 7/24/2023. On 7/25/2023 hydration rounds were increased for all residents in the center to 4 times a day (not including meal times) On 7/24/2023 the Regional Director of Operations will provide education to the Administrator via Telephone on the center's Extreme Weather Policy including assessing resident for any signs/symptoms of distress or discomfort, to re-locating resident to a cooler part of the facility if temperature go above 81 degrees, providing cool cloths and fan for circulation, encourage hydration and notification to the Regional Nurse Consultant or Regional Director of Operations if applicable. The education also covered reportable events (loss of HVAC system in an emergency and need to report). This was completed at 8:00pm on 7/24/2023. On 7/24/2023 the DON/designee will provide education to all staff currently in the center on Extreme Weather Policy.	-	-	-	-

Attachment C: Jack Shelby Affiliated Entities Owned Facilities Deficiencies and Survey Results

Source: ProPublica Nursing Home Inspection/Survey Results

List facilities that are required for review under 10.24.20.05(8)	SFF	Date of the Survey	Deficiencies	Deficiencies (Cont.)	Description	Seriousness
CHEROKEE TRAILS NURSING HOME	-	7/27/2023	Environmental Deficiency — F0919	Failure to: Make sure that a working call system is available in each resident's bathroom and bathing area.	The facility failed to be adequately equipped to allow residents to call for staff assistance when needing help due to call light malfunction. The facility failed to ensure Residents #5 and #6 had a working call light. The facility failed to ensure all residents on the secured unit had a working call light.	K

Attachment C: Jack Shelby Affiliated Entities C

Source: ProPublica Nursing Home Inspection/Survey

		Medicare			
List facilities that are required for review under 10.24.20.05(8)	**Action Taken**	**Penalty Date**	**Payment Denial Length in Days**	**Payment Denial Start Date**	**Payment Denial End Date**
CHEROKEE TRAILS NURSING HOME	1. Immediate Action Taken: Resident # 5 was given a new call button. Resident # 6 was given a Med. Alert call button. DON/Designee completed rounds for all residents on [DATE] at 7:00 pm and validated that there were 7 residents who did not have a call light system. These residents were given bells to use as audible alarms and instructions on their use on [DATE]. DON/Designee completed rounds for all residents on [DATE] at 7:00 pm and validated that there were 23 residents that do not have a visual call light system (16 of these do have a Med. Alert call system). Staff will check all Med. Alert devices every shift to ensure they are working, batteries are working, and that alarm can be heard with the door closed, and there is no signal interruption when doors are closed and that they are not broken or misplaced. This will be documented, and the documentation will be retained in the DON office. A staff member on each shift will be responsible to complete the rounds on each shift to check the Med. Alert devices and document on the Med. Alert monitoring tool. The DON or designee will be responsible to collect and review the Med. Alert monitoring tool daily. On [DATE] at 7:00 pm Staff will start every 1-hour visual check of the 23 residents that do not have a visual call light system with documentation. This will remain in effect until the call light system can be repaired. This documentation will be retained in the DON office. A staff member on each shift will be responsible to complete the rounds on each shift to check residents that do not have a visual call light and document on Every 1-hour monitoring tool. The DON or designee will be responsible to collect and review Every 1-hour monitoring tool daily. On [DATE] The Regional Director of Operations will contact a Call Light Systems Company to come onsite to provide a bid for repair. The center has contacted a company to come to the facility to provide a bid to repair the call light system on [DATE]. 2. Identification of Residents Affected or Likely to be Affected: DON/Designee completed rounds for all residents on [DATE] at 7:00 pm to validate that no resident needed emergency assistance. On [DATE] going forward, all new or readmit resident will have a call light system upon admission. This will be validated daily on rounds by DON or designee. 3. Actions to Prevent Occurrence/Recurrence: On [DATE] DON/Designee started education on Resident call light Policy for all staff. This education was completed on [DATE] at 10:00 pm, and no staff will be allowed to work until this education has been completed. On [DATE] DON/Designee started education on Monitoring tool that will be used every 1 hour to monitor residents without a visual call light. This education was completed on [DATE] at 10:00 pm, and no staff will be allowed to work until this education has been completed. This documentation will be retained in the DON office. Staff will check all Med. Alert devices every shift to ensure they are working, batteries are working, and that alarm can be heard with the door closed, and there is no signal interruption when doors are closed and that they are not broken or misplaced. This will be documented, and the documentation will be retained in the DON office 4. Monitoring On [DATE] at 7:00 pm the facility staff will use the Resident Monitoring tool to round on residents with no visual function call system every 1 hour until the call system can be repaired.	-	-	-	-

Attachment C: Jack Shelby Affiliated Entities Owned Facilities Deficiencies and Survey Results

Source: ProPublica Nursing Home Inspection/Survey Results

List facilities that are required for review under 10.24.20.05(8)	SFF	Date of the Survey	Deficiencies	Deficiencies (Cont.)	Description	Seriousness
CHEROKEE TRAILS NURSING HOME	-	7/27/2023	Freedom from Abuse, Neglect, and Exploitation Deficiency — F0600	Failure to: Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.	On 03/25/2023 at 04:39 PM, LVN P grabbed Resident #2 by the face and shoved her back on the couch, then pulled her to a standing position by the arm and turned her around and shoved her in the back pushing her away from LVN P. On 03/25/2023 CNA Q witnessed abuse by LVN P on 03/25/20223 and did not report Abuse and Neglect to the Abuse Coordinator until the day after the incident on 03/26/2023.	J
			Freedom from Abuse, Neglect, and Exploitation Deficiency — F0607	Failure to: Develop and implement policies and procedures to prevent abuse, neglect, and theft.	The facility failed to implement their policies and procedures related to reporting allegations of allegations of abuse when CNA Q failed to report abuse, she witnessed on 03/25/2023 until 03/26/2023 to the abuse coordinator.	J
			Quality of Life and Care Deficiency — F0689	Failure to: Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.	The facility failed to respond to door alarm that resulted in Resident #4 elopement on 06/14/2023. Resident #4, who had dementia and a history of previous attempts of elopement, left the facility through an alarmed door on 06/14/2023 at 04:30 AM while wearing a wander guard. The resident wandered 0.3 miles in a wheelchair down the street and was intercepted by a passerby who returned Resident #4 to the facility.	J

Attachment C: Jack Shelby Affiliated Entities C

Source: ProPublica Nursing Home Inspection/Survey

		Medicare			
List facilities that are required for review under 10.24.20.05(8)	**Action Taken**	**Penalty Date**	**Payment Denial Length in Days**	**Payment Denial Start Date**	**Payment Denial End Date**
CHEROKEE TRAILS NURSING HOME	Immediate Action: On 3/27/2023 DON/Designee immediately suspended staff member pending outcome of investigation (and was subsequently terminated) On 3/26/2023 DON/Designee reported incident to the local police department. On 3/26/2023 Administrator reported Incident to Health and Human Services Department. On 3/26/2023 and 3/27/2023 DON/Designee obtained witness statements from witnesses involved in the incident. On 3/26/2023 Administrator reviewed video surveillance of incident on facility camera. On 3/27/2023 DON/Designee started education on the facilities Abuse and Neglect Compliance Policy to all staff (which included: Signage of what and when to report abuse, Reporting Abuse guidelines, Resident Rights policy) On 7/26/2023 at 1:30 pm the Regional Nurse Consultant will provide 1:1 education to the facility's CNA Q who failed to notify the Administrator/DON immediately of the witnessed abuse on 3/25/2023. On 7/26/2023 at 1:00 pm the Regional Nurse Consultant provided 1:1 education to the Administrator and DON on the facility's abuse policy which included: o Definition of Abuse/Neglect, Explanation and compliance guidelines, Components of Abuse prohibition, Prevention of abuse/neglect, Identification of abuse neglect, investigating abuse/neglect, Resident protection, reporting timely abuse and neglect and QAPI. On 7/26/2023 the Business Office Manager completed 100% audit of all employee's personal files to validate that all required staff had required backgrounds checks completed on hire. This will be completed by 6:00 pm on 7/26/2023. Identification of Residents Affected or Likely to be Affected: On 3/27/2023 Social Services/Designee completed alert resident interview to validate that all resident felt safe. On 3/27/2023 Administrator reviewed video surveillance cameras to validate that no other residents were affected by the actions of this staff member. On 7/26/2023 Social Worker/Designee completed interviews with alert resident to validate all residents feel safe. This will be completed by 6:00 pm on 7/26/2023. The DON verbalized that she did not assess residents in the secure unit on 3/26/2023 to validated that no resident had any signs or symptoms of physical or emotional distress. DON was provided 1:1 education by the Regional Nurse Consultant on 7/26/2023 on identifying like residents when an abuse incident occurs. Actions to Prevent Occurrence/Recurrence: On 3/27/2023 DON/Designee started education with all staff on the facilities Abuse and Neglect Compliance Policy (which included: Signage of what and when to report abuse, and reporting abuse to the abuse coordinator, Reporting Abuse guidelines, Resident Rights policy) On 7/26/2023 the DON/Designee started education with staff on the facility's abuse policy which included: o Definition of Abuse/Neglect, Explanation and compliance guidelines, Components of Abuse prohibition, Prevention of abuse/neglect, Identification of abuse neglect, investigating abuse/neglect, Resident protection, reporting timely abuse and neglect, and reporting abuse to the abuse coordinator, and QAPI This was completed on 7/26/2023 at 12:00 pm, and no staff will be allowed to work after this date and time until they receive this education. Monitoring: Social Services/Designee will complete weekly alert resident interviews x 4 weeks to validate that all residents feel safe and free from abuse. The DON/designee will validate with daily rounds that cognitively impaired residents are free from signs of abuse. On 7/25/2023 at 7:30 pm the DON notified the facility's medical director regarding the Immediate Jeopardy the facility received related to abuse and neglect. On 7/26/2023 at 1:30 pm the facility will conduct an Ad Hoc QAPI meeting to discuss the cite related to abuse, and on plan to sustain compliance.	-	-	-	-
	1. Immediate Action: On 6/14/2023 resident # 4 was placed on the secure unit to prevent further attempts for elopement and to keep resident safe. Family and physician were notified. On 6/14/2023 a new elopement assessment was completed for resident # 4 by DON/designee. On 6/14/2023 an assessment of resident # 4 was completed by DON/designee with no signs of distress or injury. On 7/26/2023 all doors were checked by Maintenance Director/Designee to validate that all are secure and functional with either a wander guard system or a mag-lock system 2. Identification of Residents Affected or Likely to be Affected: On 6/14/2023 a head count was completed by DON/designee to validate that all other residents were in the facility and accounted for. On 6/16/2023 an elopement assessment was completed on all 44 other residents in the facility by DON/Designee. No other residents in the general population were identified as elopement risk per the elopement assessment. On 7/26/2023 at 9:30 am DON/Designee identified only 1 resident who had a Wander guard on in the facility. This resident was evaluated by the DON to determine Elopement risk. Based on elopement risk assessment, this resident was moved to the secure unit with notification to physician and family. No other residents in the facility are wearing a wander guard bracelet. 3. Actions to Prevent Occurrence/Recurrence: On 6/14/2023 DON/Designee educated staff on Safety Training (that included Missing resident guidelines and head count guidelines) This education provides information on: (1) missing resident guidelines what do if a resident is missing, (2) how to conduct a head count to ensure no other residents have left the facility, (3) article on Nursing home abuse, center's missing patient guideline regarding investigation and root cause analysis. On 7/26/2023 DON/Designee began education with staff on Elopement/Wandering/Missing resident Policy which entails: (1) definitions, (2) Explanation and compliance guidance, (3) Process for locating a missing resident, (4) procedure post elopement. Head Count Clinical Practice Guidelines which entail: (1 process for conducting a head count when a resident is missing, (2) explanation and compliance guidance. This will be completed at 12:00 pm on 7/26/2023, and no staff will be allowed to work after this date and time until they have completed this education. On 7/26/2023 at 2:00 pm DON/Designee will conduct a missing resident drill on the Am shift to validate staff's knowledge on response to an elopement. On 7/26/2023 DON/Designee will conduct a missing resident drill at the beginning of the evening and the night shift before staff start work, to validate staff's knowledge on response to an elopement. Beginning on 7/26/2023, any new or readmit resident will have an elopement assessment completed upon admission to determine the resident's risk for elopement. Any resident with a risk of elopement will be evaluated for placement on the secure unit with order from physician and family notification. The DON/designee will be responsible for this evaluate for placement on the secure unit based on the elopement risk assessment. As of 7/26/2023 the center will not use the Wander guard bracelets in the center. 4. On 7/25/2023 the DON/Designee notified the facility's Medical Director of the Immediate Jeopardy that facility was cited for at 7:30 pm. On 7/26/2023 the facility will conduct an Ad Hoc QAPI meeting to discuss the Immediate Jeopardy related to Accidents/Hazards and on sustaining compliance.				

Attachment C: Jack Shelby Affiliated Entities Owned Facilities Deficiencies and Survey Results

Source: ProPublica Nursing Home Inspection/Survey Results

List facilities that are required for review under 10.24.20.05(8)	SFF	Date of the Survey	Deficiencies	Deficiencies (Cont.)	Description	Seriousness
CHEYENNE MEDICAL LODGE	-	11/9/2022	Resident Rights Deficiency — F0550	Failure to: Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.	The facility staff failed to send Resident #1 to the hospital or emergency room when Resident #1 had requested at 8:47 AM, 8:49 AM and 8:59 AM on [DATE]. After one hour, Resident #1 was found unresponsive and coded at the facility on [DATE].	J
			Quality of Life and Care Deficiency — F0684	Failure to: Provide appropriate treatment and care according to orders, resident's preferences and goals.	The facility staff failed to send Resident #1 to the hospital or emergency room when Resident #1 had requested at 8:47 AM, 8:49 AM and 8:59 AM on [DATE]. After one hour, Resident #1 was found unresponsive and coded at the facility on [DATE].	J
CHILDRESS HEALTHCARE CENTER	-	-	-	-	-	-
CLARKSVILLE NURSING HOME	-	-	-	-	-	-
COLONIAL MANOR ADVANCED REHAB & HEALTHCARE	-	2/17/2024	Quality of Life and Care Deficiency — F0689	Failure to: Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.	The facility did not provide supervision to prevent Resident #51's from sustaining multiple falls in the facility.	G

Attachment C: Jack Shelby Affiliated Entities C

Source: ProPublica Nursing Home Inspection/Survey

		Medicare			
List facilities that are required for review under 10.24.20.05(8)	**Action Taken**	**Penalty Date**	**Payment Denial Length in Days**	**Payment Denial Start Date**	**Payment Denial End Date**
CHEYENNE MEDICAL LODGE	1. RN DON # 1 [DON], RN # 2 [RN Z] , LVN # 3 [ADON S], LVN # 4 [ADON E], LVN # 5 [LVN Z] , LVN # 6 [LVN C], LVN # 7 [LVN F], LVN # 8 [LVN AA] and LVN # 9 [LVN BB] on [DATE] at 4:50 p.m [PM]. immediately assessed all current residents in the facility for any condition changes or any immediate medical issues that would warrant emergency transfer to the hospital to include asking the resident if they request a transfer to a hospital. These assessments will include a thorough head to toe assessment to include vital signs; blood pressure, temperature, respiration, oxygen sats, pain, neurological, cardiovascular, respiratory, GI/elimination, musculoskeletal, skin, & psychosocial. Any immediate assessments that are being done by the facility nurses that appear to indicate a change in a resident's condition or a medical emergency, the attending physician and the family will be notified by the RN DON # 1 [DON] for further orders and disposition. These head-to-toe assessments were completed on [DATE]. Results of all head-to-toe assessments and observations indicated no signs of any changes in conditions or the need for emergency medical assistance that would warrant a transfer to a hospital. 2. RN DON # 1 [DON] conducted an in-service training on [DATE] all licensed nurses, CMAs, and CNAs on identifying and reporting resident changes in condition and reporting to the physician any changes in condition. Staff not present for the [DATE] in-service training will be in-service trained on [DATE] and completed before that staff individual is allowed to start their work shift. All newly hired nursing personnel will be trained at their Orientation to the facility on resident changes of conditions and reporting these changes to their charge nurses where further reporting will be to the resident's attending physician for appropriate disposition to include any transfers to the local hospital. Examples of changes in condition were presented in the training sessions along with verbal interaction to confirm the understanding, importance and competency of the training. The following training was competed for all facility licensed nurse and a Post Evaluation test was administered to verify competency: Detecting Changes in a Resident's Condition; Know the Resident's Normal (Baseline) Condition; Recognizing Change: Top 12 Changes in Residents; and Responsibility for Observation & Reporting. 3. If a resident request to go to the hospital the facility will contact the attending physician and family and send the resident directly to the hospital as requested. Action plan to be incorporated to ensure systems are in place to monitor corrections. The administrator and the RN DON # 1 [DON], starting [DATE] and going forward, will review all 24-hour reports at the facility's daily stand-up meetings, which are current daily on-going meetings, to ensure that any and all changes of conditions were addressed and resolved. The administrator and the RN DON #1 will review and sign off on the reports to confirm that they were reviewed and acted upon if necessary. The Corporate RN # 10 [RN CC] starting, [DATE] will do monitoring with reviews of the 24-hour reports to ensure that all issues with resident changes in conditions are being documented and addressed. Included in these reviews the Corporate RN # 10 [RN CC] will randomly interview clinical staff on the items covered in the in-service training that was concluded on [DATE] and [DATE] to ensure that staff continue to be aware of changes in resident conditions and what the communication procedures are in documenting and reporting. These 24-hour reports will be scanned to the Corporate RN # 10 [RN CC] daily who will review each report and e-mail back to the facility administrator and the RN DON # 1 [DON] with comments or further action to be done. The RN DON #1 [DON] and the facility QAPI committee met and performed a Performance Improvement Plan (PIP) the Root Cause Analysis (RCA) of the deficient practice cited on [DATE]. The facility QAPI Committee will review and monitor weekly for the next month to ensure that the intervention plan is working as designed. The facility Medical Director # 11[MD G] was notified on [DATE] of the SQC/IJ and received a copy of this action plan on [DATE]. Administration and management are confident that the immediate jeopardy to any residents at [the facility] has been removed and addressed as of [DATE].	-	-	-	-
CHILDRESS HEALTHCARE CENTER	-	-	-	-	-
CLARKSVILLE NURSING HOME	-	-	-	-	-
COLONIAL MANOR ADVANCED REHAB & HEALTHCARE	In an interview on 02/17/24 at 10:00 AM, the DON said if a fall happened, the protocol for fall management would be completed. Nursing would do their assessments and protocols of neuro checks. The immediate need would have been met. In an interview on 2/17/24 at 10:22 AM, CNA F said resident #51 required 2-person care. Resident had a helmet due to falls. CNA F said she checked on Resident #51 frequently, like every 20 minutes just to ensure he was ok. The staff had been doing hourly checks on Resident #51 for a couple months. CNA F said Resident #51's previous falls were not hard falls - there were no injuries, but staff always made sure not to move resident until the nurse checked him.	-	-	-	-

Attachment C: Jack Shelby Affiliated Entities Owned Facilities Deficiencies and Survey Results

Source: ProPublica Nursing Home Inspection/Survey Results

List facilities that are required for review under 10.24.20.05(8)	SFF	Date of the Survey	Deficiencies	Deficiencies (Cont.)	Description	Seriousness
COLONIAL MANOR ADVANCED REHAB & HEALTHCARE	-	8/17/2023	Pharmacy Service Deficiency — F0760	Failure to: Ensure that residents are free from significant medication errors.	The facility did not follow physician's orders for Resident #7 when Resident #7 was administered 1 ml of Morphine Sulfate (concentrate) Oral Solution 100 MG/5ML (Morphine Sulfate) instead physician's order of 0. 1ml morphine sulfate.	J
			Resident Rights Deficiency — F0580	Failure to: Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.	The facility failed to notify Resident #7's physician in a timely manner when Resident #7 was administered 1 ml of Morphine Sulfate (concentrate) Oral Solution 100 MG/5ML (Morphine Sulfate) instead physician's order of 0.1ml morphine sulfate on 01/10/2023.	J

Attachment C: Jack Shelby Affiliated Entities C

Source: ProPublica Nursing Home Inspection/Survey

		Medicare			
List facilities that are required for review under 10.24.20.05(8)	**Action Taken**	**Penalty Date**	**Payment Denial Length in Days**	**Payment Denial Start Date**	**Payment Denial End Date**
COLONIAL MANOR ADVANCED REHAB & HEALTHCARE	1. Immediate Action Taken On 1/10/2023 resident # 7 was sent to the hospital and never returned to the facility. On 8/11/2023 DON/Designee completed an audit of all residents receiving Morphine in the center to verify that correct dose of Morphine was entered into the computer. This will be completed at 10:00 pm on 8/11/2023. On 8/11/2023 DON/Designee completed rounds on all residents to verify that a physician's notification was completed if a resident was identified with a change of condition. No residents were identified On 8/11/2023 DON/Designee started education with all licensed nurses on: o Policy on Medication Administration Guidelines that provide directions on the process of verifying labels for accuracy, verifying administration accuracy, verifying a focused assessment, administering the medication according to the physician's orders. This will be completed by 10:00 pm on 8/11/2023, and no licensed nurse will be allowed to work until they have received this education. o Policy on Preventing/Detecting adverse consequences and Medications errors that provides directions to license nurses on immediate actions to take for a signification medication related error or adverse consequence: License nurse will notify the attending physician promptly of any significant error or adverse consequence License Nurse will Immplement (that is how it was written on POR) orders as directed by physician, and the resident is monitored closely for 24 to 72 hours or as directed. License Nurse will Communicate with other across shifts as indicated to alert staff of the need to monitor resident License Nurse will Complete an Incident report or Medication error form License Nurse to Report significant error to the DON DON will report significant error to Consultant Pharmacist This will be completed by 3:00 pm on 8/12/2023, and no licensed nurse will be allowed to work until they have received this education. The DON/Designee will be responsible for ensuring all license nurses understand and follow the guidelines for a significant error or adverse consequence. o Policy on Notification Change of Condition that provides directions on notifying family and physician when a change in a resident's conditions occurs. This will be completed by 10:00 pm on 8/11/2023, and no licensed nurse will be allowed to work until they have received this education. o A skills competency on Medication Administration will be completed for all license nurses, validating proficiency in Medication Administration to validate medication administration competency and action to take if a significant error occurs. The DON/Designee will be responsible to ensure all license nurses are proficient in Medication Administration. This will be completed by 10:00 pm on 8/11/2023, and no licensed nurse will be allowed to work until they have received this education. 2. Identification of Residents Affected or Likely to be Affected: On 8/11/2023 DON/Designee started an audit review of all residents with new orders for the past 7 days to verify that correct dose of medications was entered into the computer correctly and no significant error occurred. This will be completed by 10:00 am on 8/12/203. 3. Actions to Prevent Occurrence/Recurrence: The DON/Designee daily will review all new medication orders during the morning meeting to verify all orders were entered correctly x 30 days.	-	-	-	-

Attachment C: Jack Shelby Affiliated Entities Owned Facilities Deficiencies and Survey Results
Source: ProPublica Nursing Home Inspection/Survey Results

List facilities that are required for review under 10.24.20.05(8)	SFF	Date of the Survey	Deficiencies	Deficiencies (Cont.)	Description	Seriousness
COLONIAL MANOR ADVANCED REHAB & HEALTHCARE	-	8/17/2023	Quality of Life and Care Deficiency — F0689	Failure to: Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.	Registered Nurse (RN E) and Certified Nurse Assistant (CNA D) failed to use a mechanical lift to transfer R#4 resulting in R#4 sustaining a left femoral fracture.	J
			Pharmacy Service Deficiency — F0755	Failure to: Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.	Facility did not ensure that narcotics were reconciled as being given from the resident's eMAR to the resident's narcotic reconciliation form on medication cart.	J

Attachment C: Jack Shelby Affiliated Entities C

Source: ProPublica Nursing Home Inspection/Survey

		Medicare			
List facilities that are required for review under 10.24.20.05(8)	**Action Taken**	**Penalty Date**	**Payment Denial Length in Days**	**Payment Denial Start Date**	**Payment Denial End Date**
COLONIAL MANOR ADVANCED REHAB & HEALTHCARE	The following observations, interviews and record reviews were conducted by the survey team to ensure the Past Non-Compliance was corrected by 03/09/2023:-The following interviews were conducted by the Survey Team on 08/09/2023 and 08/10/2023: 2 CNA's, 2 LVN's, and 1 RN. -Staff acknowledged understanding of the topics they were in-serviced regarding the mechanical lift.-In-services reflect 57 staff were trained on the mechanical lift from 03/04/2023-03/09/2023.-Interviews with the DON, Administrator, and record review of the employee files reflected that CNA D and RN E were terminated due to poor performance during the incident with R #4. -On 08/17/2023, CNA N and CNA O were observed during a transfer with a mechanical lift. No discrepancies were noted.	-	-	-	-
	1. Immediate Action Taken A. DON/Designee completed a resident Pain assessment on resident #8, and #9, verified that these 2 residents did not have a negative outcome due to license nurse failure to either initial the E-MAR after the medication administration, or failure to sign out for the medication on the Narcotic controlled count sheet. Resident # 10 was discharged from the facility on 7/22/2023. This was completed on 8/13/2023 at 7:45 pm. B. On 8/13/2023 DON/Designee began education with all licensed nurses On Clinical Practice Guidelines Medication and Documentation with emphasis on: Administer the medication according to the physician order. Document initials and/or signature for medications and treatments administered on the E- MAR immediately following administration. When a controlled medication is administered the licensed nurse obtains the medication from the locked area. The licensed nurse administering the medication immediately enters the following information on the accountability record when removing the dose from controlled storage; date and time of administration, amount administered, signature of the nurse administering the dose. (Also document controlled medication dose administrated on the E-MAR) Strike out initials for those medication or treatment that were not administered and document reason for the non -administration in the clinical record. When a dose of a controlled medication is removed from the container for administration but refused or not given, the medication must be destroyed with two nurse witness. Both nurses sign the accountability record on the line representing the dose. Document PRN medication and treatment administration on the E-MAR along with the reason immediately following administration. Document effectiveness of the intervention on the E-MAR as indicated Review each E-MAR after each medication administration is completed and prior to the end of the shift to validate documentation is completed and supports services provided according to physician orders. Document omission or held medication on the 24- Hour Report Complete a Medication Error Report for medication administration discrepancies Provide a summary of medication administration issues to on-coming charge nurse during shift-to-shift report This education will be completed on 8/14/2023 by 10:00am and no licensed nurse will be able to work until this education has been completed. The DON/Designee will be responsible to ensure this education is completed and all licensed nurses understands bullet points above related to providing accurate administration and documentation of medication. 3.Actions to Prevent Occurrence/Recurrence: A. DON/Designee will use The QAPI Narcotic Monitoring form daily x 30 day to ensure that all Controlled substances are reconciled with the E-MAR: It is signed out for on the Controlled Narcotic Count sheet, that it is initialed on the E-MAR at the time of administration There is documenting for omission or held medication on the 24- Hour Report There is a completed Medication Error Report for medication administration discrepancies If a dose of a controlled medication is removed from the container for administration but refused or not given, the medication was destroyed with two nurse witness. Both nurses sign the accountability record on the line representing the dose.				

Attachment C: Jack Shelby Affiliated Entities Owned Facilities Deficiencies and Survey Results

Source: ProPublica Nursing Home Inspection/Survey Results

List facilities that are required for review under 10.24.20.05(8)	SFF	Date of the Survey	Deficiencies	Deficiencies (Cont.)	Description	Seriousness
COLONIAL MANOR NURSING CENTER	-	12/23/2023	Resident Assessment and Care Planning Deficiency — F0656	Failure to: Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.	The facility failed to update RES #28 and RES #18's CP after four separate incidents of sexual abuse: 1. The facility failed to update RES #28's CP after having climbed into RES #18's bed and having sexually touched RES #18 penis on 9-7-2023. 2. The facility failed to update RES #28's CP after having kissed RES #40 on 8-3-2023 and after having kissed RES #40 on 9-29-2023. 3. The facility failed to update RES #18's CP after having reached out and having grabbed RES #27's left breast on 11-20-2023.	K
			Freedom from Abuse, Neglect, and Exploitation Deficiency — F0600	Failure to: Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.	1. The facility failed to stop RES #28 from having climbed into RES #18's bed and having sexually touched RES #18 penis on 9/7/2023, which prompted to a law enforcement investigation, a facility self-reported incident of Resident Abuse, with no care plan update for behaviors to protect residents from further abuse. RES #18's LAR expressed RES #18 had no known history of homosexual behaviors. 2. The facility failed to stop RES #18 from having reached out and having grabbed RES #27's left breast on 11/20/2023, which led to a facility self-reported incident of Resident Abuse with no care plan update for RES #18's behaviors to protect residents from further abuse. RES #27 expressed that she did not remember the incident and maybe it was a good thing that I do not remember. 3. The facility failed to stop RES #28 from initially having kissed RES #40 on 8/3/2023, which did not prompt a care plan update for RES #28 inappropriate sexual behaviors to protect residents from further abuse or a facility self-reported incident for RES #28's behaviors; the facility failed to stop RES #28 from having kissed RES #40 a second time, on 9/29/2023, after the facility was aware of RES #28's previously known inappropriat sexual behaviors. While RES #40 recalled the second kissing incident but was unable to verbally express details, having had severely impaired cognitive impairment and having applied the reasonable person concept, RES #40 would not want a man having approached and kissed her on two separate occasions.	K

Attachment C: Jack Shelby Affiliated Entities C

Source: ProPublica Nursing Home Inspection/Survey

		Medicare			
List facilities that are required for review under 10.24.20.05(8)	**Action Taken**	**Penalty Date**	**Payment Denial Length in Days**	**Payment Denial Start Date**	**Payment Denial End Date**
COLONIAL MANOR NURSING CENTER	An IJ, Immediate Jeopardy, was identified on 12/22/2023 at 6:30 PM. While the IJ was removed on 12/23/2023 at 4:00 PM, this survey does not contain the removal plan.	-	-	-	-

Attachment C: Jack Shelby Affiliated Entities Owned Facilities Deficiencies and Survey Results
Source: ProPublica Nursing Home Inspection/Survey Results

List facilities that are required for review under 10.24.20.05(8)	SFF	Date of the Survey	Deficiencies	Deficiencies (Cont.)	Description	Seriousness
COPPERAS HOLLOW NURSING & REHABILITATION CENTER	-	1/18/2025	Quality of Life and Care Deficiency — F0742	Failure to: Provide the appropriate treatment and services to a resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder.	The facility failed to provide a response to Resident #1's dementia related mood disturbance behavior. On 09/30/24 the MD ordered psychological services to evaluate and treat Resident #1, no mental health interventions were received, and she was discharged to a BHH seven days later.	J
		3/12/2023	Quality of Life and Care Deficiency — F0689	Failure to: Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.	The facility failed to ensure Resident #1 was supervised in the dining room prior to meal service when she attempted to ambulate and fell resulting in overnight hospitalization due to a laceration to her forehead and small amounts of bleeding between the brain and its outer covering.	G
CORYELL HEALTH REHABLIVING AT THE MEADOWS	-	-	-	-	-	-
CRESTVIEW HEALTHCARE RESIDENCE	-	5/24/2023	Quality of Life and Care Deficiency — F0697	Failure to: Provide safe, appropriate pain management for a resident who requires such services.	1. The facility failed to assess, reassess, and/or take steps to manage Resident #1's pain when she informed them of the pain to her left stump. 2. The facility failed to administer Resident #1's PRN Tylenol #4 to adequately control her pain.	H

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		Medicare			
List facilities that are required for review under 10.24.20.05(8)	**Action Taken**	**Penalty Date**	**Payment Denial Length in Days**	**Payment Denial Start Date**	**Payment Denial End Date**
COPPERAS HOLLOW NURSING & REHABILITATION CENTER	Action: 5. Resident #1 currently does not reside in the facility as of 1/17/25. 6. The DON/ADON audited all psychology and psychiatry orders for active residents over the last 6 months. Two residents were identified, and both are actively receiving psychiatric services. This was completed on 1/17/25. The facility has 11 total residents on psych services and 2 of those were referred to psych services within the last 6 months. 7. The Administrator and DON will be responsible for initiating all psychological and psychiatry referrals to the provider. This will start 1/17/25. 8. The Administrator DON, and ADON were in serviced 1:1 by the Regional Compliance Nurse on the following topics below on 1/17/25. E. Abuse and Neglect Policy: Failure of the facility to initiate and provide psychological or psychiatric services to a resident could be considered abuse and neglect. F. Behavioral Management Policy: Addressing residents who display mental disorders, psychosocial disorders, or who have a history of PTSD, ensuring that residents are assessed and receive appropriate treatment and services ordered by a physician or NP. G. Following Physician Orders Policy: to include notifying the provider to initiate psychology and/or psychiatric referrals when ordered by a physician or NP. 9. The Medical Director was notified of the immediate jeopardy on 01/17/2025 by the Administrator. 10. An ADHOC QAPI meeting was completed with interdisciplinary team on 01/17/2025 which included the Medical Director, Administrator, Director of Nursing, and Assistant Director of Nursing to discuss the citations and plan of removal. In-services The Administrator and DON initiated the following in-services for Licensed Nurses. Training began 01/17/2025 and will be completed 01/17/2025. Licensed Nurses not present and PRNs will be in-serviced prior to their next shift. All new hires will be in-serviced during facility orientation. All agency staff will be in-serviced prior to their assigned shift. 11. Abuse and Neglect Policy: Failure of the facility to initiate and provide psychological or psychiatric services to a resident could be considered abuse and neglect. 12. Behavioral Management Policy: Addressing residents who display mental disorders, psychosocial disorders, or who have a history of PTSD, ensuring that residents are assessed and receive appropriate treatment and services ordered by a physician or NP. 13. Following Physician Orders Policy: to include notifying the provider to initiate psychology and/or psychiatric referrals when ordered by a physician or NP. The Administrator and DON initiated the following in-services for all staff. Training began 01/17/2025 and will be completed 01/17/2025. All staff not present, and PRNs will be in-serviced prior to their next shift. All new hires will be in-serviced during facility orientation. All agency staff will be in-serviced prior to their assigned shift. A. Abuse and Neglect Policy: Failure of the facility to initiate and provide psychological or psychiatric services to a resident could be considered abuse and neglect. Surveyor Monitoring: The administrator and/or DON will review all orders daily x 5 days a week for any orders in reference to psychological and psychiatry services to ensure that all referrals have been initiated. This will begin 1/17/25 and end on 2/14/25.	-	-	-	-
	Interview on 03/12/2023 at 1:21 PM the DON stated the procedure for high fall risk residents is to observe them at the nurse's station prior to meal service. She stated on 03/10/2023 the Department heads had left the building prior to the evening meal service. She stated a schedule was being prepared to ensure a department head would always be in the dining room to monitor residents. Interview on 03/12/2023 at 1:30 PM the ADMIN stated her expectation going forward was that all staff were going to be doing their due diligence regarding residents who are at high risk for falls. She stated the potential risk for residents if not supervised is that they might fall.				
CORYELL HEALTH REHABLIVING AT THE MEADOWS	-	-	-	-	-
CRESTVIEW HEALTHCARE RESIDENCE	No action taken.	-	-	-	-

Attachment C: Jack Shelby Affiliated Entities Owned Facilities Deficiencies and Survey Results
Source: ProPublica Nursing Home Inspection/Survey Results

List facilities that are required for review under 10.24.20.05(8)	SFF	Date of the Survey	Deficiencies	Deficiencies (Cont.)	Description	Seriousness
CRESTVIEW HEALTHCARE RESIDENCE	-	12/23/2022	Freedom from Abuse, Neglect, and Exploitation Deficiency — F0600	Failure to: Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.	The facility failed to:- Protect Resident #1 from being abused by the Registered Nurse who willfully and deliberately placed a urine-soaked towel to Resident #1's face.	J
			Freedom from Abuse, Neglect, and Exploitation Deficiency — F0607	Failure to: Develop and implement policies and procedures to prevent abuse, neglect, and theft.	The facility failed to: Develop and implement abuse and neglect policies that prohibited and prevented Resident #1 from being abused by the Registered Nurse who placed a urine-soaked towel to Resident #1's face.	J
			Quality of Life and Care Deficiency — F0689	Failure to: Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.	The facility failed to: Ensure Resident #2, who had exit seeking behaviors and resided on the secure unit, did not elope from the facility on 12-18-22.	J
EVERGREEN HEALTHCARE CENTER	-	4/11/2024	Resident Rights Deficiency — F0580	Failure to: Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.	The facility did not consult with Resident #1's Physician or Resident Representative regarding a pressure ulcer that was identified on 03/04/2024 and re-assessed on 04/07/2024.	H
			Quality of Life and Care Deficiency — F0686	Failure to: Provide appropriate pressure ulcer care and prevent new ulcers from developing.	The facility failed to notify Resident #1's Physician, Resident Representative and Hospice services after identification of wound on Resident #1's right heel. The facility failed to obtain orders for wound care for Resident #1's right heel. The facility failed to perform routine wound care for Resident #1's right heel. The facility failed to complete weekly skin assessments for Resident #1.	H
		10/27/2023	Quality of Life and Care Deficiency — F0689	Failure to: Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.	1. The facility failed to ensure a physician-ordered wander guard was in place for Resident #13. 2. The facility failed to prevent Resident #13 from leaving the facility unaccompanied on 10/05/23.	K

Attachment C: Jack Shelby Affiliated Entities C

Source: ProPublica Nursing Home Inspection/Survey

		Medicare			
List facilities that are required for review under 10.24.20.05(8)	**Action Taken**	**Penalty Date**	**Payment Denial Length in Days**	**Payment Denial Start Date**	**Payment Denial End Date**
CRESTVIEW HEALTHCARE RESIDENCE	Action Taken Abuse Prevention In-Service was conducted on 12-20-22 for the Administrator and all administrative staff at the facility. All residents are at risk for abuse and for the potential of an incomplete internal investigation. All internal and reportable investigations will be reviewed by our compliance attorney for additional review to ensure compliance with facility policy and HHSC Guidelines. Facility Assistant Administrator or designee will be responsible and the Corporate Managing Partner will monitor. Start date 12-20-22/End date 12-21-22. Ongoing, an annual in-service on Abuse Prevention and a quarterly test regarding abuse prevention will be administered. To pass the test, each participant must score 100%, the staff member must attend the In-service again and take the post-test. (The staff must pass at 100% prior to working with residents). Abuse Prevention In-Service was conducted on 12-20-22 to all staff that was working at the facility. All staff scheduled to work on 12-21-22 will be in service prior to the start of their shift. All residents are at risk for abuse. All current employees will receive abuse prevention training before beginning their next scheduled shift, and a post-test will be administered. Staff must score 100% prior to working with residents. The Administrator or designee will be responsible and the Corporate Managing Partner will monitor. Start date 12-20-22/End date 12-21-22. For current employees prior to the start of their next shift, and annual in service with a 100% post test to ensure understanding. Detailed Abuse Prevention training will be provided to all new hires upon hire and then annually by the administrator and/or designee, such as the assistant administrator. The post-test will be given, and staff must score 100%. Abuse Prevention testing will be done quarterly and on a PRN basis (as needed) to ensure staff is knowledgeable and their awareness and knowledge remain up to date. The post-test will be given and staff must score 100%. Inservice conducted on 12-20-22 with all staff on what abuse is and about preventing abuse and reporting all abuse cases and how to report them. New hires and/or agency staff will be educated on resident abuse before starting their initial shift at the facility. An abuse prevention post-test was given and completed by 12-21-22. All staff will be tested before starting their initial shift at the facility, including the post-test. The post-test will be given, and staff must score 100%. Education on what constitutes abuse will be completed on 12-21-22 with all facility staff working that day (at a mandatory meeting) and all other staff will be requested to come in for training before their next scheduled shift to complete this training. The post-test will be given, and staff must score 100%. If they don't, the staff member must attend the training again and retest. They will not be allowed to work with residents until they pass 100%. Involvement of Medical Director: The Medical Director was notified about the immediate Jeopardy on 12-20-22. The Administrator will review all complaints and investigations with the Medical Director. Involvement of QA: On 12-21-22 an Ad Hoc AQPI meeting has been held with the Medical Director, Facility Administrator, Asst. Director of Nursing, and Social Services Director to review the plan of removal.	-	-	-	-
	During the exit interview on 12-23-22 at 11:30 AM, the Administrator stated all staff had been re-trained on elopement procedures. The Administrator stated a new camera system had been ordered and would be installed upon arrival. The Administrator stated all department heads are to check all windows in the secure unit to ensure that they are secure. The Administrator stated housekeeping will also be responsible for checking the windows in the secure unit to ensure they are all secured.				
EVERGREEN HEALTHCARE CENTER	No action taken.	-	-	-	-
	No action taken.				
	Interviews with the LVN charge nurse, the medication aide, and the certified nurse aide working on Resident #13's hall, who were on duty for the evening shift on 10/26/23 revealed visual checks of the resident were conducted every 2 hours. The LVN and medication aide stated the resident's wander guard band was tested for proper functioning one time daily on another shift and was documented on the medication administration record by the nurse conducting the test. The Corporate RN Clinical Resource Nurse was observed using the scanning device to check the function of Resident #13's wander guard on 10/27/23 and the resident's wander guard was functioning properly. Interview with a certified nurse aide during the day shift on 10/27/23 revealed the Administrator had given a staff in-service training on 10/06/23 and had talked about wander guards, wandering, and visual checks of Resident #13. The certified nurse aide stated the Administrator told the staff not to use the east hall door located in the front part of the building (sunroom). Interview with the Maintenance Director on 10/27/23 revealed he checked the self-closing device and adjusted it as needed for the east hall door leading from the sunroom at the front of the building. He stated he had adjusted the self-closing device several times before Resident #13's elopement from the facility. He said he checked it and adjusted it first thing after Resident #13's elopement and return to the facility on [DATE]. He was observed adjusting the self-closure device on the east hall door in the sunroom and opening the door to test the door closure on 10/27/23 at 1:53 PM. This failure resulted in Immediate Jeopardy on 9/30/23. The noncompliance was determined to be past noncompliance (PNC). The noncompliance began on 9/30/23 at 6:37 PM and ended on 10/06/23 following a staff inservice training provided by the Administrator. The facility had implemented the actions that corrected the noncompliance before the surveyor's entrance to the facility on [DATE].				

Attachment C: Jack Shelby Affiliated Entities Owned Facilities Deficiencies and Survey Results

Source: ProPublica Nursing Home Inspection/Survey Results

List facilities that are required for review under 10.24.20.05(8)	SFF	Date of the Survey	Deficiencies	Deficiencies (Cont.)	Description	Seriousness
FAIRVIEW HEALTHCARE RESIDENCE	-	4/9/2025	Freedom from Abuse, Neglect, and Exploitation Deficiency — F0600	Failure to: Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.	The facility failed prevent CNA A, on 01/20/25, from physically abusing Resident #1 when she approached Resident #1 in an aggressive manner and pushed into residents abdominal and chest area with her stomach. CNA A shoved Resident #1 in the right arm and in the back into the hallway 01/20/25.	J
FARMERSVILLE HEALTH AND REHABILITATION	-	-	-	-	-	-
FORT WORTH WELLNESS & REHABILITATION	-	-	-	-	-	-
FT WORTH SOUTHWEST NURSING CENTER	**Graduated 02/21/2024**	7/4/2024	Freedom from Abuse, Neglect, and Exploitation Deficiency — F0600	Failure to: Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.	The facility failed to protect Resident #1, who was unable to give consent for sexual activity, from sexual abuse after Resident #2 was discovered in her bed with his pants off and buttocks exposed, laying behind her on 06/30/24.	J
			Freedom from Abuse, Neglect, and Exploitation Deficiency — F0607	Failure to: Develop and implement policies and procedures to prevent abuse, neglect, and theft.	The facility failed to implement their abuse, neglect, and exploitation policy to ensure Resident #1 was safe from sexual abuse when Resident #2 was found in her bed on 06/30/2024. Resident #2 had not been on any supervision from the time the incident occurred through 07/03/2024. The facility failed to follow their policy and investigate the alleged or suspected sexual abuse of Resident #1 and provide notification and information to the proper authorities according to state and federal regulations.	J
			Freedom from Abuse, Neglect, and Exploitation Deficiency — F0610	Failure to: Respond appropriately to all alleged violations.	The facility failed to implement their abuse, neglect, and exploitation policy and investigate an alleged or suspected sexual assault when Resident #2 was found in Resident #1's bed on 06/30/2024. The facility did not provide notification and information to the proper authorities according to state and federal regulations.	J
		6/22/2023	Quality of Life and Care Deficiency — F0689	Failure to: Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.	LVN A failed to apply two footrests on a wheelchair prior to transporting Resident #1 for dialysis. The resident suffered an injury when the foot fell off the footrest two times. The resident was admitted to the hospital and diagnosed with a fracture of the left tibial tuberosity (area of bone just below the knee).	G
GLENVIEW WELLNESS & REHABILITATION	-	3/28/2024	Quality of Life and Care Deficiency — F0689	Failure to: Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.	The facility failed to ensure Resident #2 was transferred by two staff, which resulted in a fall with fracture of her distal left Femur (a distal femur is a fracture of the thighbone that occurs just above the knee joint) on 01/19/24 .	J

Attachment C: Jack Shelby Affiliated Entities C

Source: ProPublica Nursing Home Inspection/Survey

		Medicare			
List facilities that are required for review under 10.24.20.05(8)	**Action Taken**	**Penalty Date**	**Payment Denial Length in Days**	**Payment Denial Start Date**	**Payment Denial End Date**
FAIRVIEW HEALTHCARE RESIDENCE	CNA A was placed on suspension pending termination on 4/8/2025 by the Administrator. Director of Operations conducted re-education on Abuse and Neglect including recognizing, responding, and reporting abuse and neglect with the Administrator and Director of Nursing on 4/8/2025. Administrator and Director of Nursing voiced understanding of the re-education to the Director of Operations and signed the re-education. Resident #1 was assessed for signs and symptoms of physical abuse by the Director of Nursing on 4/8/2025 with no negative findings. A progress note was charted on 4/8/2025. All residents that are able to be interviewed for any abuse and/or neglect event (no cognitive impairment) were interviewed by the Director of Nursing/Designee on 4/8/2025 with no negative findings identified. A progress note was charted for each resident on 4/8/2025. All residents with cognitive impairment/not inter-viewable were assessed by the Director of Nursing/Designee on 4/8/2025 for signs/symptoms of physical abuse with no negative findings. A progress note was charted for each resident on 4/8/2025. All staff were re-educated on abuse and neglect including recognizing, responding, and reporting abuse and neglect by the Administrator/Designee on 4/8/2025. Staff not present will be re-educated prior to the start of their next shift and this will be completed by 4/9/2025 (end of business day). Staff voiced understanding of the re-education to the Administrator/Designee and signed the re-education. The Medical Director of the center was notified of the immediate jeopardy event on 4/8/2025. The Medical Director had no recommendations. The findings of this event will be presented to the center Quality Assurance Committee. An ad hoc Quality Assurance Committee meeting will be conducted on 4/9/2025. The Administrator/Designee will monitor/review incident reports and do random resident interviews during the work week (Monday through Friday) to validate no resident abuse and/or neglect events have occurred. These audits will continue weekly for four weeks. Negative findings will be addressed at the time of discovery and presented to the center Quality Assurance Committee.	-	-	-	-
FARMERSVILLE HEALTH AND REHABILITATION	-	-	-	-	-
FORT WORTH WELLNESS & REHABILITATION	-	-	-	-	-
FT WORTH SOUTHWEST NURSING CENTER	1. Director of Nursing submitted a self-report to HHSC on July 3, 2024, regarding the incident 2. [Local Law Enforcement Agency] were notified on July 3, 2024, by Regional Nurse Consultant and an officer responded. 3. Attending Physician of Resident #1 was notified of the incident on July 3, 2024, by Assistant Director of Nursing. 4. Social Worker conducted a trauma assessment with Resident #1 on July 4, 2024. 5. Attempts to contact family of Resident #1 on July 3, 2024, were unsuccessful due to non-working phone number. They visit frequently and will be notified upon first opportunity and contact will be updated. Family of Resident # 2 were notified July 3, 2024, by facility social worker. 6. Resident #2 was placed on 1:1 monitoring on July 3, 2024, to consist of line-of-sight monitoring by facility staff. 7. Licensed Nurse conducted a head-to-toe assessment to assess for possible injuries on July 3, 2024. 8. Resident #1 was sent out for a SANE test at local hospital. Resident was unable to consent and per hospital no test was performed, and she will be returned to the facility with no new orders. 9. Director of Nursing began obtaining witness statements from staff. 10. Safe surveys (series of questions for residents to identify possible Abuse/Neglect) were completed by Social Worker and other Facility management staff with all interviewable residents. Head to toe assessments were completed with all non-interviewable residents by facility Treatment Nurses. All were completed July 3, 2024. 11. Resident #1 and Resident #2 were referred to [mental health services] on July 3, 2024, for psychological assessment and to be picked up on services if needed. In-Service conducted: Regional Nurse Consultant and Director of Nursing (after [NAME]-servicing below) in-serviced all facility staff on: 1. On 7/3/24 Director of Nursing and Administrator were in-serviced on Abuse & Neglect Policy and Texas HHSC LTCR Provider Letter PL19-17 by Regional Director of Operations. 2. An all-staff in-service was initiated on 7/3/24. All staff members were educated to report all allegations of abuse immediately upon notification or observation to the Administrator who is the abuse coordinator. All staff will complete an Abuse & Neglect competency posttest at time of in-servicing. 3. The expected completion date will be 7/4/2024. Staff who have not been trained on Abuse & Neglect will not be allowed to work until they have completed required in-services. Implementation of Changes: Staff will immediately inform the Administrator who is the abuse coordinator immediately when being made aware of the any abuse allegation or observation. The administrator or director of nursing will ensure competency through verbalization of understanding by staff through successful completion of Abuse/Neglect Post test. In the absence of Administrator abuse allegations will be reported to the Director of Nursing. The Administrator, abuse coordinator will be responsible for implementation of the process and will review process weekly X3 months by reviewing safe surveys, grievance forms and staff interviews. Weekly review will be documented on Abuse Coordinator Review Log. Monitoring: 1. Social worker/RN Supervisor will complete five safe surveys per day for two weeks then one per day for one month on interviewable residents. 10 Non interviewable residents will receive a head-to-toe physical assessment daily for two weeks then one per week. 2. Administrator and Director of Nursing will interview five staff members per day for two weeks then one staff member per day for one month for return demonstration for types of abuse and reporting requirements. Findings will be documented on Abuse & Neglect monitoring form. 3. RDO and RNC will conduct ten random staff interviews per month. 4. RDO or RNC will review grievances weekly which are located in the facility grievance binder for three months. 5. Any adverse outcomes will be reported to QAPI Committee. On July 3, 2024, an Ad Hoc QAPI meeting was held with the facility administrator, medical director, director of nursing, and social services director to review plan of removal.	-	-	-	-
	No action taken.				
GLENVIEW WELLNESS & REHABILITATION	Review of the facility's In-service Training Report .Falls, revised 06/2020, reflected nursing staff were in-serviced on falls involving procedures to proper transfers such as checking the care plan, body mechanics, transfer techniques and different transfer types. Review of the facility's In-service Training Report .Transfers, dated 01/22/24, reflected nursing staff were in-serviced on transfers involving fall management, resident assessment, care plan, universal fall precautions, documentation, and quality assurance. Review of the facility's transfer competency checklist, dated 01/22/24, reflected staff were tested for transfer competency in: Demonstrating how to correctly perform a pivot transfer with a resident Demonstrating how to correctly perform a pivot disk transfer with a resident Demonstrating how to correctly utilize a gait belt during transfer Demonstrating how to correctly utilize a slide board during transfer Demonstrating how to correctly use a mechanical lift during transfer Demonstrating knowledge of proper body mechanics for safe transfers Review of a list of residents who required two-person assistance with transfers, provided by the Administrator on 03/28/2024, reflected seven current residents .	-	-	-	-

Attachment C: Jack Shelby Affiliated Entities Owned Facilities Deficiencies and Survey Results

Source: ProPublica Nursing Home Inspection/Survey Results

List facilities that are required for review under 10.24.20.05(8)	SFF	Date of the Survey	Deficiencies	Deficiencies (Cont.)	Description	Seriousness
GLENVIEW WELLNESS & REHABILITATION	-	10/5/2023	Freedom from Abuse, Neglect, and Exploitation Deficiency — F0600	Failure to: Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.	The facility failed to provide necessary x-ray services in a timely manner and failed to follow up to get results in a timely manner for Resident #1. The facility failed to provide education and training for nursing staff on how to carry out carry out physician orders for x-rays and follow up on the results in a timely manner. The facility failed to follow their policies for laboratory, diagnostic and radiology services and physician orders.	K
			Nursing and Physician Services Deficiency — F0726	Failure to: Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being.	The facility failed to ensure:- LVN B carried out an x-ray for Resident #1.- RN C followed up with the x-ray order for Resident #1.- LVN A followed up with the x-ray order in timely manner and to get results for Resident #1.- ADON monitored that the nurses followed up with the x-ray order and received the x-ray results in timely manner for Resident #1	K
			Administration Deficiency — F0776	Failure to: Provide timely, approved x-ray services, or have an agreement with an approved provider to obtain them.	1. The facility failed to ensure that an x-ray was completed in a timely manner for Resident #1 2. The facility failed to follow up to get Resident #1's x-ray results in a timely manner.	K

Attachment C: Jack Shelby Affiliated Entities C

Source: ProPublica Nursing Home Inspection/Survey

		Medicare			
List facilities that are required for review under 10.24.20.05(8)	**Action Taken**	**Penalty Date**	**Payment Denial Length in Days**	**Payment Denial Start Date**	**Payment Denial End Date**
GLENVIEW WELLNESS & REHABILITATION	1. Abuse Coordinator (Corporate Administrator) reeducated on abuse/neglect by Regional Nurse Consultant on 10/2/23. New Administrator/ Abuse Coordinator educated on abuse/ neglect by Director Clinical Education on 10/3/2023. 2. Director of Nurses and ADON re-educated by the Regional Clinical Nurse on the facility fall evaluation and prevention policy. X-ray ordering and follow up. Education on laboratory, diagnostic and radiology services and educated on carrying out physician orders immediately no greater than 30mins of receiving order from physician on all patients including hospice patients Completed 10/1/23. Reeducated on abuse/neglect by Regional Nurse Consultant on 10/2/23. 3. All licensed nurses Registered Nurses and Licensed Vocational Nurses educated on carrying out orders for x-rays and Education on laboratory, diagnostic and radiology services on all patients immediately no greater than 30mins of receiving order from physician including hospice patients by Director of Nursing initiated on 10/1/2023 with completion date of 10/2/23. 4. All licensed nurses and LVN were re-educated on abuse/neglect by Director of Nursing initiated 10/2/23 with a completion date of 10/3/23. 5. Training for all licensed nurses RN and LVN's, follow up on x-ray results in a timely manner initiated on 10/1/2023 by the Director of Nursing. with the completion date of 10/2/23. 6. Licensed Nurses RN and LVN's in serviced by the DON on the facility policy and procedure regarding facility fall prevention policy, assessment, and notify the physician regarding change of condition. Training was initiated on 10/1/2023 with the completion date of 10/2/23. 7. Licensed Nurses RN and LVN's educated on carrying out orders on hospice patients immediately no greater than 30mins of receiving order from physician. Initiated by Director of Nursing on 10/1/2023. with the completion date of 10/2/23. 8. Director of Nursing, Assistant Director of Nursing and Weekend supervisor educated on procedure to pull report on New X-rays ordered and Falls. Completed on 10/2/23 by Regional Nurse Consultant. 9. An audit on all patients receiving x-ray in last 7 days to assure follow up completed, initiated on 10/1/2023 and completed by the Regional Nurse Consultant with no adverse findings. 10. Self-Report on Neglect made to Health and Human Services on 10/3/2023 by the Administrator. Abuse and Neglect Inservice initiated by the Regional Nurse Consultant on 10/3/2023 with a completion date of 10/4/2023. Abuse and Neglect investigation in process. Resident Safe Survey completed by the director of social services on 10/3/2023 with no negative outcome noted. 11. The licensed Nurse that didn't follow up with the X-ray was suspended on 10/1/2023 and termination of employment effective 10/3/2023. 12. New Licensed Nursing Home Administrator- Abuse Coordinator started at the facility on 10/2/2023. 13. Training and Education on Abuse and Neglect started by the Regional Nurse Consultant on 10/3/2023. In-Service conducted. 1. Abuse Coordinator reeducated on abuse/neglect by Regional Nurse Consultant on 10/2/23. The New Abuse Coordinator was reeducated on abuse/ neglect by the Director of Clinical Education on 10/3/2023. 2. Director of Nurses and ADON re-educated by the Regional Clinical Nurse on facility fall evaluation and prevention policy. X-ray ordering and follow up and. Education on laboratory, diagnostic and radiology services, and educated on carrying out physician orders on all patients including hospice patients completed 10/1/23. Re-educated on abuse/neglect policy by Regional nurse consultant on 10/2/23. 3. Director of Nursing, Assistant Director of Nursing and Weekend supervisor educated on procedure to pull report on New X-rays ordered and Falls. Completed on 10/2/23 by Regional Nurse Consultant. 4. All licensed nurses RN and LVN educated on carrying out orders for x-rays and. Education on laboratory, diagnostic and radiology services on all patients including hospice patients by Director of Nursing initiated on 10/1/2023 with completion date of 10/2/23. 5. Training for all licensed nurses RN and LVN's, follow up on x-ray results in a timely manner initiated on 10/1/2023 by the Director of Nursing with completion date of 10/2/23. 6. Licensed Nurses RN and LVN's in serviced by the DON on the facility policy and procedure regarding facility fall prevention policy, assessment, and notify the physician regarding change of condition. Training was initiated on 10/1/2023 with a completion date of 10/2/23. 7. Licensed Nurses RN and LVN's educated on carrying out orders on hospice patients immediately no greater than 30mins of receiving order from physician. Initiated by Director of Nursing on 10/1/2023 with completion date of 10/2/23. 8. All licensed nurses and LVN were re-educated on abuse/neglect by Director of Nursing initiated 10/2/23 with a completion date of 10/3/23. 9. An audit on all patients including hospice patients receiving x-ray in last 7 days to assure follow up initiated and completed on 10/1/2023 by the Regional Nurse Consultant with no adverse findings. 10. Staff Training and Education on Abuse and Neglect Policy and Process initiated by the Regional Nurse Consultant on 10/3/2023 with completion date of 10/4/2023. Any staff member that doesn't go through the training will not be allowed to work in the facility. All new hires will be trained in Abuse and Neglect policy and Process. 11. The licensed Nurse that didn't follow up with the X-ray was suspended on 10/1/2023 and termination of employment effective 10/3/2023. Abuse Coordinator reeducated on abuse/neglect by Regional Nurse Consultant on 10/2/23. New Administrator and Abuse Coordinator reeducated on abuse/neglect by the Director of Clinical Education on 10/3/2023. Director of Nurses re-educated by the Regional Clinical Nurse on facility fall prevention and evaluation, X-ray ordering and follow up Education on laboratory, diagnostic and radiology services. and educated on carrying out physician orders on all patients including hospice patients. Abuse and Neglect policy. Completed 10/2/23. Director of Nursing, Assistant Director of Nursing and Weekend supervisor educated on procedure to pull report on New X-rays ordered and Falls. Completed on 10/2/23 by Regional Nurse Consultant. Licensed nurse's RN's and LVN's re-educated on abuse/neglect policy by Director of Nursing. Initiated on 10/2/23 with completion date of 10/3/23. Licensed staff RN, LVN will review daily Monday through Friday with IDT (Therapy, Nurse managers, social worker, administrator.) all falls, and any patient receiving an X-ray. Weekend Supervisor RN to review all falls and X rays on weekends. The Director of Nursing, Assistant Director of Nursing or designee will run a daily report to identify any resident with fall or new order for X-ray.	-	-	-	-

Attachment C: Jack Shelby Affiliated Entities Owned Facilities Deficiencies and Survey Results

Source: ProPublica Nursing Home Inspection/Survey Results

List facilities that are required for review under 10.24.20.05(8)	SFF	Date of the Survey	Deficiencies	Deficiencies (Cont.)	Description	Seriousness
GRACE CARE CENTER OF HENRIETTA	-	4/25/2025	Administration Deficiency — F0837	Failure to: 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.	The facility had not had an administrator since [DATE]. The governing body failed to provide the facility with enough money to keep up services including telephone service, internet service, food services, van registration/insurance, laundry services, and fire and security services.	L
			Administration Deficiency — F0835	Failure to: Administer the facility in a manner that enables it to use its resources effectively and efficiently.	The facility failed to have sufficient resources to satisfy (pay) debts timely and when they come due. The phone and internet were disconnected, service repair bills/vendors were not paid, and the facility van did not have insurance or current registration tags. The facility failed to provide enough money to purchase the food necessary to follow the menus and to purchase printer supplies.	L

Attachment C: Jack Shelby Affiliated Entities C

Source: ProPublica Nursing Home Inspection/Survey

		Medicare			
List facilities that are required for review under 10.24.20.05(8)	**Action Taken**	**Penalty Date**	**Payment Denial Length in Days**	**Payment Denial Start Date**	**Payment Denial End Date**
GRACE CARE CENTER OF HENRIETTA	Plan of Removal 1). Action: The Chief Executive Officer (CEO) and Managing Partner re-educated the Chief Operating Officer (COO) on the governing board responsibility to ensure management and operation of the facility; emphasis was stressed on the importance of providing oversight of facility care and services in accordance with professional standards of practice and principles, to ensure there is a plan for vendors to be paid timely, so services are not rescinded and residents have the services required for the highest practicable physical, mental, and psychosocial well-being of each resident. 2). Action: The Chief Executive Officer (CEO) and Chief Operating Officer (COO) will meet to review and make payments or payment arrangements for: 1. Telephone and internet vendor on [DATE], $10,000.00 was paid, the remaining payment was made on [DATE] in the amount of $7987.28, the amount told to us from the company to activate service.; 2. Insurance vendor for the facility van has been paid in the amount of $141.99 on [DATE]. 3. Registration tags for the facility van was paid on 3.17.25 in the amount of $74.00 to County Tax Office. 4. Fire and security vendor - have confirmed that we are not on hold and have sent an email confirming so on 3.14.25. If the internet is out, the emergency plan to ensure the staff have access to MARs and TARs will be to use the Hot spots for internet. Until Telephone and internet have been restored, while these are out, the facility will continue to use mobile phone and internet Hot Spots to communicate and document as required to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. If the hot spots are not working, the DON was educated on the need to obtain paper-printed MARs and TARs from the pharmacy to be delivered on the medication run if no internet is available and printing abilities are not available locally. The facility Social Worker will call each family to share the mobile phone number if/when needed. The Activity Director will complete resident interviews to identify residents affected by phone interruption and share with them the availability of mobile phone if needed to communicate to people outside the facility. The facility's Human Resource Director will contact the facility's vendors to share the phone number if/when required. To prevent future service interruptions, the Chief Executive Officer (CEO) and Chief Operating Officer (COO) will meet monthly to review the facility's outstanding invoices and ensure vendors to be paid timely, so services are not rescinded, and residents have the services required for the highest practicable physical, mental, and psychosocial well-being of each resident. 3). Action: The Director of Nursing (DON) will complete a Medication Error Form for each of the identified 11 residents in which medication were given at a different time or omission occurred; the form includes communicating with the medical provider, the responsible party, facility management and pharmacist consultant, in addition to type of error and reason for error (Examples of medications errors include: a. Omission - a drug is ordered but not administered; b. Unauthorized drug - a drug is administered without a physician's order; c. Wrong dose (e.g., Dilantin 12 mL ordered, Dilantin 2 mL given); d. Wrong route of administration (e.g., ear drops given in eye); e. Wrong dosage form (e.g., liquid ordered, capsule given); f. Wrong drug (e.g., vibramycin ordered, vancomycin given); g. Wrong time; and the corrective action taken and measures to prevent similar error(s) recurrence. The Director of Nursing reviewed the other resident's Medication Administration Records (MARs) and did not reveal further discrepancies or errors. The Chief Nursing Officer (CNO) will confirm completion of Medication Error Forms. 4). Action: The Director of Nursing (DON) will re-educate nurses (RN/s/LVNs) and certified medication aides (CMAs) on the facility's policies: Administering Medications and Medication Errors - the different types and immediate actions to take to prevent adverse consequences. 5). Action: The Chief Executive Officer (CEO) and Chief Operating Officer (COO) will post the facility's administrator's vacant position and continue active recruitment to fill the facility administrator's vacant position. With a sign on bonus posted on 3.15.25. Until the position is filled, all items needed for resident care are to be communicated to the facility's Director of Nursing (DON), as for ancillary services, such as dietary and environmental services, are to be communicated to the facility's Human Resource Director, Both - DON and HR Director will participate in a conference call with the Chief Executive Officer (CEO) and Chief Operating Officer (COO) weekly on Thursdays at 11 am that arrangements can be made to ensure there is a plan for vendors to be paid timely, so services are not rescinded and residents have the services required for the highest practicable physical, mental, and psychosocial well-being of each resident. This conference call will continue weekly with the new administrator once onboarded and the weekly minutes reviewed monthly during the facility's monthly QAPI to determine if changes in needed supplies, their quantity and/or delivery dates are required in order to be altered to ensure timely ordering and delivery. 6). Action: Staff will be reimbursed for their out-of-pocket expenses per usual procedures, including submitting reimbursement requests and receipts. 7). Action: Annual van registration and insurance will be added to the annual maintenance checklist to ensure timely registration renewal; The facility administrator will review the yearly checklist during QAPI to ensure timely review. 8). Action: An ad-hoc QAPI meeting will be held, and the facility Medical Director will be notified of the deficient practice and the approved removal plan. Action items will be reviewed monthly during the QAPI meetings for the next 3 months and ongoing as needed. Meeting minutes will be taken and maintained for 12 months.	-	-	-	-

Attachment C: Jack Shelby Affiliated Entities Owned Facilities Deficiencies and Survey Results

Source: ProPublica Nursing Home Inspection/Survey Results

List facilities that are required for review under 10.24.20.05(8)	SFF	Date of the Survey	Deficiencies	Deficiencies (Cont.)	Description	Seriousness
GRACE CARE CENTER OF HENRIETTA	-	10/25/2024	Quality of Life and Care Deficiency — F0677	Failure to: Provide care and assistance to perform activities of daily living for any resident who is unable.	The facility failed to provide bowel and bladder incontinent care for Resident #2 and it resulted in reddened skin on buttocks area. The facility failed to provide bowel and bladder incontinent care for Resident #3 and it resulted in reddened skin on scrotum area. The facility failed to provide bowel and bladder incontinent care for Resident #4 and it resulted in reddened skin and an open area to buttock(coccyx) area. The facility failed to provide bowel and bladder incontinent care for Resident #7 and it resulted in burning sensation and reddened skin in testicle (scrotum) and buttock (coccyx) area.	H
		3/8/2024	Pharmacy Service Deficiency — F0760	Failure to: Ensure that residents are free from significant medication errors.	Facility failed to ensure residents were free from significant medication errors for 1 of 7 residents (Resident #1) reviewed for medication regimen, in that: Resident #1 was administered the morning medications for another resident, which included three different blood pressure medications, a narcotic medication, and a diuretic medication on 2/29/2024 at approximately 10:20 AM. Resident #1 became unresponsive on 2/29/2024 at 11:15 AM and was transported by ambulance to the local hospital emergency room . Resident #1 was admitted to the hospital on 2/29/2024 with a diagnosis of hypotension (abnormally low blood pressure) due to drugs.	J
GRACE CARE CENTER OF NOCONA	-	5/22/2023	Quality of Life and Care Deficiency — F0700	Failure to: Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail.	The facility failed to assess Resident #1 for entrapment from bed rails or contact Resident #1's representative to obtain informed consent, assess risk for entrapment or physician's orders. Resident #1 lodged (entrapped) his left arm on 12/28/22 into the 1/2 sized bed rail, causing him to sustain bruising to his chest, and psychosocial harm.	J

Attachment C: Jack Shelby Affiliated Entities C

Source: ProPublica Nursing Home Inspection/Survey

		Medicare			
List facilities that are required for review under 10.24.20.05(8)	**Action Taken**	**Penalty Date**	**Payment Denial Length in Days**	**Payment Denial Start Date**	**Payment Denial End Date**
GRACE CARE CENTER OF HENRIETTA	No action taken.	-	-	-	-
	The following Plan of Removal submitted by the facility and accepted on 3/08/2024 at 4:37 PM: 1. Resident #1 was immediately assessed by the Licensed Nurse (LN) on 02/29/24 and the physician was notified of the medication error with a new order to monitor the resident's blood pressure closely. The order was noted by the LN. When the LN went to monitor Resident #1 after receiving the order, the resident was found unresponsive. The LN called EMS which responded quickly, and the resident was discharged to the ER for observation on 02/29/24. 2. The 24-hour report was reviewed on 3/7/24 by the Assistant Director of Nursing (ADON) for the past 72 hours to ensure there were no further medication errors and/or changes in any resident's condition. Any concerns will be addressed by a LN if identified. The results of the report covering the past 72 hours found no additional medication errors or changes in residents' condition. No further physician notification of actions by the licensed nurse was necessary. 3. When the Director of Nursing (DON) interviewed the LN on 02/29/24 who made medication error, it was determined that the LN dispensed the medication for a resident other than resident #1. She then realized that she needed to take resident #1's blood pressure, and subsequently also gave the other resident's medication to resident #1. The education provided to this LN by the DON included avoiding distractions and completing the medication pass one resident at a time once starting the medication administration process. Beginning 3/6/24, LNs and Certified Medication Aides (CMAs) will have a medication pass observation completed by a Registered Nurse (RN) prior to the beginning of their next shift and receive education as needed for any concerns identified by the RN conducting the observation. The RN will observe a minimum of 50% of the LNs or CMAs medication pass for that scheduled time to validate competency. The RN will stop the LN or CMA if they identify a problem and provide immediate reeducation in real time on the issue identified. The medication administration observations will be documented on the facility's Medication Administration/Technique Observation tool which follows the facility's Medication Management policy. On 3/8/24, the LNs and CMAs went through additional medication administration education that was provided by the ADON. This education included avoiding distractions to the medication pass and once starting to dispense medication for a resident, not to stop and perform any other non-emergent tasks. It also included following the facilities procedure on Medication Administration from the facilities Nursing Procedure Manual. The LNs and CMAs understanding of the education will be demonstrated through RN observed medication administration observations previously described. All newly hired LNs and CMAs will go through medication pass validations by a LN with the tools mentioned above during their orientation. 4. The DON, ADON or designee will complete med pass observations weekly for 12 weeks to ensure licensed nurse and medications aides continue to administer medications per physician's orders and to the right resident. The Medical Director was notified of this survey outcome on 3/8/24 and will be involved in the facility QAPI process surrounding this plan. A report of the medication administration audits will be submitted to the QAPI committee for review and recommendations as needed. The facility held an initial QAPI meeting on 3/8/24 to review the outcome of the medication administration observations to this point. Starting the week of March 11, 2024, a QAPI meeting will be conducted weekly for 4 weeks then monthly. The DON is responsible for monitoring and additional actions to this plan if needed. Date of Compliance: 03/08/24				
GRACE CARE CENTER OF NOCONA	1. Resident #1 was assisted by staff back to bed on 12/28/2022.Resident #1 was assessed by the licensed nurse on 12/28/22with a small red indention noted to his upper middle chest, no other marks or injuries noted. Resident #1 was discharged from the facility on 2/26/23. 2. Residents have been reassessed/re-evaluated for use of bed rails to meet resident needs by the DON and designee on 5/19/2023. Those residents that require bed rails as an enabler have received verbal orders from the Medical Director on 5/19/2023. Residents/Responsible Party have been notified of the use of bed rails as an enabler for consent by the DON or designee on 5/19/2023. The DON or designee will review care plans for residents with side rails on or before 5/20/2023 to ensure care plans reflect current interventions and needs related to side rail use. The Maintenance or designee removed bed rails on 05/20/2023 from residents' beds that do not require bed rails as an enabler device and verified by surveyor. Therapy will screen residents for bed rail use on or before 5/20/2023 on the recommendation of the Certified Occupation Therapy Assistant on 05/20/23 on 4:30 PM two bed rails were removed and/or modified and verified by surveyor. 3. Education provided to licensed staff by the Administrator and designee on 5/18/2023 - 5/19/2023 regarding the requirement of providing alternatives to bed rails, and assessments for risk of entrapment. Education provided to staff by the Administrator and designee on 5/19/2023 regarding observations of residents' safety and timely assistance of residents, including resident calling out for assistance. Beginning on 5/20/2023 staff will be educated prior to the beginning of their next shift by the Administrator, DON, or designee regarding the 7 zones of bed entrapment, residents' physical conditions that increase risk of entrapment and the requirement of obtaining consents prior to implementing side rails. Staff will complete a posttest to confirm staffs understanding of education provided and verified by the surveyor. 4. The Director of Nursing or designee (DON was not available for interview but the Administrator) said audits will be will complete audits weekly for 4 weeks, then monthly for 2 months to ensure residents continue to be assessed for entrapment risk, alternatives continue to be provided for enable devices and consents continue to be obtained prior to implementing side rails. The Administrator or designee will complete audits weekly for 4 weeks and monthly for 2 months to ensure staff continue to be educated regarding bed entrapment and factors that increase risk for entrapment prior to providing resident care Findings of these audits will be presented at QAPI Committee meeting monthly for 3 months for review and recommendations as needed. The Director of Nursing is responsible for monitoring and follow-up as needed. The Assistant Director of Nursing and MDS nurse will be responsible for monitoring in the absence of the Director of Nursing. Date of compliance: 05/20//2023	-	-	-	-

Attachment C: Jack Shelby Affiliated Entities Owned Facilities Deficiencies and Survey Results

Source: ProPublica Nursing Home Inspection/Survey Results

List facilities that are required for review under 10.24.20.05(8)	SFF	Date of the Survey	Deficiencies	Deficiencies (Cont.)	Description	Seriousness
GRACY WOODS II LIVING CENTER	-	-	-	-	-	-
GRANBURY REHAB & NURSING	-	-	-	-	-	-
GREENVILLE GARDENS	-	4/11/2024	Quality of Life and Care Deficiency — F0689	Failure to: Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.	The facility failed to ensure Resident #1's safety while smoking. Resident #1 was allowed to sit on a public roadway in a space used by cars to parallel park where he could have been injured in a vehicle and pedestrian accident.	J
GREENVILLE HEALTH & REHABILITATION CENTER	-	5/12/2025	Resident Rights Deficiency — F0561	Failure to: Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice.	The facility failed to ensure Resident #9's right to make choices about aspects of his life that were significant to the resident by not ensuring his right to have access to a working debit card attached to his personal funds for his own daily use. The facility failed to prevent the Administrator from purchasing a pre-need funeral plan in the amount of $13, 034.41 when Resident #9 had expressed to his family member he did not want a pre-need funeral plan.	J

Attachment C: Jack Shelby Affiliated Entities C

Source: ProPublica Nursing Home Inspection/Survey

		Medicare			
List facilities that are required for review under 10.24.20.05(8)	**Action Taken**	**Penalty Date**	**Payment Denial Length in Days**	**Payment Denial Start Date**	**Payment Denial End Date**
GRACY WOODS II LIVING CENTER	-	-	-	-	-
GRANBURY REHAB & NURSING	-	-	-	-	-
GREENVILLE GARDENS	Identify responsible staff/ what action taken. 1. Director of Nurses and Administrator educated by the Regional Nurse Consultant on the facility policy for signing out on pass completed on 4/9/24. 2. All Staff education on out on pass process started by the DON on 4/9/24 and completed on 4/10/24, no staff will resume assignment without being in serviced. 3. All new hires will be educated on this process by DON/Designee prior to starting work. This will be ongoing. 4. Resident #1 will be provided a safe designated smoking area located on property available to resident at all times. In-Service conducted. 1. Director of Nurses and Administrator educated by the Regional Nurse Consultant on the facility policy for signing out on pass completed on 4/9/24. 2. All Staff education on out on pass process started by the DON on 4/9/24 and completed on 4/10/24, no staff will resume assignment without being in serviced. 3. All new hires will be educated on this process by DON/Designee prior to starting work. This will be ongoing. Implementation of Changes Director of Nurses and Administrator were educated on the facility policy for signing out on pass completed on 4/9/24. All Staff education on out on pass process started by the DON on 4/9/24 and completed on 4/10/2024, no staff will resume assignment without being in serviced. Smoke assessment completed on all smokers in the facility, as well as education on smoke schedule and designated area. Residents who smoke that are determined to be safe to smoke will be assessed for any additional accommodations that may be needed to ensure resident safety. All residents with BIMS of 11 (mildly impaired cognition) and below will not be allowed to sign out on pass without supervision. Facility will be respectful of resident's right to come and go from the facility by ensuring residents who are able to do so will sign in and out of the facility. Should a resident require a ride to a destination, facility will make attempt to accommodate said request. Residents who are deemed safe to go out on pass will be educated of potential safety concerns and IDT note will be placed in resident's chart. After an audit by the facility administrator no other residents are found to be signing out on pass to smoke off property or go elsewhere without facility assistance or support. All new hires will be educated on this process by DON/Designee prior to starting work. This will be ongoing. All re-education and assessments were initiated by the Regional Nurse Consultant for the DON/Administrator. The changes were implemented effective on 4/9/24 and re-education is ongoing. Staff will not be allowed to work until they have been fully re-educated. All new hires will be educated on out on pass policy prior to resuming work by Administrator/DON/Designee. Facility Smoking Policy/Smoking assessments were reviewed with no changes required. Involvement of Medical Director The Medical Director met with the Interdisciplinary team on 4/9/24 and conducted an Ad HOC QAPI regarding ensuring patient safety by properly signing out on pass prior to exiting facility. The Medical Director was notified about the immediate Jeopardy on 4/9/24, the Plan of removal was reviewed and accepted by Medical Director. Involvement of QA An Ad Hoc QAPI meeting was held with the Medical Director, facility administrator, director of nursing, to review the plan of removal on 4/9/24. Who is responsible for the implementation of the process? The Director of Nursing and Administrator will be responsible for the implementation of Process. Please accept this letter as our plan of removal for the determination of Immediate Jeopardy issued on 4/9/24. On 4/10/2024 the surveyor confirmed the facility had implemented their plan of removal sufficiently to remove the Immediate Jeopardy (IJ) by: Interview with the Administrator on 4/10/2024 at 5:00 p.m., indicated safer smoking arrangement for Resident #1 was implemented while completing the appeals process regarding the 30-day notice and sign out on pass process.	-	-	-	-
GREENVILLE HEALTH & REHABILITATION CENTER	A. On 5/9/2025 the ADON completed an assessment on Resident #9 to determine if the resident was having any emotional distress related to this incident. The resident stated he was fine and was attending church services. The assessment was conducted privately prior to church services. B. On 5/9/2025 the DON completed a Comprehensive Trauma screen on the resident, and on 5/9/2025 The V.A. Social Worker was contacted by the facility regarding the need of the resident needing a Psychology evaluation related to this incident. C. On 5/9/2025 the Regional Nurse Consultant provided 1:1 in-service with the DON on the facility's D. On 5/9/2025 the DON started in-service education with all staff on the facility's Resident Right's policy. This was completed at 8:00pm and no staff will be allowed to work until they have completed their education. E. On 5/8/2025 the Administrator was suspended by the Regional Director of Operations pending investigation. F. On 5/8/2025 the Misappropriation was reported to HHSC by DON. G. On 5/12/2025 the resident will be taken to his bank by the Maintenance Director and Social Services to obtain a new debit card. The residents' family will be encouraged to go as well. The resident does have an active Trust fund in the facility and has access to immediate funds if he chooses. The Resident has made 10 trust fund withdrawals in April 2025, and 4 in May 2025. 1. Identification of Residents Affected or Likely to be Affected: A. On 5/9/2025 the nurse manager on duty completed alert resident questionnaires to determine if any other resident was not allowed to make choices about aspects of his/her life in the facility. The questionnaire included financial choices as well. No other residents were found to be affected by this practice. 2. Actions to Prevent Occurrence/Recurrence: A. Starting 5/7/25 the Social Worker/designee will complete alert resident interviews 3 x week for 3 weeks, then weekly x 6 weeks to validate that all residents are allowed to make choices about aspects of his/her life in the facility, including financial choices. This will be reviewed after each interview is completed by the DON and Social Services so any issues, if applicable, can be addressed immediately. 3. On 5/9/25the facility's DON notified the Medical Director regarding the Immediate Jeopardy the facility received related to Self-determination and Resident Rights. 4. On 5/9/25 the facility conducted an Ad Hoc (created or done as necessary) QAPI meeting to discuss Resident Self-Determination and Resident Rights and sustaining compliance.	-	-	-	-

Attachment C: Jack Shelby Affiliated Entities Owned Facilities Deficiencies and Survey Results

Source: ProPublica Nursing Home Inspection/Survey Results

List facilities that are required for review under 10.24.20.05(8)	SFF	Date of the Survey	Deficiencies	Deficiencies (Cont.)	Description	Seriousness
GREENVILLE HEALTH & REHABILITATION CENTER	-	5/12/2025	Freedom from Abuse, Neglect, and Exploitation Deficiency — F0602	Failure to: Protect each resident from the wrongful use of the resident's belongings or money.	The facility failed to protect Resident #9 from misappropriation of his personal funds when CNA D and CNA E attempted an ATM transaction for $200.00 on 2/21/2025 with unauthorized use of Resident #9's debit card. The facility failed to protect Resident #9 from misappropriation when Resident #63 used Resident #9's debit card and gave it to CNA E and CNA D to withdraw money that was not authorized by Resident #9 to allow CNA E and CNA D to use his debit card. The facility failed to prevent unauthorized transactions on Resident #9's debit card account on 1/27/25, 2/6/25, 2/7/25, and 2/10/25.	J
			Freedom from Abuse, Neglect, and Exploitation Deficiency — F0607	Failure to: Develop and implement policies and procedures to prevent abuse, neglect, and theft.	The facility failed to implement their abuse policy and failed to protect Resident #9 from misappropriation of his personal funds when CNA D and CNA E attempted an ATM transaction on 02/21/25 using Resident #9's debit card associated with his personal bank account. The facility failed to implement their policy when they failed to conduct an investigation of misappropriation of Resident #9's monies and unauthorized transactions.	J
			Freedom from Abuse, Neglect, and Exploitation Deficiency — F0609	Failure to: Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.	The facility failed to report timely to HHSC when CNA D and CNA E attempted an ATM transaction on 02/21/25 using Resident #9's debit card associated with his personal bank account. The facility failed to ensure that CNA E, LVN FF, and LVN YY reported the resident-to-resident altercation between Residents #126 and Resident #54 to the Administrator, who was the abuse coordinator, immediately on 02/22/25, which resulted in the Administrator not learning of the altercation until 02/25/25.	J
		8/18/2023	Quality of Life and Care Deficiency — F0689	Failure to: Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.	The facility failed to provide adequate supervision for Resident #1 when she left the facility with a stranger on [DATE]. Resident #1 was taken approximately 25 miles away from the facility to her former residence, where the stranger dropped her off. Resident #1 was gone from the facility for approximately 1 and ,d+[DATE] hours. The facility was not aware she had left the facility. The facility failed to complete an updated elopement assessment when Resident #1 displayed wandering/elopement behaviors. The facility failed to complete a quarterly elopement assessment for Resident #1 #2, #3, #4, #5, #6, #7, #8, #9, #10, #11, #12 #13, and #14.	J

Attachment C: Jack Shelby Affiliated Entities C

Source: ProPublica Nursing Home Inspection/Survey

		Medicare			
List facilities that are required for review under 10.24.20.05(8)	**Action Taken**	**Penalty Date**	**Payment Denial Length in Days**	**Payment Denial Start Date**	**Payment Denial End Date**
GREENVILLE HEALTH & REHABILITATION CENTER	Immediate Action Taken: V. On 5/9/2025 DON completed an assessment on Resident # 9 to determine if resident was having any emotional distress related to this incident. The resident stated he was fine and was attending church services. The assessment was conducted privately prior to church services. W. On 5/9/2025 the DON completed a Comprehensive Trauma screen on the resident, and resident will be referred to Psychology services for further evaluation. On 5/9/2025 The V.A. Social Worker was contacted by the facility regarding the need of the resident needing a Psychology evaluation related to this incident. X. On 5/9/2025 the Regional Director of Operations provided 1:1 in-service with the Regional Nurse Consultant on the facility's abuse, Neglect, and Misappropriations policy. Y. On 5/9/2025 The Regional Nurse Consultant provided 1:1 education to the facility DON on the Abuse, Neglect, and Misappropriations policy. This was completed on 5/9/25. Z. On 5/9/2025 DON started in-service education with all staff on the facility's Abuse, Neglect, Misappropriations policy, including post-test. This was completed at 8:00pm on 5/9/2025, and no staff will be allowed to work until they have completed their education. AA. On 5/8/2025 the Administrator was suspended by the Regional Director of Operations pending investigation. BB. On 5/12/2025 the resident will be taken to his bank by the Maintenance Director and Social Services to obtain a new debit card. Residents' family will be encouraged to go as well. Resident does have an active Trust fund in the facility and has access to immediate funds if he chooses. Residents have made 10 trust fund withdrawals in April 2025, and 4 in May 2025. CC. On 5/8/2025 the Misappropriation incident was reported to HHSC by DON. DD. On 5/8/2025 the Misappropriation incident was also reported to the local law enforcement agency. EE. On 5/9/2025 this incident was reported to HHSC by DON regarding resident # 63 not being authorized to use resident #9 debit card. FF. Resident # 63 was discharged from the facility on 5/7/2025 and does not have access to resident # 9 debit card. GG. On 5/8/2025 the facility started an investigation into the incident, the investigation was completed on 5/10/2025 at 12:00 pm. HH. On 5/9/2025 C.N.A. E was suspended by the DON related to this incident. II. C.N.A. D was suspended on 2/24/2025 and never returned to work. 2. Identification of Residents Affected or Likely to be Affected: A. Starting 5/7/25 the Social Worker/designee will complete alert resident interviews 3 x week for 3 weeks, then weekly x 6 weeks to validate that all residents are allowed to make choices about aspects of his/her life in the facility, including financial choices. This will be reviewed after each interview is completed by the DON and Social Services so any issues, if applicable, can be addressed immediately. B. The Regional Nurse Consultant will oversee this process weekly x 6 weeks. 7. On 5/9/25 the facility's DON notified the Medical Director regarding the Immediate Jeopardy the facility received related to failure to implement the abuse policy 8. On 5/9/25 the facility conducted an Ad Hoc QAPI meeting to discuss Misappropriation, and implementation of the abuse policy and sustaining compliance. The surveyor confirmed the following actions had been implemented sufficiently to remove the immediacy by: Record review of Resident #9's emotional assessment was completed by the DON on 5/09/2025. Record review of Resident #9's Comprehensive Trauma assessment was completed by the DON on 5/09/2025. Record review of a referral dated 5/09/2025 to the VA Social Worker for psychological services. Record review of the Administrator's suspension form dated 5/08/2025 indicated she was suspended pending investigation. Record review of the DON's in-service on the facilities Resident Rights policy dated 5/09/2025. Record review of the Regional Nurse Consultant's 1:1 in-service with the DON on the Abuse, Neglect, and Misappropriation policy. Record review of the Regional Director of Operation's 1:1 in-service with the Regional Nurse Consultant on the Abuse, Neglect, and Misappropriation policy. Record review of the in-service on the facility's Abuse, Neglect, Misappropriation policy dated 5/09/2025 conducted by the DON. The in-service also included a post test. During an observation on 5/12/2025 Resident #9 was driven to his financial institution where he was able to obtain a new debit card to his personal account.	-	-	-	-
	An Immediate Jeopardy (IJ) was identified on [DATE] at 9:45 a.m. The IJ template was provided to the facility on [DATE] at 10:14 a.m. While the IJ was removed on [DATE] at 3:24 p.m., this survey does not contain the full plan of removal.				

Attachment C: Jack Shelby Affiliated Entities Owned Facilities Deficiencies and Survey Results

Source: ProPublica Nursing Home Inspection/Survey Results

List facilities that are required for review under 10.24.20.05(8)	SFF	Date of the Survey	Deficiencies	Deficiencies (Cont.)	Description	Seriousness
GREENVILLE HEALTH & REHABILITATION CENTER	-	7/11/2023	Quality of Life and Care Deficiency — F0689	Failure to: Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.	1. The facility failed to have a system in place to ensure resident safety while residents were signed out of the facility when smoking and traveling by themselves. 2. The facility failed to provide supervision for Resident #1, who was allowed to sign herself out and self-propel in a wheelchair to a local convenience store down the street (0.2 miles from facility), loiter in a neighboring medical parking lot, and smoked at the entrance of the facility's parking lot near a two-lane street with a posted speed limit of 30 mph. 3. The facility failed to follow their smoking policy by allowing multiple residents to sign themselves out and smoke and allowing Resident #1 and Resident #2 who required supervision while smoking to smoke unsupervised. There was no designated smoking area in the front of the facility where residents go smoke. 4. The facility had no policy to address resident signing themselves out. 5. The facility did not have a covered area or approved ash trays to fire extinguisher.	K
HENDERSON HEALTH & REHABILITATION CENTER	-	3/3/2023	Infection Control Deficiency — F0880	Failure to: Provide and implement an infection prevention and control program.	The facility failed to initiate transmission-based precautions with the onset of the diagnosis of shingles F(painful rash with blisters) for Resident #45. The facility failed to initiate transmission-based precautions with the onset of and ongoing of diarrhea for Resident #74. CNA C failed to change gloves and washing her hands during incontinent care and prior to exiting Resident #74's room. The facility failed to separate the linen from the rooms with communicable infections from the general linen for Resident #'s 45 and 74. The facility failed to test Resident #41 for Clostridium Difficile (Inflammation of the colon caused by bacteria) when he had chronic diarrhea. The facility failed to document tracking and trending of infection and antibiotic use for January of 2023. LVN F failed to remove soiled gloves after obtaining Resident #50's blood sugar and he failed to perform hand hygiene before donning clean gloves. The facility failed to ensure LVN D did not use a dirty cloth to clean Resident #54's catheter during catheter care. The Infection Preventionist allowed RN G to work with a temperature of 102.2	L

Attachment C: Jack Shelby Affiliated Entities C

Source: ProPublica Nursing Home Inspection/Survey

		Medicare			
List facilities that are required for review under 10.24.20.05(8)	**Action Taken**	**Penalty Date**	**Payment Denial Length in Days**	**Payment Denial Start Date**	**Payment Denial End Date**
GREENVILLE HEALTH & REHABILITATION CENTER	An Immediate Jeopardy (IJ) situation was identified on 07/08/2023 at 5:00 p.m. The IJ template was provided to the facility on [DATE] at 5:00 p.m. While the IJ was removed on 07/11/2023 at 12:58 p.m., this survey does not contain the full plan of removal.	-	-	-	-
HENDERSON HEALTH & REHABILITATION CENTER	Immediate Action: *On 02/27/2023 Resident #45 was placed in contact isolation *On 02/28/2023 Resident #74 was placed in contact isolation *On 02/28/2023 Resident #45 was removed from contact isolation per physician's order, related to a negative Herpes Simplex IGM test on 02/21/2023, Medical Director ordered Acyclovir treatment which was administer per physician's order *On 03/01/2023 after Medical Director spoke to the survey team, the Medical Director ordered Resident #45 to be placed back in isolation, restart Acyclovir, and PCR (Polymerase chain reaction) testing for HSV (herpes simplex virus) and VZV (varicella-zoster virus). *On 03/01/2023 Resident #45 was placed back on contact isolation *On 02/28/2023 Regional Nurse Consultant completed an assessment of resident #74 to validate Resident had no negative outcome from alleged improper peri-care. Facility's plan to ensure compliance quickly: *On 02/28/2023 DON/designee began training on Transmission Based Precautions to guide the center on when and what precautions to take to prevent transmission of pathogens base on mode of transmission including linen handling, storage, and sanitation for residents with presumed or confirmed infections, with all staff on duty. This education was completed on 02/28/2023with 20 of 89 staff trained. On 03/01/2023 at 2:00 p.m., no staff will be allowed to work until his education was completed. *The DON/Designee was responsible for ensuring residents were placed on appropriate isolation precautions. *On 03/01/2023 the DON was provided 1:1 education on Transmission Based Precautions to guide the center on when and what precautions to take to prevent transmission of pathogens based on mode of transmission, on monitoring, tracking, trending of infections by Regional Nurse Consultant. *On 03/01/2023 an additional 8 staff were trained prior to working *Again, no staff would be allowed to work until the education had been completed *On 03/01/1023 DON/designee began performing Hand Hygiene Skills Validation with Nurse Assistants. The skill competencies were completed on 02/28/2023 at 10:00 p.m., with 19 of 89 staff trained. NO staff would be allowed to work until the skills competency was completed. *On 03/01/2023 DON/designee began performing Hand Hygiene Skills Validation with all staff with an additional 39 of 89 staff trained. *On 02/28/2023 DON/designee began performing Peri-Skills Validation with Nurse Assistants. The skills competencies were completed on 02/28/2023 at 10:00 p.m. with 11 of 29 Nurse Assistants trained. No Nurse Assistants would be allowed to work until the education was completed. *On 03/01/2023 DON/designee began performing Peri-Skills Validation with Nurse assistants with an additional 10 of 29 staff trained. *On 03/01/2023 housekeeping staff completed deep thorough cleaning/disinfection of resident #'s 45, 74, and 1 other identified resident's room. The cleaning included halls and common areas. Quality Assurance: *Medical Director was notified on 02/28/2023 at 8:00 p.m. of the Immediate Jeopardies. *On 03/01/2023 an Ad Hoc QAPI meeting was conducted to discuss identified issues and to develop plan for sustaining compliance. In-services Conducted: Transmission Based (Isolation) Precautions dated 10/24/2022 indicated it was the policy to take appropriate precautions to prevent transmission of pathogens, based on the pathogens' mode of transmission. For training and quick referencing purposes a summary of precautions was contained at the end of the policy.Airborne Precautions refer to actions taken to prevent or minimize the transmission of infectious agents/organisms that remain infections over long distances when suspended in air. Contact precautions refer to measures that were intended to prevent transmission of infectious agents which were spread by direct or indirect contact with the resident or the resident's environment. Droplet precautions refer to actions designed to reduce/prevent the transmission of pathogens spread through close respiratory or mucous membrane contact with respiratory secretions. Transmission-based precautions (aka Isolation Precautions) refer to actions implemented in addition to standard precautions that were based upon the means of transmission (airborne, contact, and droplet) in order to prevent or control infections.	-	-	-	-

Attachment C: Jack Shelby Affiliated Entities Owned Facilities Deficiencies and Survey Results

Source: ProPublica Nursing Home Inspection/Survey Results

List facilities that are required for review under 10.24.20.05(8)	SFF	Date of the Survey	Deficiencies	Deficiencies (Cont.)	Description	Seriousness
HENDERSON HEALTH & REHABILITATION CENTER	-	3/3/2023	Resident Rights Deficiency — F0580	Failure to: Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.	The facility failed to notify the resident's physician when Resident #45 had worsening symptomatic shingles (painful rash with blisters) covering his right eye lid. The facility failed to notify the resident's physician when Resident #74 had diarrhea since admission on 01/24/2023.	K
			Quality of Life and Care Deficiency — F0684	Failure to: Provide appropriate treatment and care according to orders, resident's preferences and goals.	The facility failed to ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices for 3 of 6 residents reviewed changes of condition. (Resident #'s 41, 45 and 74) The facility failed to obtain a PCR HSV and VZV lab when Resident #45 had worsening symptomatic shingles (painful rash with blisters) covering his right eye lid. The facility failed to obtain a stool culture when Resident #74 had on-going diarrhea since admission on 01/24/2023.	K
HERITAGE HOUSE AT KELLER REHAB & NURSING	-	10/24/2023	Quality of Life and Care Deficiency — F0689	Failure to: Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.	The facility failed to: 1. ensure Resident #1's prescribed tramadol was in the facility and provided to Resident #1 for her pain after Resident #1 suffered a fall on [DATE] around 5:47 am and reported constant pain in her left arm and had a visible hematoma (swollen knot) on her right forehead. 2. ensure Resident #2's prescribed hydrocodone was in the facility and available to Resident #2 for 3 days which led to pain that went as high as a 9, especially at night, which caused sleep loss, and pain that averaged a 6 for the duration of the time his medication was unavailable	J

Attachment C: Jack Shelby Affiliated Entities C

Source: ProPublica Nursing Home Inspection/Survey

		Medicare			
List facilities that are required for review under 10.24.20.05(8)	**Action Taken**	**Penalty Date**	**Payment Denial Length in Days**	**Payment Denial Start Date**	**Payment Denial End Date**
HENDERSON HEALTH & REHABILITATION CENTER	Immediate action: *On 02/28/2023 the physician was notified of Resident #74's on-going diarrhea *On 02/28/2023 the physician was notified of Resident #45's worsening symptoms of shingles. Facilities plan to ensure compliance quickly: *On 02/28/2023 DON/designee began training on notification of change in condition policy which provides guidance on when to communicate acute changes in status to physician and the need to significantly alter the resident's treatment with all licensed nurses on duty to include post-tests. This education was completed on 02/28/2023 at 10:00 p.m. with 11 of 34 licensed nurses trained. No licensed nurse will be allowed to work until this education is completed. *On 03/01/2023 an additional 6 of 34 (total 17) licensed nurses were trained prior to working. *Again, no licensed nurse will be allowed to work until this education has been completed *On 03/01/2023 DON/designee began training on Clinical Documentation Guidelines which provides direction to the healthcare team on documentation and communication with the resident's progress and current treatment with all licensed nurse on duty. This education was completed on 03/01/2023 at 2:00 p.m. with 7 of 34 licensed nurses trained. No licensed nurse will be allowed to work until this education is completed. *On 03/01/2023 an additional 6 of 34 (13 total) licensed nurses were trained prior to working *Again, no licensed nurse will be allowed to work until this education has been completed. Quality Assurance *The Medical Director was notified on 02/28/2023 at 08:00 p.m., of the Immediate Jeopardies. On 03/01/2023 An Ad Hoc QAPI meeting was conducted to discuss identified issues, and to develop plan for sustaining compliance Monitoring included: During Interviews on 03/03/2023 from 3:08 p.m. until 1:21 p.m., the surveyors confirmed the facility implemented their plan of removal sufficiently to remove the IJ by: Interview with the DON stated she was in-serviced on her role as Director of Nurses and Infection Preventionist. She was in-serviced on documentation of changes of condition requirements, notification of the responsible party and physicians, and following up on changes of condition to ensure all care needs were met. Interviews with 2 RNs: DON and RN KK (6am-6pm); 4 nurses LVN L (6a-6p), LVN A (6a-6p), LVN F (6a-6p), LVN B (6p-6a), ADON (all shifts), Tx nurse (all shifts) in-serviced on transmission-based precautions, notification of the physician and family of acute changes such as accidents, illness, transfers, emergencies, and injuries. Immediate action: On 02/27/2023 Stool culture was obtained and sent to lab for Resident #74. On 02/28/2023 DON RN completed a Hydration assessment on Resident #74. On 03/01/2023 Regional Registered Dietician completed a Nutritional assessment on Resident #74 with no new recommendations. On 02/28/2023 Social Services/Designee obtained an Ophthalmology consult for Resident #45 for 03/03/23 related to worsening symptomatic Shingles. On 02/28/2023 ADON LVN completed rounds and identified 1 other resident with diarrhea who is in a private room and was placed on isolation precautions on 02/28/2023. DON RN completed a hydration assessment on this resident and notified the Physician 02/28/2023 regarding on-going diarrhea and hydration assessment. On 02/28/2023 stool culture was obtained and sent to lab for the one other identified resident. On 03/01/2023 Regional Registered Dietician completed a review on the 1 other resident in the center who was experiencing diarrhea, an identified as having the potential to be affected by this alleged practice with no recommendations. Facilities plan to ensure compliance quickly On 03/03/2023 DON Designee began training on Provision of Quality of Care to ensure that residents receive treatment and care by qualified persons in accordance with professional standards of practice. This education will be completed on 03/03/2023. No staff will be allowed to work until this education is completed. Quality Assurance Medical Director was notified on 02/28/2023 at 08:00 p.m., of the Immediate Jeopardies. On 03/01/2023 An Ad Hoc QAPI meeting was conducted to discuss identified issues, and to develop plan for sustaining compliance In-services: *Provision of Quality Care: The facility will ensure that residents receive treatment and care by qualified persons in accordance with professional standards of practice, the comprehensive person-centered care plans, and the resident's choice. During an interview on 03/03/2023 at 11:15 a.m., the Interim Administrator said she expected the physician to be notified off all changes of condition. Interviews with 2 RNs: DON and RN KK (6am-6pm); 4 nurses LVN L (6a-6p), LVN A (6a-6p), LVN F (6a-6p), LVN B (6p-6a), ADON (all shifts), Tx nurse (all shifts) in-serviced on transmission-based precautions, notification of the physician and family of acute changes such as accidents, illness, transfers, emergencies, and injuries. Record review of Resident #74's laboratory PCR HSV and VSV pending taking 5-7 days for return. Record review of Resident #74's stool culture dated 2/27/2023 indicated a negative result for C-diff. Record review of Resident #45's ophthalmologist appointment dated 03/02/2023 at 3:15 p.m. but he slid from his wheelchair preparing to leave the facility. The facility working with a local EMS ambulance to take Resident #45 to the ophthalmologist on a stretcher.	-	-	-	-
HERITAGE HOUSE AT KELLER REHAB & NURSING	Record review of the following in-services, dated 09/25/23 and 09/28/23, reflected the in-services were conducted and signed by all facility staff on all three shifts, 6:00 AM to 2:00 PM, 2:00 PM to 10:00 PM and 10:00 PM to 6:00 AM:- Missing resident guidelines;- Missing resident protocol-Elopement binder;- Code Silver;- Exit seeking behavior; and- Head count procedural guidelines. Interviews on 10/24/23 from 9:34 AM to 3:59 PM with the Receptionist, HR Director, Restorative Aide, Maintenance Director, ADON, LVN A, LVN B, CNA C, LVN D, and LVN E who worked all three shifts revealed they were able to conduct a code silver drill for a missing resident, perform a head count check, what to do when they heard a door alarm and monitor any changes in condition that could indicate a resident was a high elopement risk. Record review of the facility's Code Silver drills revealed they were conducted daily on each shift beginning on 09/25/23 and they were currently being done monthly with no end date. Record review of exit door checks on 09/25/23, after Resident #1 eloped, revealed all exit doors were functioning properly. Record review dated 09/28/23 revealed staff were doing 15 minute checks on the 200 hall door from 4:20 PM until the Maintenance Director arrived and it was fixed at 6:47 PM. Record review of the fire and security invoice revealed that on 09/30/23 a delayed egress lock was replaced on the 200 hall. Record review of the door alarm checks dated 09/29/23 to 10/23/23 revealed they were being checked daily by the Maintenance Director. Record review revealed an elopement assessment was completed on all the residents on 09/29/23 to identify any additional high risk residents. Two additional residents were identified as being at high risk for elopement. One of the resident was transferred out to a more secure facility and the other resident was monitored until he was deemed safe to remain at the facility.	-	-	-	-

Attachment C: Jack Shelby Affiliated Entities Owned Facilities Deficiencies and Survey Results

Source: ProPublica Nursing Home Inspection/Survey Results

List facilities that are required for review under 10.24.20.05(8)	SFF	Date of the Survey	Deficiencies	Deficiencies (Cont.)	Description	Seriousness
HERITAGE HOUSE AT PARIS REHAB & NURSING	-	-	-	-	-	-
HICO NURSING AND REHABILITATION	-	3/7/2024	Freedom from Abuse, Neglect, and Exploitation Deficiency — F0600	Failure to: Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.	An observation and interview on 11/16/23 at 3:45 PM revealed Resident #4 was sitting in a Geri chair watching television by the nurse's station. She stated her bottom hurt if she sat in the chair for too long. Resident #4 stated it was nice to be in up out of bed and in the chair, today. She had participated in an activity, which she had enjoyed. This occurred after surveyor intervention on behalf of Resident #1.	K
			Freedom from Abuse, Neglect, and Exploitation Deficiency — F0607	Failure to: Develop and implement policies and procedures to prevent abuse, neglect, and theft.	The facility failed to implement its policies and procedures that were designed to prevent abuse, neglect and exploitation by failing to: 1. ensure Resident #1's pain in her arm and hip was addressed after a fall on [DATE] by providing her prescribed tramadol which had run out and hospice nurse reported constant pain in left forearm 2. ensure Resident #1's neuro checks were completed and documented after a fall [DATE] in which she hit her head and displayed an increase in confusion 3. ensure Resident #1's x-rays were performed in a timely manner after a fall on [DATE] after which she complained of pain and x-rays were not performed until [DATE] 4. ensure Resident #2's pain was addressed by providing his prescribed hydrocodone for 3 days while it had run out leading to pain that went as high as a 9, especially at night causing inability to sleep, but averaged at a 6 for the duration of this time when his medication was unavailable	K
			Quality of Life and Care Deficiency — F0697	Failure to: Provide safe, appropriate pain management for a resident who requires such services	The facility failed to: 1. ensure Resident #1's prescribed tramadol was in the facility and provided to Resident #1 for her pain after Resident #1 suffered a fall on [DATE] around 5:47 am and reported constant pain in her left arm and had a visible hematoma (swollen knot) on her right forehead. 2. ensure Resident #2's prescribed hydrocodone was in the facility and available to Resident #2 for 3 days which led to pain that went as high as a 9, especially at night, which caused sleep loss, and pain that averaged a 6 for the duration of the time his medication was unavailable	K
LANDMARK OF AMARILLO REHABILITATION AND NURSING CE	-	11/20/2023	Quality of Life and Care Deficiency — F0686	Failure to: Provide appropriate pressure ulcer care and prevent new ulcers from developing.	The facility failed to prevent the development of one facility-acquired Stage III pressure injury for Resident #4.	H

Attachment C: Jack Shelby Affiliated Entities C

Source: ProPublica Nursing Home Inspection/Survey

		Medicare			
List facilities that are required for review under 10.24.20.05(8)	**Action Taken**	**Penalty Date**	**Payment Denial Length in Days**	**Payment Denial Start Date**	**Payment Denial End Date**
HERITAGE HOUSE AT PARIS REHAB & NURSING	-	-	-	-	-
HICO NURSING AND REHABILITATION	Immediate Interventions: 1. Consultation and notification made to Medical Director, of Immediate Jeopardy on [DATE] at 4:45 pm by the DON. Ad Hoc QAPI meeting conducted with action plan developed on [DATE] attended by Administrator, Director of Nursing, Assistant Director of Nursing, and Regional Nurse. 2. On [DATE] the DON and ADON were in-serviced, by Regional Nurse, on neglect, expectations in responding to X-Ray needs, and timeliness of obtaining an X-Ray in the event of an injury and complaints of pain. The DON and ADON then in-serviced the licensed nursing staff to include, newly hired, PRN, and agency, on neglect, expectations in responding to X-Ray needs, timeliness of obtaining an X-Ray in the event of an injury, and complaints of pain on [DATE] and [DATE]. Staff not present will be in-serviced, by DON or designee, prior to next shift. Newly hired will be in-serviced, by DON or designee, upon hire prior to working on the floor. Agency and PRN will not be allowed to work on the floor until in-service and post-test is completed by DON or Designee 3. On 2/ ,d+[DATE] the DON and ADON were in-serviced , by Regional Nurse, on notification of medication refill needs, when medication card is at the blue on the medication card, or the medication is down to , d+[DATE] days of administration. The DON and ADON then in-serviced the licensed nursing staff to include, newly hired, PRN, and agency, on notification of medication refill needs, when medication card is at the blue on the medication card, or the medication is down to ,d+[DATE] days of administration . Staff not present will be in-serviced, by DON and ADON, prior to next shift. Newly hired will be in-serviced, by DON and ADON, upon hire, prior to working on the floor. Agency and PRN will not be allowed to work on the floor until in-service and post-test is completed by DON and ADON. 4. On [DATE] the DON, ADON, and 3 licensed nurses completed a pain assessment on all residents to identify any unmet pain needs or change in pain. Completed audit did not identify any unmet pain needs or change in pain. And an audit of medication availability for all residents on pain medications was also completed [DATE] by the ADON, Treatment Nurse, and Regional Nurse. The DON and ADON had oversight of the audit. Monitoring: 1. The DON, ADON, or designee will review 24-hour report daily for any X-Ray orders to ensure timely follow up and intervention occurs. The Care plan will be updated at that time to reflect the intervention. This will be an ongoing monitoring system completed by the DON/ADON. 2. Administrator or designee, will review this process in the Clinical Meeting scheduled 5 times per week to monitor for compliance, and to make changes based on the interdisciplinary team's decision. This Process Review will be monitored for 12 weeks. 3. The facility's plan for pain management of new admits will be as follows: a) If the resident is coming from home, DON or designee, will ask the resident's family to bring any medications that the resident is currently taking. If not possible, we revert to step c. b) If the resident is coming from another nursing facility, DON or designee, will ask the DC facility to send the resident's current med supply. Also, if appropriate, DON or designee, will request the resident be given their medication before they discharge. If not possible, we revert to step c. c) If the resident is DC from the hospital, DON or designee, will ask the hospital to medicate prior to discharge. Charge nurse will pull available medications from the nexsys system (supply of extra medication) if necessary. If not available in the nexsys system, DON or designee, will call the PCP and order medications as substitutes until orders arrive. If we still do not have medications, and we cannot treat the resident as ordered, DON or designee, will call 911 and send them back to the hospital. d) New admissions medication availability will be monitored, by DON and Administrator, during the morning clinical meeting during weekdays. On weekends, the medication availability will be monitored by the weekend supervisor. MONITORING THE POR : Record review of in-service sign-in sheets revealed the DON and ADON were in-serviced on [DATE] by the corporate nurse related to Pain medication orders/refills. Record review of in-service sign-in sheets revealed the DON and ADON were in-serviced on [DATE] by the corporate nurse related to Post Fall X-Ray Protocol. Record review of in-service sign-in sheets revealed on [DATE] the DON in-serviced staff related to post fall x-ray protocols, which included a post-test. Record review of in-service sign-in sheets revealed on [DATE] the DON in-serviced staff related to pain medication orders/refills, which included a post-test. Record review of in-service sign-in sheets revealed on [DATE] the DON in-serviced staff related to abuse/neglect, which stated at the bottom that it was a refresher for nursing as it was in-serviced in January. No post-test included. Record review of in-service sign-in sheets revealed on [DATE] the DON and ADON in-serviced staff related to New Admission Medications and it was documented as completed and signed by RN B and LVN B.	-	-	-	-
LANDMARK OF AMARILLO REHABILITATION AND NURSING CE	An observation and interview on 11/16/23 at 3:45 PM revealed Resident #4 was sitting in a Geri chair watching television by the nurse's station. She stated her bottom hurt if she sat in the chair for too long. Resident #4 stated it was nice to be in up out of bed and in the chair, today. She had participated in an activity, which she had enjoyed. This occurred after surveyor intervention on behalf of Resident #1.	10/5/2022	11	11/8/2022	11/19/2022

Attachment C: Jack Shelby Affiliated Entities Owned Facilities Deficiencies and Survey Results

Source: ProPublica Nursing Home Inspection/Survey Results

List facilities that are required for review under 10.24.20.05(8)	SFF	Date of the Survey	Deficiencies	Deficiencies (Cont.)	Description	Seriousness
LANDMARK OF PLANO REHABILITATION AND NURSING CENTE	-	3/18/2025	Freedom from Abuse, Neglect, and Exploitation Deficiency — F0600	Failure to: Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.	The facility failed to ensure CNA A did not abuse Resident #1 on 03/14/25 by taking a private photo of her. This was determined to be past non-compliance.	G
		6/23/2023	Quality of Life and Care Deficiency — F0684	Failure to: Provide appropriate treatment and care according to orders, resident's preferences and goals.	The facility failed to assess Resident #1's left knee for pain and swelling on 05/22/23 and 05/28/23. There were multiple opportunities for the staff to assess the resident and provide follow-up care when it was noted by the facility staff and responsible party that Resident #1's leg was swollen, and she was in pain. As a result, she experienced continued pain per facility staff, and suffered fracture(s) of her left knee (acute transverse impacted fracture at proximal and fibular metaphysis which affects the neck of the bone (metaphysis), where the tibia starts to narrow down. Due to Resident #1's injury, she was sent to the hospital.	K
			Resident Rights Deficiency — F0580	Failure to: Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident	The facility failed to notify the physician when Resident #1 complained of right leg pain on 05/22/23. There were multiple opportunities for the staff to notify the physician when it was noted by the facility staff and responsible party that Resident #1's leg was swollen and she was in pain. The physician indicated he should have been notified on 5/18/23, 5/22/23, and 5/28/23. As a result, she experienced continued pain per facility staff, and suffered fracture(s) of her left knee (acute transverse impacted fracture at proximal and fibular metaphysis which affects the neck of the bone (metaphysis), where the tibia starts to narrow down. Due to Resident #1's injury, she was sent to the hospital.	K
LEXINGTON MEDICAL LODGE	-	-	-	-	-	-
MATADOR HEALTH AND REHABILITATION CENTER	-	-	-	-	-	-

Attachment C: Jack Shelby Affiliated Entities C

Source: ProPublica Nursing Home Inspection/Survey

		Medicare			
List facilities that are required for review under 10.24.20.05(8)	**Action Taken**	**Penalty Date**	**Payment Denial Length in Days**	**Payment Denial Start Date**	**Payment Denial End Date**
LANDMARK OF PLANO REHABILITATION AND NURSING CENTE	The noncompliance was identified as PNC. The noncompliance began on 03/14/25 and ended on 03/16/25. The facility had corrected the noncompliance before the survey began.Record reviews of facility in-services for abuse, personal cell phone usage, and HIPPA were completed. Some of the in-services were not dated and some were dated 03/16/25. The facility also completed safe surveys with residents. Interviews with facility staff and residents on 03/18/25 from 9:15 AM to 3:00 PM revealed staff knew not to take pictures of residents and the residents said no one had taken their picture. Resident #1 was assessed on 6/1/2023 by LVN A charge nurse and was noted with swelling to the left knee, physician was notified and order for a stat x-ray was obtained. Facility received X-ray results noted an acute, transverse, impacted fracture at proximal received on 6/1/2023. 1.) Resident#1's attending physician was notified on 6/1/2023 of Resident #1 x-ray result. Resident's attending physician gave an order to send resident to the E.R. for further evaluation. 2.) On 6/1/2023 resident #1's family member was notified at resident #1's bedside of the fracture and physician orders to send resident to the hospital for further evaluation, but Resident#1's requested that be sent to the hospital the following morning 6/2/2023. Physician ok with s request. 3.) Resident #1 was transferred to the hospital 6/2/2023 and discharged to another facility from the hospital. 4.) LVN B was in-serviced, then suspended on 6/7/2023 pending investigation and was terminated on 6/9/2023 due to investigation findings. 5.) LVN F was in-serviced regarding documentation, proper assessments, and notifying physicians regarding change of conditions on 5/31/2023. 6.) On 6/22/2023 a facility-wide 30 day look back audit was conducted to ensure that any resident who met the criteria for a change of condition, did, in fact, have this change of condition addressed per policy and regulation, to include making all appropriate notifications to the physician as well as the resident and/or the resident's responsible party. Additionally, to ensure that any appropriate assessments were completed and that any orders were obtained. Further, to see that the resident's care plan was revised as indicated. Any concerns were addressed. Training: A. During a mandatory nurse's meeting on 5/31/2023 the ADON in-serviced licensed nurses regarding documentation, proper assessments, notifying physicians regarding change of conditions. All nurses at the facility were in-serviced at this time. B. On 6/21/2023 after the IJ was identified the ADON began in-servicing all nursing staff, regarding documentation, proper assessments, notifying physicians regarding change of conditions. The facility does not use any agency staff. In the event of agency staff use, the facility will provide the same in-servicing before agency staff could work at the facility. o Change of Condition policy o Discussion of examples of changes of condition (to include pain, swelling, and fractures) o What should you do, in your staff member role if you observe what you believe to be a change in condition in a resident? Whom do you tell? When? Why? o (Nurses) What do you do? Assess? When? Whom do you notify? What/When do you document? What if the change of condition meets reportable criteria? Whom do you notify? When? o Discussion --- Questions/Answers Learning will be measured by a pre/post-test that required 100% of the questions to be answered correctly. Any staff who fail to comply with the points of the in-servicing will be further educated and/or progressively disciplined as indicated. C. Newly hired nurses will be in-serviced by the ADON/designee regarding documentation, proper assessments, notifying physicians regarding change of conditions during facility orientation upon hire. Any staff members who are unable to physically attend the in-service training in person will be in-serviced via phone and provided with in-service handouts via telephone or email. Staff members in-serviced over the phone will be required to obtain in person training prior to working completing the pre/post-tests. During the in-service training there will be a discussion QA to ensure staff understanding and competency. Learning will be measured by a pre/post-test that required 100% of the questions to be answered correctly. Any staff who fail to comply with the points of the in-servicing will be further educated and/or progressively disciplined as indicated.	-	-	-	-
LEXINGTON MEDICAL LODGE	-	-	-	-	-
MATADOR HEALTH AND REHABILITATION CENTER	-	-	-	-	-

Attachment C: Jack Shelby Affiliated Entities Owned Facilities Deficiencies and Survey Results

Source: ProPublica Nursing Home Inspection/Survey Results

List facilities that are required for review under 10.24.20.05(8)	SFF	Date of the Survey	Deficiencies	Deficiencies (Cont.)	Description	Seriousness
Mcallen Nursing Center	-	10/28/2024	Quality of Life and Care Deficiency — F0689	Failure to: Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.	Facility failed to ensure adequate supervision was provided for 1 of 6 residents reviewed for accidents and supervision. (Resident #1) The facility failed to ensure Resident#1 received adequate supervision to prevent elopement. Resident #1 eloped from the facility and was found by the police department approximately 0.2 miles away from the facility.	J
		7/26/2024	Quality of Life and Care Deficiency — F0689	Failure to: Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.	Facility failed to ensure adequate supervision was provided to prevent accidents for 1 of 5 residents (R #1) reviewed for supervision. The facility failed to ensure R #1 received adequate supervision as R #1 eloped from the facility without anyone's knowledge on 07/19/24 between 7:30-7:40 PM and was found at an apartment complex approximately 0.2 mile away. R #1 was exit seeking, had increased behaviors, and staff placed R #1 in his room and failed to request additional interventions or increased supervision. R #1 was out of the facility for approximately 30 minutes before the facility became aware that he had eloped.	J
		8/29/2023	Environmental Deficiency — F0921	Failure to: Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.	Facility failed to provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public for 3 of 6 halls and 1 of 1 dining rooms reviewed for environment, in that: The facility failed ensure that 3 of 11 rooms (room [ROOM NUMBER], 21 and 22) in Hall B, 4 of 12 rooms (room [ROOM NUMBER], 47, 48, and 49) in Hall E, 5 of 11 rooms (room [ROOM NUMBER], 54, 55, 57 and 59) in Hall F received repair and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior that was free of environmental hazards.	L

Attachment C: Jack Shelby Affiliated Entities C

Source: ProPublica Nursing Home Inspection/Survey

		Medicare			
List facilities that are required for review under 10.24.20.05(8)	**Action Taken**	**Penalty Date**	**Payment Denial Length in Days**	**Payment Denial Start Date**	**Payment Denial End Date**
Mcallen Nursing Center	The plan of removal was accepted on 10/26/2024 at 1:33pm. 1.Immediate Action Taken On 10/11/2024 The DON/ Designee completed a head-to-toe physical assessment with no negative findings noted On 10/11/2024 [Resident #1] was returned back to the facility and wander guard bracelet placed on resident On 10/11/24 [Resident #1] was returned back to the facility and placed on 1:1 observation. On 10/11/24 The DON/ Designee updated [Resident #1] care plan for wandering/exit seeking. On 10/11/24 The DON/ Designee completed elopement assessments on all facility residents with no changes noted. On 10/11/24 The maintenance director/ Designee completed environmental assessments to include checks on all door alarms and windows. On 10/11/24 The DON/ Designee completed in-service education with facility direct care staff on the missing resident policy which ensures that residents who exhibit wandering behavior and/or are at risk for elopement receive adequate supervision to prevent accidents. On 10/11/24 The DON/ Designee completed a Missing Resident Drill with facility direct care staff to ensure staff know the proper procedure for locating missing residents to include when a staff member hears the alarm sound they will initiate the code silver alert to notify all other staff members of the missing resident and to not turn the alarm sound off until all staff are notified of the missing resident and headcount guidelines which requires visual confirmation and documentation regarding the location of each resident in the center. On 10/25/24 The facility administrator spoke with tech support in regards to functioning door alarm who stated alarm volume could not be adjusted and is functioning at manufacture guidelines. Record reviews and interviews were conducted by the survey team to ensure the staff's understanding on in-service trainings received between 10/11/2024 and 10/25/2024	-	-		-
	The facility corrected the noncompliance on 7/22/24, before the investigation began Staff were re-educated on elopment risk and proper maintenance of resident care plans.				
	A Plan of Removal (POR) was first submitted by the Administrator on 07/21/23 at 8:00 PM with a revised POR accepted on 07/22/23 at 4:30 PM and read as follows: Preparation and/or execution of this plan do not constitute admission or agreement by the provider that immediate jeopardy exists. This response is also not to be construed as an admission of fault by the facility, its employees, agents, or other individuals who draft or may be discussed in this response and immediate jeopardy removal plan. This immediate jeopardy removal plan is submitted as the facility's immediate actionable plan to remove the likelihood that serious harm to a resident will occur or recur. 1. Immediate Action: A. On 7/22/2023 all residents will be transferred from E Hall to a sister facility or alternative. The transfer will occur on 7/22/2023. Residents and RPs were notified of transfer on 7/21/2023 via telephone by Social Services/designee and notification was documented in resident's medical record. There will be one licensed nurse and one certified nurse assistance accompanying residents during transport. B. On 7/22/2023 all residents will be transferred from F Hall to a sister facility or alternative. This will be completed on 7/22/2023. Residents and their RPs were notified of transfer on 7/21/2023 via telephone by Social Services/designee and notification was documented in resident's medical record. There will be one licensed nurse and one certified nurse assistance accompanying residents during transport. C. On 7/22/2023 all residents will be transferred from B Hall to a sister facility or alternative. This will be completed on 7/22/2023. Residents and RPs were notified of transfer on 7/21/2023 via telephone by Social Services/designee and notification was documented in resident's medical record. There will be one licensed nurse and one certified nurse assistance accompanying residents during transport. D. Residents were provided options other than a sister facility. Four residents have elected to be transferred to a long-term care center in (City) E. On 7/21/2023 the facility Administrator scheduled (Asbestos Abatement/Mold Remediation Company) (Project Manager employee) to come on-site 7/22/2023 to test for Mold and Asbestos. Test results will be pending. F. There will be at least 1 licensed nurse, as well as at least 1 certified nurse assistant from the (City) facility, who will remain on-site at the receiving facilities for at least a week to ensure continuity of care. 2. Identification of Residents Affected or Likely to be Affected: A. On 7/22/2023 DON/Designee completed respiratory assessment of each resident to determine if any resident was experiencing any new or exacerbation of respiratory issues. No resident identified from assessments. 3. Actions to Prevent Occurrence/Recurrence: A. Once the environmental mold testing has been completed, and the findings identified, repair of the facility roof and other identified repairs will begin within 48 to 72 hours.B. Contingency plans if mold is identified, and levels above a safe threshold would be to remove all residents form the center. C. The facility has a Scope of Work ([NAME]) emergency services agreement signed on 7/22/2023 in their possession. 4. Monitoring: A. Regional Director of Operations will complete a center visit weekly for the next 4 weeks to validate all repairs are progressing as scheduled. 5. The center's medical director was notified on 7/21/2023 at 8:00 pm of the Immediate Jeopardy. On 7/22/2023 the center will conduct an Ad Hoc QAPI meeting to review the citation, and sustaining compliance.				

Attachment C: Jack Shelby Affiliated Entities Owned Facilities Deficiencies and Survey Results

Source: ProPublica Nursing Home Inspection/Survey Results

List facilities that are required for review under 10.24.20.05(8)	SFF	Date of the Survey	Deficiencies	Deficiencies (Cont.)	Description	Seriousness
MEADOW PARK REHABILITATION AND HEALTH CENTER L L C	-	-	-	-	-	-
MEMPHIS CONVALESCENT CENTER	-	12/17/2023	Freedom from Abuse, Neglect, and Exploitation Deficiency — F0600	Failure to: Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.	The facility failed to protect residents of verbal abuse and neglect for 1 (Resident #1) of 6 residents reviewed for abuse and neglect. 1) AD verbally abused Resident #1 by yelling at her in front of residents and family members during an activity. 2) ADM failed to protect Resident #1 from verbal abuse from AD when it was reported to her by other staff members.	K
			Freedom from Abuse, Neglect, and Exploitation Deficiency — F0607	Failure to: Develop and implement policies and procedures to prevent abuse, neglect, and theft.	The facility failed to implement its' written policies and procedures that prohibit and prevent abuse and neglect for 1 of 6 residents (Resident #1) reviewed for abuse and neglect when:-The ADM was made aware of an allegation that AD was yelling during an activity and failed to follow policy and procedures of abuse and neglect. The facility's failure to ensure suspicions of abuse/neglect were investigated and reported to State could place all residents at risk for injuries, physical and mental decline, decrease in social gatherings, and delay of care.	K
			Freedom from Abuse, Neglect, and Exploitation Deficiency — F0610	Failure to: Respond appropriately to all alleged violations.	1. The facility failed to report that Resident #1 had a laceration to the lower left leg which required 9 stitches. 2. The facility failed to report that Resident #1 was verbally abused by Activity Director. 3. The facility failed to report bruises to Resident #6's upper right arm, origin of injury could not be determined.	J
MESQUITE TREE NURSING CENTER	-	8/27/2023	Pharmacy Service Deficiency — F0760	Failure to: Ensure that residents are free from significant medication errors.	The facility failed to ensure Resident #1 was free of any significant medication errors by failing to ensure a resident received the correct prescribed intravenous (IV) medication, which resulted in the resident being given an IV medication that she had a known allergy to.	J
	-	5/4/2023	Quality of Life and Care Deficiency — F0686	Failure to: Provide appropriate pressure ulcer care and prevent new ulcers from developing.	1. Resident #1 admitted with a pressure ulcer on 12/02/22 and the facility failed to perform and document a wound assessment, notify the physician, and obtain wound care orders until six days later on 12/08/22. 2. The facility failed to ensure Resident #1 was provided with wound care to promote healing until six days after admission on 12/08/22 when he was assessed by the Wound Care Physician (WCP) with an unstageable deep tissue injury to the sacrum. (Unstageable-full thickness tissue loss covered by extensive necrotic (dead skin tissue) tissue or eschar (Eschar-dead tissue that falls off (sheds) from healthy skin). (Deep Tissue Injury-Intact or non-intact skin with localized area of persistent non-blanchable deep red, maroon, purple discoloration or epidermal (outer layer of skin) separation revealing a dark wound bed or blood-filled blister).	J

Attachment C: Jack Shelby Affiliated Entities C

Source: ProPublica Nursing Home Inspection/Survey

		Medicare			
List facilities that are required for review under 10.24.20.05(8)	**Action Taken**	**Penalty Date**	**Payment Denial Length in Days**	**Payment Denial Start Date**	**Payment Denial End Date**
MEADOW PARK REHABILITATION AND HEALTH CENTER L L C	-	-	-	-	-
MEMPHIS CONVALESCENT CENTER	Facility Plan of Removal states: One on One in-service on Abuse Investigation with the Administrator/DON by Area Director of Operations on 12/16/2023 3:52 pm. o Staff working with alleged perpetrator have been interviewed. o The alleged perpetrator was suspended on 12/16/2023 pending the outcome of investigation. o Resident safe surveys have been initiated by Administrator/ADON/MDS Nurse. on 12/16/2023 for all interview able residents. Those who cannot be interviewed will have a head-to-toe assessment completed. No abuse incidents have been reported. o The employees will protect the potential victims of A/N/E by stopping alleged behavior and removing the resident from harm. Then they will report the incident to the Abuse Coordinator immediately. o A complete investigation will be done following our Protocol/Ad Hoc QAPI - Actual/Alleged Abuse o The investigation will be evaluated by the Area Director of Operations &/or the Corporate Compliance nurse to ensure complete interviews of all possible witnesses prior to determining a conclusion. o The following in-services were initiated on 12/16/2023 by Administrator/DON/ADON/MDS Nurse: Any staff member not present or in-serviced on 12/16/2023, will not be allowed to assume their duties until in-serviced by Admin/DON/ADON/MDS Nurse. O All Staff o Abuse/Neglect o Abuse/Neglect Reporting o Who to Report Abuse/Neglect to o All staff will need to be able to articulate back on reporting any type of abuse allegation and to whom to report. The in-service includes if they believe the report was not acted upon to contact the [Abuse hotline for company] [###-###-####], the ADO [Area Director of Operations] at [###-###-####] or call HHSC at [###-###-####]. o Any employees that are reported of any abuse will be suspended pending investigation. o The medical director was notified of the immediate jeopardy situation on 12/16/2023 at 4:30 pm. Monitoring of the Plan of Removal Included: Record review of assessments, dated 12/16/23, revealed 23 Safe Surveys and 6 skin assessments completed. Record review of in-service for Abuse and Neglect, dated 12/17/23, revealed ADM and DON received education over policy Abuse and Neglect. Record review of Employee Disciplinary Report, dated 12/16/23, revealed AD had been suspended via text message from ADM. An interview on 12/17/23 at 4:00 PM, ADO revealed company accepted AD letter of resignation effective immediately and did not return to the facility. An observation on 12/17/23 at 11:25 AM revealed a photo taken from ADM phone with a text message to AD that stated AD was placed on suspension again and AD confirmed she had received it. On 12/17/23 from 11:41 PM to 2:22 PM, 23 residents were interviewed regarding safe surveys that were conducted by staff. 18 residents confirmed speaking with staff regarding safe surveys and abuse and neglect. 6 residents were unable to recall the surveys. Residents confirmed or denied knowing who to report abuse and neglect to. If they denied, safe surveys show they were educated on who the abuse coordinator is. On 12/17/23 from 12:22pm to 3:15pm, 40 employees (1 PT, 2 OT, 4 RN, 8 LVN, 11 CNA, 1 HA, 1 MDSN, 1 BOM, 7 DS, 4 HK, 2 LS, and 2 MS, 1 ADON, 1 DON, and 1 ADM) were interviewed and confirmed obtained training via phone or in person. Training attached to in-services that identified the seven areas of the Abuse/Neglect/Exploitation policy along with the types of abuse and how/who to report to. Employees that were contacted were able to state they received abuse and neglect training, knows who to report to and feels comfortable with reporting.	-	-	-	-
MESQUITE TREE NURSING CENTER	The facility had corrected the IJ (Immediate Jeopardy) prior to entry for abbreviated survey. There was no resident in the facility on IV therapy, facility had completed staff in-service on medication administration and LVN A had been educated on medication administration prior to entry. QAPI skin prevention audits completed for all residents with Braden scale (Assessment for predicting the risk for pressure ulcer development) scores of twelve or less pressure indicating risk for impaired skin integrity, to ensure orders, treatments, and other interventions to include nutritional support provided. In-service training provided on 05/01/23 to all licensed nursing staff on facility skin management P/P, skin assessments and wound care orders.	-	-	-	-

Attachment C: Jack Shelby Affiliated Entities Owned Facilities Deficiencies and Survey Results

Source: ProPublica Nursing Home Inspection/Survey Results

List facilities that are required for review under 10.24.20.05(8)	SFF	Date of the Survey	Deficiencies	Deficiencies (Cont.)	Description	Seriousness
MIDLAND MEDICAL LODGE	-	-	-	-	-	-
NEW HOPE MANOR	-	10/14/2024	Resident Rights Deficiency — F0580	Failure to: Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.	The facility failed to notify the NP in a timely manner when Resident #1 voiced pain to her left knee, swelling, and heat to the touch was observed by LVN B. LVN B noted swelling and warm to touch on Resident #1's knee at approximately 4:00 PM. LVN B noted they contacted the NP when Resident #1's family was present at approximately 10:00 PM. Resident #1 was sent to the hospital and found to have a fractured left patella (kneecap).	J
			Quality of Life and Care Deficiency — F0689	Failure to: Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.	LVN A did not ensure Resident #1, who had a history of a left hip fracture, had a footrest on her wheelchair before transferring her, resulting in a fractured left patella (kneecap).	J
		1/25/2024	Quality of Life and Care Deficiency — F0697	Failure to: Provide safe, appropriate pain management for a resident who requires such services.	The facility failed to provide effective pain management for Resident #1 while on hospice services and comfort measures in place. He was found by his Hospice Nurse on 12/24/23 writhing in pain, thrashing, grimacing, and mouthing help me.	J
OAK MANOR OF COMMERCE NURSING AND REHABILITATION	-	-	-	-	-	-
OAKMONT GUEST CARE CENTER	-	12/20/2023	Quality of Life and Care Deficiency — F0689	Failure to: Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.	The facility failed to safely transfer Resident #1 and prevent injury during the use of the mechanical Hoyer lift, resulting in a laceration on the forehead on 12/16/23 and back pain on 11/20/23.	G

Attachment C: Jack Shelby Affiliated Entities C

Source: ProPublica Nursing Home Inspection/Surve

		Medicare			
List facilities that are required for review under 10.24.20.05(8)	**Action Taken**	**Penalty Date**	**Payment Denial Length in Days**	**Payment Denial Start Date**	**Payment Denial End Date**
MIDLAND MEDICAL LODGE	-	-	-	-	-
NEW HOPE MANOR	Review of the facility's in-services reflected staff were educated on abuse and neglect on 09/06/24 by the ADON. Staff were also educated on treatment of pain, ambulation, and abuse and neglect on 09/06/24 by the ADON. Review of the facility's in-services reflected staff were educated on change in condition on 09/21/24 by RN D, which covered nurses assessing and documenting/reporting change in condition or level of consciousness. Staff were also in-serviced on assessing, treating, and documenting pain and follow-ups and incident reporting on 09/06/24 . During an interview on 09/30/24 at 11:07 a.m., the ADM stated LVN A was suspended and still suspended at the time of the interview because the facility was waiting for the SSA to investigate Resident #1's incident.	-	-	-	-
	Regional Director of Operations re-educated Administrator on ensuring resident pain control needs are met per current policy by facility staff. Initiated 1/24/2024. Completed 1/24/2024 Regional Nurse Consultant re-educated Interim Director of Nursing and Assistant Director of Nursing on ensuring resident pain control needs are met per current policy by facility. Initiated 1/24/2024. Completed 1/24/2024 Evaluation of all current residents for pain performed by DON/ADON and/or designee with orders verified and any changes required noted and enacted immediately upon finding of IJ allegation. Initiated 1/24/2024. Completed 1/24/2024 DON/designee completed audit of all resident charts for current pain documentation to be performed every shift and as needed according to individualized needs with routine pain assessments added to four consolidated orders found lacking routine pain assessment. There were no relevant findings of unaddressed pain found upon resident assessments and interviews as noted below. Initiated 1/24/2024. Completed 1/25/2024 Re-education of all licensed staff members occurred per DON/ADON and designees in areas of pain control, medication, pain scales, documentation, and communication to adjunct personnel such as hospice and monitoring noting concern, if any, following verbal understanding and post test noted by licensed staff. Initiated 1/24/2024 Completed 1/25/2024 All residents currently receiving pain control or possible pain indications immediately checked by ADON, unit managers, and a designated licensed nursing team member for appropriate interventions if any noted with no relevant findings of unaddressed pain found from resident assessment/interviews. Initiated 1/24/2024 Completed 1/24/2024 Interventions and Monitoring Plan to Ensure Compliance Quickly: The facility will follow current policy and procedure for compliance and maintenance of pain control with understanding of pain control management and communication by nursing staff to be obtained on hire by DON/ADON and/or appointed designee for all full time and PRN staff and at least annually with re-education to be performed by DON/ADON and/or appointed designee as noted per skills checklist. The facility does not employ the use of temporary or agency staff. Initiated: 1/24/2024 Completion: 1/25/2024 Audit of all existing and newly hired nursing staff to be performed weekly by DON and/or designee, to ensure completion of pain management understanding with emphasis on special circumstances, such as palliative care, to be ongoing following completion date per systems put in place. Initiated: 1/24/2023 Completion: 1/25/2024 and ongoing. Any nursing staff identified through ongoing education as noted above that require acute training on pain management will have education performed prior to presenting on shift until such time as knowledge and competencies in pain control and management are adequate. This will be ongoing following completion date per systems put in place. Initiated: 1/24/2024 Completion: 1/25/2024 and ongoing				
OAK MANOR OF COMMERCE NURSING AND REHABILITATION	-	-	-	-	-
OAKMONT GUEST CARE CENTER	The DON stated it is the responsibility of her staff to ensure the batteries were charged before they used them on Hoyer lifts. She stated during her investigation she noted one charging port was not charging the batteries, and it was replaced. She stated it was her responsibility and her ADONs to ensure the staff were charging the batteries. She stated staff should swap batteries every shift and as needed. She stated the Hoyer lifts were maintained every time they suspected there was a problem. She stated the maintenance personnel checked on them every month. She had done in-services on Hoyer lift transfers on 12/16/23 and 11/21/23 with all her staff and also one-on-one with CNA A and LVN B.	-	-	-	-

Attachment C: Jack Shelby Affiliated Entities Owned Facilities Deficiencies and Survey Results

Source: ProPublica Nursing Home Inspection/Survey Results

List facilities that are required for review under 10.24.20.05(8)	SFF	Date of the Survey	Deficiencies	Deficiencies (Cont.)	Description	Seriousness
OAKMONT GUEST CARE CENTER	-	8/24/2023	Freedom from Abuse, Neglect, and Exploitation Deficiency — F0600	Failure to: Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.	The facility failed to ensure Resident #2 did not elope from the facility. The facility staff did not notice the resident was missing from Saturday, 08/19/23 at approximately 7:40 PM to the following Sunday, 08/20/23 around noon. The resident was located around 6:00 pm 12 miles away from the facility after police became involved and a Silver Alert had been issued.	K
			Quality of Life and Care Deficiency — F0689	Failure to: Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.	The facility failed to ensure their abuse and neglect policy was implemented for Resident #1 when he eloped from the facility. The facility staff did not notice the resident was missing from Saturday, 08/19/23 at approximately 7:40 PM to the following Sunday, 08/20/23 around noon. The resident was located around 6:00 pm 12 miles away from the facility after police became involved and a Silver Alert had been issued.	K
			Freedom from Abuse, Neglect, and Exploitation Deficiency — F0607	Failure to: Develop and implement policies and procedures to prevent abuse, neglect, and theft.	1. The facility failed to develop a comprehensive person-centered care plan to address Resident #1's use of an antipsychotic medication-Seroquel, diabetes, insulin use and hospice care. 2. The facility failed to develop a comprehensive person-centered care plan to address Resident #6's seizures.	K
PRINCETON MEDICAL LODGE	-	-	-	-	-	-

Attachment C: Jack Shelby Affiliated Entities C

Source: ProPublica Nursing Home Inspection/Survey

		Medicare			
List facilities that are required for review under 10.24.20.05(8)	**Action Taken**	**Penalty Date**	**Payment Denial Length in Days**	**Payment Denial Start Date**	**Payment Denial End Date**
OAKMONT GUEST CARE CENTER	An Immediate Jeopardy was identified on 08/22/23. The IJ Template was provided to the facility on [DATE] at 5:03 PM. While the Immediate Jeopardy was removed on 08/24/23, this survey does not contain the full removal plan	-	-	-	-
	A policy for care plans was requested on 08/11/23 but was not provided. A policy for baseline care plans only was provided.				
PRINCETON MEDICAL LODGE	-	-	-	-	-

Attachment C: Jack Shelby Affiliated Entities Owned Facilities Deficiencies and Survey Results

Source: ProPublica Nursing Home Inspection/Survey Results

List facilities that are required for review under 10.24.20.05(8)	SFF	Date of the Survey	Deficiencies	Deficiencies (Cont.)	Description	Seriousness
RALLS NURSING HOME	-	6/10/2024	Freedom from Abuse, Neglect, and Exploitation Deficiency — F0600	Failure to: Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.	1. The facility failed to put protective measures in place on 05/11/24 to protect Resident #4 from sexual abuse after knowing Resident #2 had displayed inappropriate sexual behavior with Resident #3. 2. The facility failed to put protective measures in place on 06/02/24 to protect Resident #3 in place from sexual abuse after knowing Resident #5 had a history of inappropriate sexual behavior. 3. The facility failed to put protective measures in place on 06/02/24 to protect Resident #6 in place from sexual abuse after knowing Resident #5 had a history of inappropriate sexual behavior.	K
			Freedom from Abuse, Neglect, and Exploitation Deficiency — F0607	Failure to: Develop and implement policies and procedures to prevent abuse, neglect, and theft.	The facility failed to implement their abuse and neglect policy when: 1. The facility failed to investigate the fall incident that occurred with Resident #1 while in the care of CNA E on 05/30/24. CNA E failed to notify the nurse of the fall. Resident #1 sustained a hip fracture. 2. The facility failed to report to the state agency and investigate a sexual incident that occurred on 05/10/24 between Resident #2 and Resident #3. 3. The facility failed to report to the state agency and investigate a sexual incident that occurred on 05/11/24 between Resident #2 and Resident #4. 4. The facility failed to notify Family Member C of the inappropriate sexual incident that involved Resident #3. 5. The facility failed to report to the state agency and investigate a sexual incident that occurred on 06/02/24 between Resident #5 and Resident #3. 6. The facility failed to report to the state agency and investigate a sexual incident that occurred on 06/02/24 between Resident #5 and Resident #6.	K
		5/9/2024	Quality of Life and Care Deficiency — F0689	Failure to: Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.	The facility staff (Administrator and DON) failed to adequately address Resident #2's ongoing behavior of entering Resident #1's room. The facility (Administrator and DON) failed to address resident #2's ongoing physical and verbal behavior with appropriate interventions.	G
		4/17/2023	Freedom from Abuse, Neglect, and Exploitation Deficiency — F0600	Failure to: Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.	The facility failed to ensure a safe environment free from abuse for Resident #1 when can D was suspected to have used unnecessary force causing a spiral fracture to Resident #1 on night shift on 04/12/2023. The facility failed to ensure Resident #1, Resident #2, Resident #3, Resident #4, Resident #5, Resident #6, Resident #7, Resident #8, Resident #9, Resident #10 resided in a safe environment after making allegations of abuse toward CNA D and CNA D was continued to allow to work with all resident's even after prior allegations of abuse.	K
ROCKVILLE SKILLED NURSING & REHAB CENTER, L L C	-	-	-	-	-	-
SENIOR CARE HEALTH & REHABILITATION CENTER - WICHI	-	-	-	-	-	-

Attachment C: Jack Shelby Affiliated Entities C

Source: ProPublica Nursing Home Inspection/Survey

		Medicare			
List facilities that are required for review under 10.24.20.05(8)	**Action Taken**	**Penalty Date**	**Payment Denial Length in Days**	**Payment Denial Start Date**	**Payment Denial End Date**
RALLS NURSING HOME	On 06/07/24 at 5:00 PM an Immediate Jeopardy (IJ) was identified. The IJ was removed on 06/09/24 at 3:30 PM the removal plan is not included in this survey	6/10/2024	11	7/12/2024	7/23/2024
	The ADM said the facility staff monitored incident/accident prevention through daily standup meetings, talking to staff, and in-service. The ADM said she had not done anything specific for the night-time staff but that they had received the same ANE and resident rights training. The ADM said she had no formal training regarding preventing incidents/accidents, but they trained the staff through in-services. The ADM said she had not observed Resident #2 go into Resident #1's room but expected her staff to monitor and redirect as much as possible.	10/3/2022	16	11/1/2022	11/17/2022
	This failure was determined to be an Immediate Jeopardy situation that was identified on 04/14/2023 at 5:51 p.m. While the IJ was removed on 04/17/2023, the survey does not contain the removal plan.				
ROCKVILLE SKILLED NURSING & REHAB CENTER, L L C	-	-	-	-	-
SENIOR CARE HEALTH & REHABILITATION CENTER - WICHI	-	-	-	-	-

Attachment C: Jack Shelby Affiliated Entities Owned Facilities Deficiencies and Survey Results

Source: ProPublica Nursing Home Inspection/Survey Results

List facilities that are required for review under 10.24.20.05(8)	SFF	Date of the Survey	Deficiencies	Deficiencies (Cont.)	Description	Seriousness
SHERIDAN MEDICAL LODGE	-	-	-	-	-	-
SKYLINE NURSING CENTER	-	9/27/2023	Quality of Life and Care Deficiency — F0742	Failure to: Provide the appropriate treatment and services to a resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder.	Facility failed to ensure a resident who displayed or is diagnosed with a mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder, received appropriate treatment and services to correct the assessed problem or to attain the highest practicable mental and psychosocial well-being for two (Residents #1 and #4) of five residents reviewed for psychosocial concerns.	K
			Freedom from Abuse, Neglect, and Exploitation Deficiency — F0600	Failure to: Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.	1. The facility failed to provide prescribed psychotropic medications to Resident #1, who lived with dementia and mental illness, and moved her to several different rooms in a week's time which resulted in her having increased behaviors resulting in two separate unwitnessed resident to resident altercations. 2. The facility failed to notify the MD when Resident #1 refused her psychotropic medications prior to the two resident to resident altercations.	K
			Freedom from Abuse, Neglect, and Exploitation Deficiency — F0607	Failure to: Develop and implement policies and procedures to prevent abuse, neglect, and theft.	The facility failed to provide prescribed psychotropic medications to Resident #1, who lived with dementia and mental illness, and moved her to several different rooms in a week's time which resulted in her having increased behaviors resulting in two separate unwitnessed resident to resident altercations. The facility failed to notify the MD when Resident #1 refused her psychotropic medications prior to the two resident to resident altercations. The facility did not provide Resident #1 with behavioral interventions and instead, initiated an unplanned and inappropriate transfer that led to Resident #1 being left across the street from the facility and subsequently arrested and incarcerated for a week. The facility was unaware Resident #1 had been arrested for two days and did not attempt to look for her and discharged her from the facility.	K
			Resident Rights Deficiency — F0580	Failure to: Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.	1. The facility failed to ensure Resident #1's physician and psychiatrist was notified when she refused her prescribed psychotropic and blood pressure medications consistently for over a week from 09/01/23 through 09/09/23 . 2. The facility failed to ensure Resident #1's RP/family member(s) were notified when she refused her prescribed psychotropic and blood pressure medications consistently for over a week from 09/01/23 through 09/09/23.	K
			Resident Rights Deficiency — F0624	Failure to: Prepare residents for a safe transfer or discharge from the nursing home.	The facility failed to provide or document sufficient preparation for an orderly transfer when Resident #1 allegedly got into an unwitnessed physical altercation with her new roommate.	J
		5/26/2023	Resident Rights Deficiency — F0550	Failure to: Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.	The facility failed to ensure Resident #1's bed was in a lowered position.	G

Attachment C: Jack Shelby Affiliated Entities C

Source: ProPublica Nursing Home Inspection/Surve

		Medicare			
List facilities that are required for review under 10.24.20.05(8)	**Action Taken**	**Penalty Date**	**Payment Denial Length in Days**	**Payment Denial Start Date**	**Payment Denial End Date**
SHERIDAN MEDICAL LODGE	-	-	-	-	-
SKYLINE NURSING CENTER	Identify responsible staff/ what action taken: 1. Licensed Nurses and medication aides in serviced by the DON on the facility policy and procedure regarding documentation, assess, and notify the physician regarding change of condition. 9/14/23 2. Certified Nursing Assistant received education on reporting changes in behavior in a resident by the DON. 9/14/23 3. Initiated staff interviews and established a timeline of the sequence of events by Administrator on 9/14/2023. 4. Audit of all resident's MARs completed to assure if and care planned by licensed staff on 9/14/23. In-Service conducted. 1. Change in condition. 2. Medication administration The in-service was attended by licensed caregivers which include Registered Nurse, Licensed Vocational Nurse, Certified Nursing Assistants, Certified Medication Aide. This in-service was initiated on 9/14/23 and all staff must be in-service before they are allowed to work. New staff will be educated about resident change in condition, medication administration before their floor orientation. Facility is currently not using agency staff. Implementation of Changes: The changes, which include monitoring of medications not given, and a change in condition of residents through 24 [hour] reports, were s [TRUNCATED]	-	-	-	-
	Interview with ADON and DON on 05/26/23 at 6:33 PM revealed Resident #1 preferred his bed to be in a lowered position. They stated he was able use the bed remote to lower his bed. They stated he had a history of anxiousness when his bed was not lowered. They stated Resident #1 was able to notify staff if his bed needed to be lowered. They stated they did not know the bed control remote was out of reach for the resident. They stated there were no risk to Resident #1 because they mitigate the risks.				

Attachment C: Jack Shelby Affiliated Entities Owned Facilities Deficiencies and Survey Results

Source: ProPublica Nursing Home Inspection/Survey Results

List facilities that are required for review under 10.24.20.05(8)	SFF	Date of the Survey	Deficiencies	Deficiencies (Cont.)	Description	Seriousness
SOUTHEAST NURSING & REHABILITATION CENTER	-	8/19/2023	Freedom from Abuse, Neglect, and Exploitation Deficiency — F0600	Failure to: Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.	The facility failed to develop and implement systems to properly treat Resident #1's arterial wound to his left foot great toe from [DATE] until [DATE] which resulted in hospitalization , sepsis, gangrene, necrosis and amputation.	K
			Quality of Life and Care Deficiency — F0684	Failure to: Provide appropriate treatment and care according to orders, resident's preferences and goals.	The facility failed to assess and treat resident #1's left foot great toe when the resident developed a wound to his LLE from [DATE] until [DATE] which resulted in a decline in health, a worsening of the wound including the toe turning black, infection, necrosis, gangrene, sepsis, hospitalization , and amputation. The facility also failed to identify and treat a wound to Resident #1's sacrum.	K
			Nursing and Physician Services Deficiency — F0726	Failure to: Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being.	1. The facility failed to ensure the Wound Care Nurse had completed training for a license violation and remediation and failed to ensure she was competent to perform skin assessments, wound assessments, obtain and implement physician orders and document her finding in the medical record resulting in Resident #1 becoming septic and the amputation of the resident's big toe. 2. The facility failed to ensue RN D had the competencies to identify a resident change of condition, obtain and implement physician orders for wound care, assess wounds and document her findings in the medical record resulting in Resident #1 becoming septic and the amputation of the resident's big toe. 3. The facility failed to ensure LVN B had the competencies and training to assess and identify wounds, obtain, and implement wound care orders and document her findings in the medical record resulting in Resident #1 becoming septic and the amputation of the resident's big toe. 4. The facility failed to ensure LVN II had the competencies and training to assess and identify wounds, obtain, and implement wound care orders and document her findings in the medical record resulting in Resident #1 becoming septic and the amputation of the resident's big toe.	K

Attachment C: Jack Shelby Affiliated Entities C

Source: ProPublica Nursing Home Inspection/Survey

		Medicare			
List facilities that are required for review under 10.24.20.05(8)	**Action Taken**	**Penalty Date**	**Payment Denial Length in Days**	**Payment Denial Start Date**	**Payment Denial End Date**
SOUTHEAST NURSING & REHABILITATION CENTER	B. On 7/28/2023 and on 7/30/2023 RN D received education from Regional Nurse consultant of Skin management policy regarding . physician notification . C. On 7/28/2023 and on 7/30/2023 LVN B received education from Regional Nurse consultant on Skin management policy regarding . physician notification . D. On 7/28/2023 and on 7/30/2023 LVN II received education from Regional Nurse consultant on Skin management policy regarding . physician notification . 2. Identification of Residents Affected or Likely to be Affected: A. On 7/27/2023 the DON/Designees completed 100% skin audit throughout the facility and identified other residents with new pressure ulcers. This was completed at 5:30 pm on 7/27/2023. No other resident has been affected by this since 7/27/2023. B. On 7/27/2023 an audit was completed by DON/Designee to validate residents with no pressure ulcers receive a weekly skin assessment by Charge nurse and initialed completion on the skin observation worksheet. This was completed at 8:00 pm on 7/27/2023 and no other resident has been affected by this since 7/27/2023. 3.Actions to Prevent Occurrence/Recurrence: A. On 7/27/2023 the DON/Designee began education with all licensed nurses on Skin Management policy which details . physician notification . This was completed at 6:00 pm on 7/27/2023 and no licensed nurse was allowed to work until they completed this education. C. On 7/27/2023 the DON/Designee began education with licensed nurses and nurse assistants on completion of skin observation worksheets at time of shower/bath to document any identified skin issues and allow charge nurse to complete an assessment and notify the DON/Designee on any identified issue. This was completed at 6:00 pm on 7/27/2023 and no licensed nurse or nurse assistant was allowed to work until they had completed this education. D. On 7/27/2023 the DON/Designee began education with licensed nurses and nurse assistants on Pressure Injury Prevention/Management Policy which details definitions of avoidable and unavoidable, compliance guidance, interventions for prevention, promote healing, treatments, and monitoring. This was completed at 6:00 pm on 7/27/2023, and no licensed nurse or nurse assistant was allowed to work until they had completed this education. On 8/18/2023 the facility administrator notified the Medical Director of Immediate Jeopardy the facility received regarding Abuse and Neglect related to skin management.	-	-	-	-

Attachment C: Jack Shelby Affiliated Entities Owned Facilities Deficiencies and Survey Results

Source: ProPublica Nursing Home Inspection/Survey Results

List facilities that are required for review under 10.24.20.05(8)	SFF	Date of the Survey	Deficiencies	Deficiencies (Cont.)	Description	Seriousness
SOUTHEAST NURSING & REHABILITATION CENTER	-	8/19/2023	Resident Rights Deficiency — F0580	Failure to: Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.	The facility failed to notify the wound care physician and primary care provider (physician) when Resident #1's left foot great toe had a worsening of the wound and turned black.	J
Sulphur Springs Health And Rehabilitation	-	12/12/2024	Quality of Life and Care Deficiency — F0689	Failure to: Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.	Facility failed to ensure the resident environment remained as free of accident hazards as was possible and failed to ensure each resident received supervision and assistance devices to prevent accidents for 1 of 3 residents (Resident #14) reviewed for accidents and supervision. 1. The facility failed to ensure 2-person assistance was used while providing Resident #14 a bed bath on 06/09/2024. This resulted in Resident #14 falling out of bed and fracturing her right distal tibia (right lower end of the leg). 2. The facility failed to ensure staff knew where to find resident information on the required level of assistance each resident needed.	J

Attachment C: Jack Shelby Affiliated Entities C

Source: ProPublica Nursing Home Inspection/Survey

		Medicare			
List facilities that are required for review under 10.24.20.05(8)	**Action Taken**	**Penalty Date**	**Payment Denial Length in Days**	**Payment Denial Start Date**	**Payment Denial End Date**
SOUTHEAST NURSING & REHABILITATION CENTER	See page 62	-	-	-	-
Sulphur Springs Health And Rehabilitation	The following Plan of Removal submitted by the facility was accepted on 12/12/2024 at 1:41 PM: 1. Immediate Action Taken: A. On 6/9/2024 Resident #14 was assessed by charge nurse, notification to physician and X-rays obtainedafter the fall. Resident #14 was monitored every shift. B. On 6/10/2024 the Nurse Assistance was suspended pending investigation where she was subsequentlyterminated due to failure to report back to work. C. On 6/10/2024 the DON/Designee completed an investigation into an incident involving Resident #14. D. On 6/10/2024 the DON provided in-service education to all staff on Abuse and neglect. This education was completed on 6/10/2024. E. On 6/14/2024 the DON/Designee in-service education with license nurses and Nurse aide on use of PCC Kardex that determines type and amount of care residents required for all ADL's. This was completed on 6/15/2024. All clinical staff are provided with training and access upon hire. F. On 12/11/2024 DON/Therapy assessed all residents to determine the type and number of staff assistance required for ADL's and validated that all Kardex have been updated. This was completed on 12/11/2024. F. On 12/11/2024 the DON/Designee provided in-service education with all license nurses and Nurse aide on use of PCC Kardex that determines type and amount of care residents required for all ADL's. This was completed on 12/12/2024 at 6:30 am, and no licensed nurse or Nurse Aide will be allowed to work until this education has been provided. 2. Identification of Residents Affected or Likely to be Affected: On 6/14/2024 the DON/Designee reviewed all residents requiring 2 persons bed mobility and bathing to verify that care plan and C.N.A. Kardex reflected the type of care residents require. 3. Actions to Prevent Occurrence/Recurrence: A. DON/Designee will review 24-hour nurse report daily in the morning meeting to validate that the care plan and Kardex has been reviewed/revised for any resident that has a change in bed mobility or bed bath. B. The DON/Designee will review all Incident/Accidents daily in the morning meeting to validate those residents with falls that involved bed mobility or falls during bed baths, had the appropriate number of staff needed during the transfer. C. The Regional Nurse Consultant will provide oversight into this process weekly x 4 weeks. D. The facility will continue to provide training to all license nurse and Nurse Aides upon hire and as need on documentation procedures for the Kardex system on PCC to identify type and amount of care a resident requires.	-	-	-	-

Attachment C: Jack Shelby Affiliated Entities Owned Facilities Deficiencies and Survey Results
Source: ProPublica Nursing Home Inspection/Survey Results

List facilities that are required for review under 10.24.20.05(8)	SFF	Date of the Survey	Deficiencies	Deficiencies (Cont.)	Description	Seriousness
SUNNY SPRINGS NURSING & REHAB	-	7/14/2023	Resident Rights Deficiency — F0580	Failure to: Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.	Facility failed to accurately identify a resident, follow facility policy, and accurately identify a code status of one resident (#1) out of six residents reviewed for advance directives. Resident #1, had physician orders and care plan showing her wishes were for a Full Code (meaning all resuscitation procedures will be provided to keep her alive if found without a pulse and/or respirations). On [DATE] when Resident #1 was found to be unresponsive without pulse and respirations, resuscitation efforts were begun, and then stopped due to a mistake in identifying the correct medical record. Resuscitation efforts were started again after Resident #1's actual medical record was found and a nurse realized the error. The resident was not successfully revived and was pronounced dead by Emergency Medical Service (EMS) staff.	J
			Quality of Life and Care Deficiency — F0684	Failure to: Provide appropriate treatment and care according to orders, resident's preferences and goals.	1. The facility failed to intervene when Resident #4, who was taking an anticoagulant medication (blood thinner that works by preventing red blood cells from forming clots), had increased bruising, which indicated a change of condition. 2. The facility did not ensure LVN L, who was the treatment nurse, accurately performed weekly skin assessments.	J

Attachment C: Jack Shelby Affiliated Entities C

Source: ProPublica Nursing Home Inspection/Survey

		Medicare			
List facilities that are required for review under 10.24.20.05(8)	**Action Taken**	**Penalty Date**	**Payment Denial Length in Days**	**Payment Denial Start Date**	**Payment Denial End Date**
SUNNY SPRINGS NURSING & REHAB	Immediate action(s) taken for the resident(s) found to have been affected include: 1. Resident Notification to Family Treatment nurse at 1:59pm attempted left message and 2:02pm family called back and was notified by ADON, Medical Director/Physician 7-12-23 ADON 1:25pm 2. SBAR (change in condition) Completed 7-12-23 ADON 1:25pm 3. Medical Director / Physician Evaluated Resident for changes in condition related to bruises 7-12-23 1:45pm 4. New orders to monitor bruising, Labs - CBC/INR Orders 7-12-23 1:25pm Labs Drawn at 2:21PM on 7-12-23 and results received at 3:21PM and MD notified 3:25pm and order to repeat CBC in one week received. 5. Trauma Assessment completed 7-12-23 Charge Nurse LVN A 1:47 PM 6. Pain Assessment completed 7-12-23 Charge Nurse LVN A 1:45pm 7. Care Plan Updated 7-12-23 MDS Nurse, Added Skin Care BUE/BLE Bruising- updated with Intervention monitoring skin for the bruising until healed and report abnormality to MD. 8. Therapy Screening completed 7-12-23 RN DON 3:57pm and Therapy screened completed DOR COTA on 7-12-23 7:15pm, Resident is on services as of 7-13-23 on OT services. 9. Incident Report ADON LVN 7-12-23 at 6:42pm Self-Report Completed 7-12-23 by the Administrator 3:21PM 10. Skin assessment conducted for all residents that resided in the facility completed 7-12-23 7:30pm completed by Charge Nurse A LVN, Charge Nurse B LVN, all undocumented concerns were reported to MD/Families by LVN ADON, and RN DON completed by 7-13-23 by 4:00pm Include actions that were performed toa address to citation: 7-13-23 11:00am 1. Facility Wide Resident Skin Sweep completed 7-12-23 Charge Nurses A LVN, Charge Nurse LVN B, completed at 7:30pm 2. Safe Survey with residents that are cognitively intact. 7-13-23 at 1:47pm by Social Worker completed at 4:00pm 3. Staff Safe Survey completed 7-13-23 Administrator and Regional Director of Operations started at 12:25pm completed at 3:45pm. 4. One on One Inservice with treatment nurse on skin assessment initiated 4:00pm and completed on 7-12-23 conducted by DON RN completed 4:30pm on 7-12-23, Training consisted of how to conduct a thorough skin assessment, documentation, weekly skin assessment, changes in skin and care plan and job duties.5. One on One Inservice with DON conducted by Regional Nurse Consultant on change in condition/skin assessment and notification. Training consisted of how to conduct a thorough skin assessment, documentation, weekly skin assessment, changes in skin and care plan. Initiated 3:00pm 7-12-23 and completed on 7-12-23 3:30pm. Regional Nurse Consultant 6. In-services for licensed nursing staff on Skin Assessment/Skin initiated on 7/13/2023 at 11:45am by Regional Nurse Consultant. Training consisted of how to conduct a thorough skin assessment, documentation, weekly skin assessment, changes in skin and care plan. Completed 7-13-23 5:00pm. 7. Training for licensed staff was initiated 7-12-23 at 11:45am on Anticoagulant monitoring/documentation timely and accurately 7-13-23 at 5:00pm. Training consisted of how to recognize changed with anticoagulant, monitoring, and orders and care plan in place. 8. Training for licensed staff was initiated 7-12-23 at 11:45am on Following care plan of anticoagulant completed 7-13-23 at 5:00pm. Training consisted of the following care plan. 9. Training for Clinical Licensed staff was initiated 7-12-23 at 11:45am on ADL transfers, this Inservice training consisted of transfer safety and how to conduct proper transfers. This Inservice was conducted at a precaution. Training completed on 7-13-23 at 5:00pm. 10. Training for Clinical Licensed staff was initiated on 7/12/23 at 11:45am, on Notification of Change completed on 7/13/23 at 5:00pm. This training includes what is a change in a condition, proper notification, reported and documentation of change in conditions. 11. Training with facility staff was initiated on 7/12/23 at 11:45am, by DON on Abuse and Neglect. This training includes what is abuse and neglect, procedures of abuse and neglect, reporting of abuse and the abuse coordinator, completed on 7/13/23 at 5:00pm. 12. All new hires will be educated on abuse and neglect protocol/change in condition/skin assessment, and anticoagulant ongoing. 13. The ADON and Director of Nursing will ensure competency through signing of in service, verbalization of understanding. All licensed nurses will notify DON/Administrator/Physician/Family regarding change in conditions. The ADON/DON will audit all skin assessments daily in morning clinical meetings to ensure compliance. 14. Team members will receive required training prior to their shifted. Involvement of Medical Director The Medical Director met with the Interdisciplinary team on 7/12/2023 at 4:00pm and conducted an Ad HOC QAPI regarding the change in condition and skin assessment protocol. An Ad Hoc QAPI meeting was held with the Medical Director via phone, facility administrator, director of nursing, and social services director to review plan of removal on 7/13/2023 at 2:30pm. The Director of Nursing and Administrator will be responsible for the implementation of New Process. The New Process/ system was started on 7/12/2023. Monitoring and reviewing skin assessment during clinical meeting to ensure compliance with facility policy.	-	-	-	-

Attachment C: Jack Shelby Affiliated Entities Owned Facilities Deficiencies and Survey Results

Source: ProPublica Nursing Home Inspection/Survey Results

List facilities that are required for review under 10.24.20.05(8)	SFF	Date of the Survey	Deficiencies	Deficiencies (Cont.)	Description	Seriousness
THE HEIGHTS NURSING AND REHABILITATION	-	12/29/2023	Freedom from Abuse, Neglect, and Exploitation Deficiency — F0610	Failure to: Respond appropriately to all alleged violations.	The facility failed to investigate after Resident #1 was diagnosed with a Fentanyl overdose on 12/25/23.	J
			Resident Assessment and Care Planning Deficiency — F0656	Failure to: Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.	The facility failed to care plan Resident #1's history of illegal drug abuse. On 12/25/23, Resident #1 went unresponsive and was diagnosed with a Fentanyl overdose in the hospital.	J
			Quality of Life and Care Deficiency — F0689	Failure to: Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.	The facility failed to supervise or prevent access to illegal drugs for Resident #1, knowing he had a history of drug use. On 12/25/23, Resident #1 went unresponsive and was diagnosed with a Fentanyl overdose in the hospital.	J

Attachment C: Jack Shelby Affiliated Entities C

Source: ProPublica Nursing Home Inspection/Survey

		Medicare			
List facilities that are required for review under 10.24.20.05(8)	**Action Taken**	**Penalty Date**	**Payment Denial Length in Days**	**Payment Denial Start Date**	**Payment Denial End Date**
THE HEIGHTS NURSING AND REHABILITATION	Immediate Action: 1. Action: Resident returned from the hospital and assessed by licensed nurse and care plan updated by MDS Nurse. Current interventions include scheduling a care conference with resident and responsible party to discuss current interventions put into place to prevent reoccurrence. Resident is receiving (psychiatry care services). Referral for face-to-face visit requested. Start Date: 12/28/2023 Completion Date: 12/28/2023 at 5:35 p.m. Responsible: MDS Nurse and Charge Nurse 2. Action: Incident report completed by Interim DON of alleged incident occurring on 12/25/2023 Start Date: 12/28/2023 Completion Date: 12/28/2023 @ 4:42 p.m. Responsible: Interim DON 3. Action: Ad Hoc QAPI Notified Medical Director of IJ template and action items to lower the immediacy. Start Date: 12/28/2023 Completion Date: 12/28/2023 @ 6:34 p.m. Responsible: Administrator, Medical Director, [NAME] President of Clinical Operations Identification of Resident(s) Affected or Likely to be Affected: 1. Action: Review of all residents ICD-10 codes completed by MDS nurse for identification of other residents with illicit drug history to ensure care plans are in place. No other residents identified. Start Date: 12/28/2023 Completion Date: 12/29/2023 at 5:00 p.m. Responsible: MDS Nurse Actions to Prevent Occurrence/Recurrence: 1. Action: Education provided to Administrator and Interim DON on investigating allegations of residents under the facility's care being on illegal drugs and contacting the proper authorities. Start Date: 12/28/2023 Completion Date: 12/28/2023 at 5:35 p.m. Responsible: [NAME] President of Clinical Operations 2. Action: Signage posted at all facility entrances on no illicit drugs are to be brought in by visitors and/or staff. All facility staff educated on signage posted at all entrances indicating no illicit drugs are to be brought in by visitors and/or staff prior to working their next shift. All new hires will be educated prior to working their first shift. Administrator will designate Department Managers and/or designee to visualize signage remains in place every 8 hours x 7 days a week x 4 weeks. Start Date: 12/28/2023 Completion Date: 12/28/2023 at 6:30 p.m. Responsible: Administrator, Department Managers, [NAME] President of Clinical Operations, and/or designee 3. Action: Visitor log placed at nursing station for facility staff to write name of who is visiting and which resident they are visiting. All facility staff educated on new visitor log and how to complete prior to working their next shift. All new hires will be educated prior to working their first shift. Start Date: 12/28/2023 Completion Date: 12/28/2023 7 p.m. Responsible: Administrator, Interim DON, [NAME] President of Clinical Operations, and/or designee4. Action: All facility staff educated on Illegal Drug Use Policy and immediately reporting any illegal drugs found in a residents room or on the facility grounds to the Administrator immediately. Start date: 12/29/2023 Completion: 12/29/2023 Responsible: Administrator, Interim DON, [NAME] President of Clinical Operations, and/or designee Action Item: Monitoring for compliance Vice President of Clinical Operations will review all Incident and Accident reports 5 days a week (Monday to encompass Friday-Sunday) x 4 weeks to ensure thorough investigations were completed and interventions care planned. MDS nurse to complete weekly audits of residents ICD-10 codes for current illicit drug use and/or history and such is care planned. Interim DON to audit visitor list at nurses station 5 days a week (Monday to encompass Friday-Sunday) x 4 weeks to ensure visitors are appropriately logged and log indicates which resident they were visiting. Interim DON and/or ADON to validate all staff education completed weekly x 4 weeks. Administrator to validate completion of the above weekly x 4 weeks. Vice President of Clinical Operations to validate completion of the above weekly x 4 weeks. Start Date: 12/28/2023 Completion Date: 2/1/2023 Responsible: [NAME] President of Clinical Operations, MDS nurse, Interim DON, Administrator and/or designee	4/29/2023	6	7/4/2024	7/10/2024

Attachment C: Jack Shelby Affiliated Entities Owned Facilities Deficiencies and Survey Results

Source: ProPublica Nursing Home Inspection/Survey Results

List facilities that are required for review under 10.24.20.05(8)	SFF	Date of the Survey	Deficiencies	Deficiencies (Cont.)	Description	Seriousness
THE HEIGHTS NURSING AND REHABILITATION	-	4/29/2023	Freedom from Abuse, Neglect, and Exploitation Deficiency — F0600	Failure to: Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.	The facility failed to ensure Resident # 1 was not assaulted by Resident # 4 on [DATE]. Resident #1 was hospitalized on [DATE] and died from the injuries sustained on [DATE]. Resident # 1 had a history or wandering in residents rooms and Resident # 4 had a history of aggressive behaviors towards other residents and staff.	J
			Quality of Life and Care Deficiency — F0689	Failure to: Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.	The facility failed to supervise and redirect Resident # 1 from entering Resident # 4's room resulting in Resident # 1 being assaulted by Resident # 4 on [DATE]. Resident # 1 died from the injuries sustained on [DATE]. Resident # 1 had a history of wandering behavior and would often wander into other residents rooms. Resident # 4 had a history of aggressive behaviors towards staff and residents.	J

Attachment C: Jack Shelby Affiliated Entities C

Source: ProPublica Nursing Home Inspection/Survey

		Medicare			
List facilities that are required for review under 10.24.20.05(8)	**Action Taken**	**Penalty Date**	**Payment Denial Length in Days**	**Payment Denial Start Date**	**Payment Denial End Date**
THE HEIGHTS NURSING AND REHABILITATION	Review of QAPI - (Quality Assurance and Performance Improvement) dated Nov. 2022- [DATE]. ADM. reported the incident was discussed in the meeting along with the other incidents and accidents. Record review of in-service completed [DATE], reflected staff in-serviced on Abuse/Neglect. Record review of facility Abuse /Neglect policy dated [DATE] which reflected: Our resident has the right to be free from abuse/neglect Protect our residents from neglect by anyone including but not necessarily limited to facility staff other residents, consultants, and volunteer staff from other agencies. An Immediate Jeopardy was identified on [DATE]. The ADM. was informed of the IJ on [DATE] and provided with the IJ template on [DATE] at 4:20pm. Record review on [DATE] reflects staff in-serviced on Dementia / Behavioral issues 73 staff have been in-serviced. Record review on [DATE] reflected the DON/ADON, and DON completed a training on governance and Leadership on [DATE]. Records review on [DATE] reflected staff were in-serviced on Dementia care 73 staff have been trained and 17 more staff still need to be trained. Review of records reflect 19 staff have been trained on the mealtime monitoring services. Review of records on [DATE] reflected residents identified as wander risk had been reassessed on [DATE], which indicated they were no longer a wander risk. Review of care plans on [DATE], reflected the care plans for residents identified as wander risk had been updated to reflect any new interventions. Record review on [DATE] reflected, the MD (Medical Director) was made aware of the IJ, consulted regarding the plan of removal and agreed with the plan presented. Record review on [DATE] reflected, a QAPI meeting was held on [DATE] the IJ was discussed and plan of correction.	4/29/2023	6	7/4/2024	7/10/2024

Attachment C: Jack Shelby Affiliated Entities Owned Facilities Deficiencies and Survey Results

Source: ProPublica Nursing Home Inspection/Survey Results

List facilities that are required for review under 10.24.20.05(8)	SFF	Date of the Survey	Deficiencies	Deficiencies (Cont.)	Description	Seriousness
THE HIGHLANDS GUEST CARE CENTER	-	4/14/2025	Freedom from Abuse, Neglect, and Exploitation Deficiency — F0600	Failure to: Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.	On 2/21/2025, CNA A transferred Resident #1 without a gait belt from the shower chair to the bed. As a result, Resident #1 suffered a fracture to the left distal diaphysis of the tibia (lower area of the shin bone). Oversight and monitoring of direct care staff (nurse aides), was not addressed. CNA A transferred Resident #1 inappropriately on 2/21/25 causing a left lower extremity fracture, was not retrained and or monitored, and then CNA A transferred Resident #1 inappropriately on 04/07/25 causing a right lower extremity fracture. CNA A was aware Resident #1 required two staff to transfer but transfered the resident alone.	K
			Quality of Life and Care Deficiency — F0689	Failure to: Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.	On 2/21/2025, CNA A transferred Resident #1 without a gait belt from the shower chair to the bed. As a result, Resident #1 suffered a fracture to the left distal diaphysis of the tibia (lower area of the shin bone). Oversight and monitoring of direct care staff (nurse aides), was not addressed. CNA A transferred Resident #1 inappropriately on 2/21/25 causing a left lower extremity fracture, was not retrained and or monitored, and then CNA A transferred Resident #1 inappropriately on 04/07/25 causing a right lower extremity fracture.	K

Attachment C: Jack Shelby Affiliated Entities C

Source: ProPublica Nursing Home Inspection/Survey

		Medicare			
List facilities that are required for review under 10.24.20.05(8)	**Action Taken**	**Penalty Date**	**Payment Denial Length in Days**	**Payment Denial Start Date**	**Payment Denial End Date**
THE HIGHLANDS GUEST CARE CENTER	Interventions: On 4/10/2025 the center will in-service nursing staff on where to find the resident's care plan to determine how to care for the resident. This care plain is found on the electronic screen system on each hall and general area. The resident transfer section on the care plan will tell the Nursing tea member how the resident is to be transferred. On 4/10/2025 the center will educate nursing team members on the process of transferring residents by using their proper body mechanics or using a transfer device for the safety of both residents and staff. On 4/10/2025 the center will complete a skills check-off tool on the nursing team members so they can demonstrate the process of transferring residents by using their proper body mechanics or using a transfer device for the safety of both resident and staff. The following in services were immediately initiated by . Chief Nursing Officer on 4/10/2025. Any nurse not present or in-serviced by 4/12/2025 by 12pm, will not be allowed to assume their duties until in-serviced. ADM . will ensure these team members are removed from the time clock and PCC access removed, this will be monitored until 100% complete or the team members are terminated. On going in-service will be completed by . the DON; ADON D and ADON E until all staff, Weekend, and PRN are completed by 4/12/2025 at 12:00pm. Systemic Change 4/11/2025:On 4/11/2025 it was found that identified CNAs were not following the education and Skills check-off they had completed before they started their shift. (IDT Team - I) decided to bring in a Licensed Physical Therapist to educate, complete a skills check-off list, and post-test on transferring a resident. On 4/12/2025 PT educated, completed a skills check-off list, and post-test on transferring a resident with body techniques and mechanical devices with .DON; ADON D and ADON E. After they completed and passed their education, PT observed DON; ADONs educate, complete a skills check-off list, and post-test on transferring a resident with body techniques and mechanical devices with 3 CNAs. Moving forward only DON; ADONs, and PT will be able to in-service, complete a skills check-off list, and post-test on transferring a resident with body techniques and mechanical devices.Moving forward a resident can only be transferred using a Hoyer lift with a licensed nurse present. This practice will continue until the (IDT Team - I) decides the CNAs are able to complete this transfer without supervision.The following in services were immediately initiated by Chief Nursing Officer on 4/10/2025. Any nurse not present or in-serviced by 4/12/2025 by 12pm, will not be allowed to assume their duties until in-serviced. ADM and HR will ensure these team members are removed from the time clock and PCC access removed, this will be monitor until 100% complete or the team members are terminated. On going in-service will be completed by DON and ADONs until all staff, Weekend, and PRN are completed by 4/12/2025 at 12:00pm. The following in-services were initiated by Chief Nursing Officer on 4/10/2025: Nursing Department (CNAs):- In-service nursing staff on where to find the resident's care plan to determine how to care for the resident. (See in-service 600-1)- Educate nursing team members on the process of transferring residents by using their proper body mechanics or using a transfer device for the safety of both residents and staff. (See in-service 600-2) (See Check-off list 600-2) (See Post-test 600-2).The medical director was notified of the immediate jeopardy situation on 4/10/2025 by the DON.The Ombudsmen was notified of this Immediate Jeopardy situation on 4/10/2025 by the Administrator. Monitoring as of 4/11/2025:The DON and ADONs will monitor resident transfers by CNA every shift for 7 days. Administrator will monitor this process daily for the next 7 days. The DON and ADONs will test nursing staff on where to find the resident's care plan every shift for 7 days. The ADM will monitor this process daily for the next 7 days. QAPI:1. Ad Hoc QA meeting held on 4/10/2025 to discuss causes, in-services and review interventions. 2. Any negative findings in the monitoring and/or auditing system will be reviewed and addressed by the QAPI committee for a potential systemic change. On 04/14/2025 CNA A, was terminated for failure to follow company policies and procedures while providing resident care.	-	-	-	-

Attachment C: Jack Shelby Affiliated Entities Owned Facilities Deficiencies and Survey Results

Source: ProPublica Nursing Home Inspection/Survey Results

List facilities that are required for review under 10.24.20.05(8)	SFF	Date of the Survey	Deficiencies	Deficiencies (Cont.)	Description	Seriousness
THE HIGHLANDS GUEST CARE CENTER	-	4/14/2025	Quality of Life and Care Deficiency — F0697	Failure to: Provide safe, appropriate pain management for a resident who requires such services.	1. The facility failed to ensure Resident #1 did not experience additional pain after sustaining a fracture on 2/21/2025 to the left distal diaphysis of the tibia (lower area of the shin bone) and was not transferred to the hospital until 2/26/2025 (five days later). 2. The facility failed to ensure Resident #1's pain was accurately assessed and documented.	K
			Administration Deficiency — F0777	Failure to: Provide or obtain x-rays/tests when ordered and promptly tell the ordering practitioner of the results.	1. The facility failed to notify and consult with Resident #1's physician on 2/21/2025 when x-ray results were received revealing Resident #1 had a fracture to the left distal diaphysis of the tibia (lower area of the shin bone). Resident #1 was not sent to the hospital until five days later, on 2/26/2025. 2. The facility failed to notify and consult with Resident #1's physician on 4/07/2025 when x-ray results were received revealing Resident #1 had an oblique fracture (a bone break that occurs at an angle to the bone's long axis) to the right distal diaphysis of the tibia (lower area of the shin bone). Resident #1 was not sent to the hospital until the next day on 4/08/2025.	K
THE LAKES AT TEXAS CITY	-	-	-	-	-	-
THE MANOR HEALTHCARE RESIDENCE	-	6/12/2023	Quality of Life and Care Deficiency — F0689	Failure to: Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.	The facility failed to ensure Resident #92 was transferred using a gait belt .	G

Attachment C: Jack Shelby Affiliated Entities C

Source: ProPublica Nursing Home Inspection/Survey

		Medicare			
List facilities that are required for review under 10.24.20.05(8)	**Action Taken**	**Penalty Date**	**Payment Denial Length in Days**	**Payment Denial Start Date**	**Payment Denial End Date**
THE HIGHLANDS GUEST CARE CENTER	Interventions: All residents were immediately assessed on 4/10/2025 for any change in condition from their baseline including pain assessment. Any resident who verbalized or showed nonverbal signs of pain, was addressed at that time following that resident's physician orders for pain management.On 4/12/2025 either DON; ADON D; ADON E; and LVN CC; will round the center and observe each resident every 12 hours looking for indications of pain or change of conditions, these rounds will be documented on the resident 24-hour report for the next 7 days. The ADM will monitor this process daily for the next 7 days.The following in services were immediately initiated by the Chief Nursing Officer on 4/10/2025. Any nurse not present or in-serviced by 4/12/2025 by 12pm, will not be allowed to assume their duties until in-serviced. The ADM and HR will ensure these team members are removed from the time clock and PCC access removed, this will be monitor until 100% complete or the team members are terminated. On going in-service will be completed by DON; ADON D; ADON E until all staff, Weekend, and PRN are completed by 4/12/2025 at 12:00pm. Post Test will be completed to evaluate team members understanding of in-services covered. The passing score will be 80% - 100%. (See Post-test POR-1) The following in-services were initiated by CNO: Licensed Nurses: How to assess residents for signs and symptoms of pain using a pain scale appropriate for them. (See In-service 600-I1) How to reassess pain after medication administration for effectiveness and process for if not effective. (See In-service 600-I2) Each resident will have a pain management treatment plan as part of their plan of care. (See In-service 600-I3) The medical director was notified of the immediate jeopardy situation on 4/10/2025 by the DON.The Ombudsmen was notified of this Immediate Jeopardy situation on 4/10/2025 by the ADM. Monitoring as of 4/10/2025: All residents were immediately assessed on 4/10/2025 for any change in condition from their baseline including pain assessment. Any resident who verbalized or showed nonverbal signs of pain, was addressed at that time following that resident's physician orders for pain management. On 4/12/2025 either DON; ADON D; ADON E; and LVN CC; will round the center and observe each resident every 12 hours looking for indications of pain or change of conditions, these rounds will be documented on the resident 24-hour report for the next 7 days. The ADM will monitor this process daily for the next 7 days. The following in services were immediately initiated by the Chief Nursing Officer on 4/10/2025. Any nurse not present or in-serviced by 4/12/2025 by 12pm, will not be allowed to assume their duties until in-serviced. The ADM and HR will ensure these team members are removed from the time clock and PCC access removed, this will be monitor until 100% complete or the team members are terminated. On going in-service will be completed by DON; ADON D; ADON E until all staff, Weekend, and PRN are completed by 4/12/2025 at 12:00pm.	-	-	-	-
THE LAKES AT TEXAS CITY	-	-	-	-	-
THE MANOR HEALTHCARE RESIDENCE	Admin stated this incident had not had a project improvement plan or a QAPI plan put in place.	-	-	-	-

Attachment C: Jack Shelby Affiliated Entities Owned Facilities Deficiencies and Survey Results

Source: ProPublica Nursing Home Inspection/Survey Results

List facilities that are required for review under 10.24.20.05(8)	SFF	Date of the Survey	Deficiencies	Deficiencies (Cont.)	Description	Seriousness
TOMBALL REHAB & NURSING	-	2/9/2024	Quality of Life and Care Deficiency — F0678	Failure to: Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident's advance directives.	The facility failed to ensure that a resident received CPR in accordance with professional standards of practice. The facility failed to immediately initiate CPR at about 3:28 AM on [DATE] when CR#1 was found unresponsive, by waiting an additional 7 minutes. The facility failed to ensure CPR was performed appropriately and accurately for approximately 10 minutes once initiated by staff.	J

Attachment C: Jack Shelby Affiliated Entities C

Source: ProPublica Nursing Home Inspection/Survey

		Medicare			
List facilities that are required for review under 10.24.20.05(8)	**Action Taken**	**Penalty Date**	**Payment Denial Length in Days**	**Payment Denial Start Date**	**Payment Denial End Date**
TOMBALL REHAB & NURSING	B. On [DATE] the DON/Designee began In Service education to all licensed nurses on Cardiopulmonary Resuscitation Policy that is a guideline for processing the patient's right and choice regarding Cardiopulmonary Resuscitation, to provide basic life support, including CPR to any resident requiring such care prior to the arrival of emergency medical personnel in the absence of advanced directive or a Do Not Resuscitate order. This In-Service education was completed on [DATE] at 7:30 pm, and no licensed nurse was allowed to work until they had completed this In-Service. C. On [DATE] Social Worker/Designee began 100% audit of all resident's code status to correctly identify if they are a full code or DNR. This will be completed on [DATE] at 7:30 pm and corrective action will be addressed if identified. D. On [DATE] DON/Designee reviewed the crash cart check list and validated that all items were present on crash cart. E. On [DATE], an audit was completed by Human Resources to validate that 14 of 17 licensed nurses were CPR certified. The 3 licensed nurses what were not CPR certified, will not be allowed to work until they attend the CPR training course on [DATE]. F. On [DATE] the primary night nurse for resident # 1was suspended and will be terminated. Two other nurses involved in the incident will not be allowed to work until they receive 1:1 education from the DON or Regional Nurse Consultant regarding Cardiopulmonary Resuscitation, to provide basic life support, including CPR to any resident requiring such care prior to the arrival of emergency medical personnel in the absence of advanced directive or a Do Not Resuscitate order. G. On [DATE] the DON/Designee conducted a mock CPR drill with the 2 pm to 10 pm shift, after the IJ was called. H. The DON/Designee will conduct a mock CPR drill on each shift daily x 3 days, beginning on [DATE]. 1. Identification of Residents Affected or Likely to be Affected: 2. The DON/Designee validated that there are no other like residents in the facility at this time. 3. Actions to Prevent Occurrence/Recurrence: A. On [DATE] all license nurses will receive in-person CPR training by a Certified CPR Instructor. No license nurse will be allowed to work until they have received CPR certification. B. On [DATE] all certified Nurse Aides on the evening and night shifts will receive in-person CPR training by a Certified CPR Instructor. No certified Nurse Aide on the evening or night shift will be allowed to work until they have received CPR certification. C. DON/Designee will do mock drills weekly x 4 weeks, 2 x month x 2 months, then monthly ongoing. D. Starting [DATE] any newly hired licensed nurse, or certified nurse aide will be required to have CPR certification within 2 weeks of hire. E. For all new or readmissions, the social worker or designee will review resident's code status daily in the morning meeting to validate that resident's code status is correct. F. DON will review crash cart check list 5 x weekly to validate that all needed items to conduct a code is available, this will be on going. G. On [DATE] an ad hoc meeting regarding the immediate Jeopardy was conducted to review the plan of removal and interventions. On [DATE] the facility's Administrator notified the Medical Director regarding the Immediate Jeopardy the facility received related to failure to start CPR in accordance with professional standards of practice, and reviewed plan to sustain compliance.	-	-	-	-

Attachment C: Jack Shelby Affiliated Entities Owned Facilities Deficiencies and Survey Results

Source: ProPublica Nursing Home Inspection/Survey Results

List facilities that are required for review under 10.24.20.05(8)	SFF	Date of the Survey	Deficiencies	Deficiencies (Cont.)	Description	Seriousness
TOMBALL REHAB & NURSING	-	9/12/2023	Quality of Life and Care Deficiency — F0686	Failure to: Provide appropriate pressure ulcer care and prevent new ulcers from developing.	1. The facility failed to ensure Resident #1, who admitted on [DATE] with a stage 4 pressure wound of the sacrum, stage 3 pressure wound of the right heel, stage 3 pressure wound of the left heel, stage 3 pressure wound of the right elbow, and skin tear wound of the left elbow, had documented and individualized wound care orders until 08/17/2023. Resident #1's wounds were not assessed by a wound care physician until 08/30/2023 and were not consistently tracked or measured for progression/regression. The facility also failed to ensure Resident #1 had weekly skin assessments on 08/12/2023, 08/19/2023, and 09/02/2023, and daily wound care treatments on 08/18/2023, 08/19/2023, 08/21/2023, 08/27/2023, 08/30/2023, 08/31/2023, and 09/02/2023, and resulted in wound deterioration, drainage, and odor. 2. Treatment LVN A falsely documented that Resident #1's wounds were treated as ordered by his physician on 08/25/2023, 08/30/2023 and 08/31/2023, when they were not.	K
		2/15/2023	Quality of Life and Care Deficiency — F0695	Failure to: Provide safe and appropriate respiratory care for a resident when needed.	-The NF failed to ensure all Nursing staff caring for residents with tracheotomies had been trained on maintaining artificial airway if a trach dislodged. -The NF failed to have emergency tracheostomy equipment at CR #1's bedside at all times when CR #1 trach dislodged. -The NF failed to order sufficient tracheostomy/respiratory equipment for residents with tracheotomy in the event of an emergency. CR #1 was found in bed on [DATE] with trach dislodged. CR #1 was transported to the hospital via EMS where he passed away shortly after arriving at the hospital.	K
TRAYMORE NURSING CENTER	-	1/24/2024	Quality of Life and Care Deficiency — F0677	Failure to: Provide care and assistance to perform activities of daily living for any resident who is unable.	The facility failed to provide effective oral care to Resident #1, who had a severe dry mouth that caused the skin inside and outside of his mouth to flake and peel off.	G
VILLA HAVEN HEALTH AND REHABILITATION CENTER	-	-	-	-	-	-

Attachment C: Jack Shelby Affiliated Entities C

Source: ProPublica Nursing Home Inspection/Survey

		Medicare			
List facilities that are required for review under 10.24.20.05(8)	**Action Taken**	**Penalty Date**	**Payment Denial Length in Days**	**Payment Denial Start Date**	**Payment Denial End Date**
TOMBALL REHAB & NURSING	An Immediate Jeopardy (IJ) situation was identified on 09/06/2023 at 12:08 p.m. The IJ was removed on 09/08/23. Details of the successful removal plan are not included in the survey.	-	-	-	-
	The IJ was removed on [Date]. While removed as a result of a successful removal plan, the details of action taken are not provided in the survey.				
TRAYMORE NURSING CENTER	Staff were re-educated on patient care policies already in place.	-	-	-	-
VILLA HAVEN HEALTH AND REHABILITATION CENTER	-	-	-	-	-

Attachment C: Jack Shelby Affiliated Entities Owned Facilities Deficiencies and Survey Results

Source: ProPublica Nursing Home Inspection/Survey Results

List facilities that are required for review under 10.24.20.05(8)	SFF	Date of the Survey	Deficiencies	Deficiencies (Cont.)	Description	Seriousness
WEDGEWOOD NURSING HOME	-	1/31/2025	Quality of Life and Care Deficiency — F0693	Failure to: Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube.	1. RN G failed to contact the physician and obtain orders before using a de-clogger (a device designed to clear obstructed feeding tubes) to unclog Resident #67's g-tube (Gastrostomy tube, tube inserted through the belly that brings nutrition directly to the stomach) on [DATE]. The facility had de-clogger tools onsite, even though they did not train nurses on their use, and it was not an approved method for de-clogging a g-tube. 2. The facility failed to follow physician orders for Resident 67's enteral feeding tube to be flushed with 100 ml of water every 2 hours.	J
		2/7/2024	Nursing and Physician Services Deficiency — F0726	Failure to: Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being.	Facility failed to ensure LVN C was competent in medication administration when LVN C failed to ensure Resident #1 was administered nitroglycerin (medication used to prevent or relieve chest pain caused by coronary artery disease by relaxing blood vessels), as ordered by the physician on 02/04/24. LVN C dispensed an entire bottle of nitroglycerin, which consisted of 25 (0.4 mg) tablets, to Resident #1 when the physician order was for 1 (0.4 mg) tablet resulting in Resident #1 being sent to the emergency room . Resident #1's initial blood pressure at the ER was 86/42.	J
			Pharmacy Service Deficiency — F0760	Failure to: Ensure that residents are free from significant medication errors.	On 02/04/24, LVN C failed to ensure Resident #1 was administered nitroglycerin (medication used to prevent or relieve chest pain caused by coronary artery disease by relaxing blood vessels), as ordered by the physician. LVN C dispensed an entire bottle of nitroglycerin, which consisted of 25 (0.4 mg) tablets to Resident #1, when the physician order was for 1 (0.4 mg) tablet. Resident #1 was transferred to the emergency room , his initial blood pressure at the ER was 86/42.	J

Attachment C: Jack Shelby Affiliated Entities C

Source: ProPublica Nursing Home Inspection/Survey

		Medicare			
List facilities that are required for review under 10.24.20.05(8)	**Action Taken**	**Penalty Date**	**Payment Denial Length in Days**	**Payment Denial Start Date**	**Payment Denial End Date**
WEDGEWOOD NURSING HOME	On [DATE] resident was immediately assessed BY ADON head to toe without any noted signs or symptoms of injury. On [DATE] the 2 other g-tube residents with g-tubes were immediately assessed By ADON LVN head to toe without any noted signs or symptoms of injury. II. System changes On [DATE] all g-tube de-clogger devices were immediate removed from the facility at the time they were identified during the annual survey as this is not part of our policy. On [DATE] all g-tube de-cloggers were brought to the DON office by Central supply for immediate destruction. On [DATE] Central supply and ADON's were immediately instructed to not order any g-tube de-cloggers moving forward no matter who requested them. And to notify the Administrator if asked. On [DATE] Director of Nurses was terminated for failure to participate in this investigation. On [DATE] Facility policy was updated by VP of clinical services to include problem solving to prevent g-tube clogging. III. Education On [DATE] all licensed nurses were immediately in-serviced by ADON on the facility policy is not to use g-tube de-cloggers and on the facility policy on care of the tube fed resident (prevention of gastrointestinal complications, prevention of mechanical complications, prevention of dignity issues, observations and reporting) On [DATE] all licensed nurses were immediately in-serviced by ADON on following physicians orders for administering flushes. This in-service included validating the pump was programmed to match the physician's order at the beginning of their shift. On [DATE] all nurses were in-serviced by ADON on the updated facility policy for care of the tube fed resident (which includes the notification of the physician anytime a g-tube is clogged). All staff that did not attend the in-service's will be in-serviced on all education completed by ADON prior to their next scheduled shift. IV. Monitoring Nursing supply orders will be pulled weekly x 1 month to ensure de-cloggers are not being ordered. DON/Designee will do random checks weekly x 4 weeks to ensure auto flush pumps are programmed to match the flush ordered by the physician. DON and Administrator will review nursing orders monthly at the facility QAPI meeting to ensure continued compliance. The facility took the following actions to correct the non-compliance prior to the investigation: A record review of the facility's document titled Associate Disciplinary Memorandum, dated 02/04/24 and completed by the DON, reflected LVN C was suspended due to medication error. A record review of the facility's document titled Termination Report, dated 02/06/24, reflected LVN C was terminated due to safety violations. A record review of the facility's document titled Medication Cart Audit, dated 02/04/24 and completed by ADON A, reflected the medication carts for the 100 hall was audited and had no issues. A record review of the facility's document titled Medication Cart Audit, dated 02/04/24 and completed by ADON B, reflected the medication carts for the 200 hall was audited and had no issues. A record review of the facility's in-services titled Medication Pass Policy and Nitroglycerin uses and directions, dated 02/04/24, reflected all Med Aides and nursing staff, were educated on the facility's policy titled Medication- Treatment Administration Documentation Guidelines, dated 02/02/14 and training document Nitroglycerin Oral: Uses, Side Effects, Interactions, Pictures, Warning & Dosing, undated. A record review of the facility's documents titled Validation Checklist Medication Pass, dated 02/04/24, reflected Purpose: To determine if the nurse is performing a medication pass procedure in accordance with the facility's standard of practice. Enter Nurse/Nurse Aide Initial Record observation below. Review findings with the nurse. Provide correction action as needed. The documents reflected ADON A and ADON B completed observations of medication pass on all Med Aides and nurses, which revealed there were no issues. A record review of the facility's in-services titled Abuse and Neglect, dated 02/04/24, reflected all staff were in-serviced on the facility's policy titled Abuse Policy, dated 02/01/21, and completed a posttest titled Resident Abuse Prevention and Reporting, which reflected no issues. Interviews were conducted from 02/06/24 between 11:40 AM and 2:20 PM to 02/07/24 between 10:10 and 10:30, with 3 Med Aides, 4 RNs, 5 LVNs, and two ADONs, from various shifts. The staff all stated they had been in-serviced on medication administration, nitroglycerin administration, and abuse and neglect. The staff were able to identify and define medication errors, and were knowledgeable on procedures for administering all medications, specifically nitroglycerin. The staff were knowledgeable of abuse & neglect policy and procedures.	1/31/2025	2	3/5/2025	3/7/2025

Attachment C: Jack Shelby Affiliated Entities Owned Facilities Deficiencies and Survey Results

Source: ProPublica Nursing Home Inspection/Survey Results

List facilities that are required for review under 10.24.20.05(8)	SFF	Date of the Survey	Deficiencies	Deficiencies (Cont.)	Description	Seriousness
WELLINGTON CARE CENTER	-	-	-	-	-	-
WESLEY WOODS HEALTH & REHABILITATION	-	4/8/2025	Pharmacy Service Deficiency — F0755	Failure to: Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.	Facility failed to maintain accurate and timely medication records to minimize the potential for medication related adverse consequences or events for three (Resident #1, Resident #2 and Resident #3) of five residents reviewed for med errors. A medication error occurred on 11/28/2024 where residents # 1, #2 and #3 all received a double dose of their scheduled narcotic pain medication. Residents #1, #2 and #3 received their first dose at 7pm and the second dose at 8:30 pm.	K
		6/13/2024	Freedom from Abuse, Neglect, and Exploitation Deficiency — F0600	Failure to: Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.	The facility failed to prevent abuse by failing to ensure Resident #1 was not pushed by CNA A resulting in a fall in his room on 5/27/2024.	G

Attachment C: Jack Shelby Affiliated Entities C

Source: ProPublica Nursing Home Inspection/Survey

		Medicare			
List facilities that are required for review under 10.24.20.05(8)	**Action Taken**	**Penalty Date**	**Payment Denial Length in Days**	**Payment Denial Start Date**	**Payment Denial End Date**
WELLINGTON CARE CENTER	-	-	-	-	-
WESLEY WOODS HEALTH & REHABILITATION	o on 11/28/24 a medication error occurred and there was not documentation by facility staff of a medication error in the progress notes. Responsible parties for Residents # 1, 2, and 3 were contacted and made aware of the med errors on 4/4/2025. The Medical Director was made aware of past med error. o All residents have the potential to be affected by deficient practices of medication administration. o Missed Medication Report was pulled for the past 6 months to ensure no other residents were administered narcotics twice. o Review of all Narcotic sheets for the past 6 months was reviewed to ensure that there were no double doses of narcotics based on the sign out sheets and comparing to nurse notes and EMARs. o To prevent from occurring, the ADONs are reviewing count sheets daily to ensure no double doses have been administered. Training Topic: Administering Medications, Medication Errors, and Notification to Physicians, Family, and others. The Chief Operating Officer and Director of Clinical Operations educated the DON and Administrator with a posttest to show understanding The Director of Nurses Provided training to the nurses and medication aides on duty Training started on 4/4/25 at 2:50pm for nurses and med aides on duty with a post test to show understanding Training was concluded at 6:15 for all staff on-site Training will be concluded for those not present, they will be educated and required to pass a post test before they take their next assignment. New Hire's will receive training from the DON or designee during new hire orientation. The facility does not utilize agency staff. Notification:Chief Operating Officer was notified at 2:31 on 4/4/25, Director of Clinical Operations was notified at 2:31 on 4/4/25, Medical Director was notified by the administrator on 4/4/25 at 2:43 pm. Immediate Action: The person who made the error(s) received an in-service and a disciplinary action. Residents with med errors on 11/28/24 were assessed on 4/4/25 and 4/5/25 and all notifications were made and documented on 4/4/25 and 4/5/25 by the ADON and CHARGE NURSE AD-HOC QA meeting: Ad-Hoc QAPI meeting was held on 4/4/25 at 3:30PM-attendance was Medical Director via email and phone contact- COO via email and phone contact- ADON in person- DON in person- Administrator in person preparing the meeting Recurrence Prevention: Missed Medications report will be ran during daily stand-up meeting to review medications that were missed. Any medication errors, the staff member will be contacted and an in-service and disciplinary action (where necessary) will be initiated. All nursing staff who administer medications will be given reminder. education over the policy and procedures by the DON or Nurse Managers that will be initiated immediately following the med error until all staff who administer medications has received re-education. The ADONs are reviewing count sheets to ensure no one has been doable dosed or that a dose has been missed and not documented in the EMAR. This is part of their morning routines. Monitoring for effectiveness: Missed Medication Report will be ran prior to daily stand-up meeting by the DON This will be an ongoing process. Review of facility self-report dated 5/29/2024 that included Plan of Correction and steps taken reflected: o Reviewed footage from the family multiple times and then reviewed footage from the facility cameras and it Is almost definite that the resident was pushed by CNA [CNA A] resulting in him becoming unsteady and falling. He fell on to his left side brushing against the bed frame and the overbed table. o Interview with resident with officer [name omitted] present-resident able to recall that he fell . He was not able to recall the day, but he recalls someone pushing him from behind causing him to lose his balance and he fell . He pulled up his sweater and showed the officer the area on his left clavicle and the scratch on his left lower back. Review of CNA A onboarding folder reflected she had received training on ANE on 9/16/2002 and the form was signed by CNA A. Further review reflected a document Senate [NAME] 9. Legislation on curbing abuse was signed on 9/16/2020 by CNA A indicating CNA A had been made aware of how to curb abuse. Review of background check information provided by facility on 6/13/2024 reflected appropriate background checks (employability, criminal and license checks) were performed prior to hire and yearly as required for CNA A and RN B.Review of facility in-service training sheet dated 5/21/2024 with topics Abuse and Neglect, who to report allegations of abuse to, Resident Rights, Customer Service reflected the printed name and signature of CNA A. The in-service sheet had a copy of the facility Abuse and Neglect Policy attached, copy of the Resident Rights hand out attached, as well as hand out with the Abuse Coordinator's information and phone number.	-	-	-	-

Attachment C: Jack Shelby Affiliated Entities Owned Facilities Deficiencies and Survey Results

Source: ProPublica Nursing Home Inspection/Survey Results

List facilities that are required for review under 10.24.20.05(8)	SFF	Date of the Survey	Deficiencies	Deficiencies (Cont.)	Description	Seriousness
WESLEY WOODS HEALTH & REHABILITATION	-	8/2/2023	Resident Rights Deficiency — F0583	Failure to: Keep residents' personal and medical records private and confidential.	Facility failed to respect the residents' right for 3 (Resident #1, Resident #27, and Resident #42) of 3 residents to send and promptly receive unopened mail, letters, and packages each postal delivery day.	G
		6/9/2023	Freedom from Abuse, Neglect, and Exploitation Deficiency — F0600	Failure to: Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.	Facility failed to ensure a safe environment free from abuse for Resident #1 when CNA A pulled a taser out to scare Resident #1 on 04/29/2023.	J

Attachment C: Jack Shelby Affiliated Entities C

Source: ProPublica Nursing Home Inspection/Survey

		Medicare			
List facilities that are required for review under 10.24.20.05(8)	**Action Taken**	**Penalty Date**	**Payment Denial Length in Days**	**Payment Denial Start Date**	**Payment Denial End Date**
WESLEY WOODS HEALTH & REHABILITATION	Facility member at fault was re-educated on patient policies. The facility took the following actions to correct the non-compliance: 1. 04/29/23 Administrator immediately removed CNA A from the facility, and they were not allowed to return to the facility. 2. 04/29/23 DON has been in-serviced on abuse and neglect and workplace. 3. 04/29/23 The Administrator then immediately notified the [staffing agency name] Agency and police department. 4. 04/29/23 The facility self-reported the incident to HHS. 5. 04/29/23 The facility gave the resident a head-to-toe assessment. No injuries were noted. 6. 04/29/23 The facility gave the resident a psychological assessment. No psychological harm was noted. 7. 04/29/23 The facility notified family. 8. 04/29/23 The facility notified the facility's medical director. 9. 04/29/23 The facility placed the CNA A the do not return list. 10. 04/29/23 The Staffing Agency terminated the CNA A for their agency. 11. 04/29/23 The facility implemented a procedure for in-servicing agency staff. 12. 04/29/23 The facility in-serviced staff on Preventing Abuse, Abuse Coordinator & Violence Free Workplace.13. 04/29/23 The Staff Agency implemented in-serving for agency staff. Agency staff are receiving an abuse, neglect and misappropriation in-servicing prior to them receiving an assessment. 14. 05/26/23 interview with Agency Staff and Facility Staff revealed they had been in-serviced from the facility on Abuse, Neglect Exploitation, Workplace violence.15. 05/31/23 QAPI met in reference to the incident on 04/29/23. 16. 06/09/23 interviews with AD, CNA D, CNA F and CNA G revealed they had been in-serviced from the facility on Abuse, Neglect Exploitation, Workplace violence.	-	-	-	-

Attachment C: Jack Shelby Affiliated Entities Owned Facilities Deficiencies and Survey Results

Source: ProPublica Nursing Home Inspection/Survey Results

List facilities that are required for review under 10.24.20.05(8)	SFF	Date of the Survey	Deficiencies	Deficiencies (Cont.)	Description	Seriousness
WEST SIDE CAMPUS OF CARE	-	5/8/2025	Freedom from Abuse, Neglect, and Exploitation Deficiency — F0600	Failure to: Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.	The facility failed to ensure that Resident #1 was free from physical abuse when he alleged he received methadone from a staff member, was found unresponsive, required Narcan, and tested positive for Methadone for which he did not have an order for. Resident #1 was transported to the local hospital on 4/30/25 and diagnosed with hypoxia (low oxygen) likely due to acute-on-chronic systolic heart failure.	J
			Freedom from Abuse, Neglect, and Exploitation Deficiency — F0607	Failure to: Develop and implement policies and procedures to prevent abuse, neglect, and theft.	The facility failed to implement the abuse and neglect policy and procedures to ensure that Resident #1 was free from physical abuse when he alleged he received methadone from a staff member, was found unresponsive, required Narcan, and tested positive for Methadone for which he did not have an order for. Resident #1 was transported to the local hospital on 4/30/25 and diagnosed with hypoxia (low oxygen) likely due to acute-on-chronic systolic heart failure.	J

Attachment C: Jack Shelby Affiliated Entities C

Source: ProPublica Nursing Home Inspection/Survey

		Medicare			
List facilities that are required for review under 10.24.20.05(8)	**Action Taken**	**Penalty Date**	**Payment Denial Length in Days**	**Payment Denial Start Date**	**Payment Denial End Date**
WEST SIDE CAMPUS OF CARE	Identify residents who could be affected: All Residents have the potential to be affected by this deficiency Identify responsible staff/ what action taken: 1. Alleged employee suspended pending investigation. Last day employee worked was 4/27/25 2. Attending Physicians was notified of the incident involving the resident on 5/2/25 3. Trauma screen was completed on 5/6/25. 4. Police notified on 5/6/25. 5. Resident referred to Deer OAKS for psychological assessment on 5/5/25 6. Care plans updated on 5/5/25 7. Reviewed out on pass for 5/2/25 8. Reviewed advance entry for visitors on 5/2/25 9. Reviewed facility medications for use of methadone 5/2/25 10. Completed care plan conference with residents on 5/5/25 11. Resident seen by psychologist on 5/5/25 12. Drug abuse contract and policy discussed with residents and signed 5/5/25 13. Staff in-service on facility drug policy, identifying intoxicated residents, Narcan administration on 5/7/25, and will be completed on 5/8/25. All staff in-services will be ongoing to ensure all PRN, new staff, and any staff who are not in-serviced for any reason will receive it before the start of the shift.14. Abuse and neglect in-service started on 5/7 /25 and will be completed on 5/8/25. All staff in services will be ongoing to ensure all PRN, new staff, and any staff not in-serviced for any reason receive them before the start of the shift. In-service will be conducted by the Administrator/DON or Designee.15. 1:1 in-service conducted for DON and Administrator on Abuse and Neglect Policy. In-service conducted by RDO and RNC on 5/7/25 16. Staff and resident questionnaires 5/5/25.17. Safe surveys on 5/2/25 18. Offered drug rehab services to resident 5/5/25 Implementation of Changes:1. Audit of all residents who have a drug history or potential for drug use and have completed the drug policy acknowledgement form. This started on 5/7/25 and will end on 5/8/25. This will be ongoing to ensure all new admits and changes are made where necessary. This will be conducted by the DON or Designee. 2. Appropriate interventions are being put in place as needed. 3. All staff were re-educated on identifying intoxicated residents and the resident drug and alcohol abuse policy. This started on 5/7/25 and will end on 5/8/25. All staff in-services will be ongoing to ensure all PRN, new staff, and any staff not in-serviced for any reason receive then1 before the start of the shift. In-service will be conducted by the Administrator/DON or Designee. 4. Staff (nurses) in-service on facility drug policy, identifying intoxicated residents, Narcan administration, abuse, and neglect started on 5/7/25 and will end on 5/8/25. All staff in-services will be ongoing to ensure all PRN, new staff, and any staff not in-serviced for any reason receive them before the start of the shift. In-service will be conducted by the Administrator/DON or Designee. Monitoring: The Administrator/DON/Designee will be responsible for monitoring the implementation and effectiveness of in-service conducted on 5/7 /25 and ongoing. The Administrator/DON will review the effectiveness of this daily X 7 days and weekly X 4 weeks, then X 3 monthly, continued monitoring will be ongoing and report any adverse findings to the QAPI committee. All concerns noted will be addressed at the time of discovery. Involvement of Medical Director: The Medical Director met with the Interdisciplinary team on 5/6/25 and conducted an Ad HOC QAPI regarding resident drug use. The Medical Director was notified about the immediate Jeopardy on 5/7/25, the Plan of removal was reviewed and accepted by Medical Director. Involvement of QA:An Ad Hoc QAPI meeting was held with the Medical Director, facility administrator, director of nursing, to review the plan of removal on 5/7/25. Who is responsible for the implementation of the process? The Director of Nursing and Administrator will be responsible for the implementation of Process.	-	-	-	-

Attachment C: Jack Shelby Affiliated Entities Owned Facilities Deficiencies and Survey Results
Source: ProPublica Nursing Home Inspection/Survey Results

List facilities that are required for review under 10.24.20.05(8)	SFF	Date of the Survey	Deficiencies	Deficiencies (Cont.)	Description	Seriousness
WEST SIDE CAMPUS OF CARE	-	5/8/2025	Quality of Life and Care Deficiency — F0695	Failure to: Provide safe and appropriate respiratory care for a resident when needed.	The facility failed to ensure that Residents #2, who required continuous oxygen therapy, continued to receive adequate oxygen when her portable oxygen tank ran out of oxygen while the resident was in the community at an appointment on 4/28/2025. Resident #2 was sent to the local hospital by the clinic after running out of oxygen and complaining of SOB and chest pain.	J
		10/5/2023	Quality of Life and Care Deficiency — F0689	Failure to: Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.	1. On 09/28/23 the facility failed to ensure adequate supervision and services were provided to Resident #1, when she was allowed to sign herself out of the facility even though it was known she had impaired cognitive function, impaired thought process, and potential for delirium or acute episodes of confusion, due to dementia. 2. On 09/28/23 the facility failed to notify Resident #1's RP/POA she signed out of the facility, which caused the RP/POA not to know Resident #1's location and if she was safe for approximately 5 hours. Resident #1 was located at a nearby fast-food restaurant in a high-traffic area with a sunburn.	J

Attachment C: Jack Shelby Affiliated Entities C

Source: ProPublica Nursing Home Inspection/Survey

		Medicare			
List facilities that are required for review under 10.24.20.05(8)	**Action Taken**	**Penalty Date**	**Payment Denial Length in Days**	**Payment Denial Start Date**	**Payment Denial End Date**
WEST SIDE CAMPUS OF CARE	Record review on 5/6/25 of in-service titled Portable Oxygen Tanks, dated 4/28/25, reflected all staff were educated by the DON on ensuring that residents on oxygen therapy always had adequate oxygen available and to notify the nurse or clinical staff if portable oxygen tanks were low. Record review on 5/6/25 of in-service titled Oxygen Supply for Appointments, dated 4/28/25, reflected all nurses were in-serviced by the DON regarding appointments for residents who required continuous oxygen therapy to ensure the residents had adequate oxygen while in the community. The nurses were educated on determining the approximate length of time of each appointment, documenting and communicating the information to all staff interacting with the residents and ensuring an extra portable oxygen tank was sent on appointments that would be longer than 2 hours. Record review on 5/6/25 of in-service titled Oxygen Supply for Appointments, dated 4/28/25, reflected all nurses were in-serviced by the DON regarding appointments orders for residents who required continuous oxygen therapy. The nurses were educated on putting orders for appointments by transportation in the EHR 3 days prior to the appointment date, and including information about the approximate length of time for the appointments to ensure the residents are transported with adequate oxygen. Record review on 5/6/25 of in-service titled Portable Oxygen Tanks, dated 4/28/25, reflected LVN C had 1 on 1 education by the DON on ensuring that residents on oxygen therapy always had adequate oxygen available and to switch out low portable oxygen tanks with full ones. Record review on 5/6/25 of in-service titled Portable Oxygen-Appointments, dated 4/28/25, reflected LVN C had 1 on 1 education by the DON on ensuring that residents on continuous oxygen therapy had a full portable oxygen tank before leaving the facility for an appointment and that an extra portable oxygen tank was sent with the residents for all appointments that would be longer than 2 hours. Record review on 5/6/25 of in-service titled Portable Oxygen Tanks, dated 4/28/25, reflected CNA D had 1 on 1 education by the DON on ensuring that residents on oxygen therapy always had adequate oxygen available and to notify the nurse if portable oxygen tanks were low. Record review on 5/6/25 of in-service titled Portable Oxygen-Appointments, dated 4/28/25, reflected CNA D had 1 on 1 education by the DON on ensuring that residents on continuous oxygen therapy had a full portable oxygen tank before leaving the facility for an appointment and that an extra portable oxygen tank was sent with the residents for all appointments that would be longer than 2 hours.Record review on 5/6/25 of in-service titled Portable Oxygen Tanks, dated 4/28/25, reflected the Van Driver had 1 on 1 education by the DON on ensuring that residents on oxygen therapy always had adequate oxygen available and to notify the nurse or clinical staff if portable oxygen tanks were low. Record review on 5/6/25 of in-service titled Portable Oxygen-Appointments, dated 4/28/25, reflected the Van Driver had 1 on 1 education by the DON on ensuring that residents on continuous oxygen therapy had full portable oxygen tanks before being transported to appointments with and extra portable oxygen tank if the appointments would be longer than 2 hours.	-	-	-	-
	An IJ was identified on 10/04/23 at 5:08 PM. The IJ template was provided to the facility's Administrator on 10/04/23 at 5:15 PM. The IJ was removed on 10/05/23, the removal plan is not included in this survey				

Attachment C: Jack Shelby Affiliated Entities Owned Facilities Deficiencies and Survey Results

Source: ProPublica Nursing Home Inspection/Survey Results

List facilities that are required for review under 10.24.20.05(8)	SFF	Date of the Survey	Deficiencies	Deficiencies (Cont.)	Description	Seriousness
WESTERN HILLS HEALTHCARE RESIDENCE	-	3/25/2024	Pharmacy Service Deficiency — F0760	Failure to: Ensure that residents are free from significant medication errors.	Facility failed to remain free of significant medication errors for 4 of 6 (Resident #3, Resident #11, Resident # 31, Resident #38) residents reviewed for medication administration.	K
			Resident Rights Deficiency — F0580	Failure to: Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.	Facility failed to have a system in place to monitor that nursing staff were notifying the physician for 4 of 6 residents (Resident #3, Resident #11, Resident #31, Resident #38) when insulin was held and resident blood glucoses over 250 for 2 of 6 (Resident #38, Resident #31) residents reviewed for diabetic care.	K
			Nursing and Physician Services Deficiency — F0726	Failure to: Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being.	Facility failed to provide residents with the appropriate competencies and skills sets 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 for 4 of 6 (Resident #3, Resident #11, Resident # 31, Resident #38) residents reviewed for Diabetic care.	K
WHISPERING OAKS REHAB & NURSING	-	-	-	-	-	-

Attachment C: Jack Shelby Affiliated Entities C

Source: ProPublica Nursing Home Inspection/Survey

		Medicare			
List facilities that are required for review under 10.24.20.05(8)	**Action Taken**	**Penalty Date**	**Payment Denial Length in Days**	**Payment Denial Start Date**	**Payment Denial End Date**
WESTERN HILLS HEALTHCARE RESIDENCE	Clinical Compliance Nurse [Nurse Name] RN, BSN, clinical compliance nurse, will: On 03/23/2024, provide re-education for facility director of nursing regarding notifying physician of change in resident condition, including notifying physician when holding resident's insulin, and documentation of the notification, Inservice on scope of practice decision making module, Nursing scope of practice as related to medication administration, med error policy, policy on nursing care of older adult with diabetes. Pharmacy Consultant: Pharmacy consultant notified of medication errors and immediate jeopardy deficiencies and will schedule a follow up educational in-service to nursing staff within the next 30 days for further prevention. On 3/23/24, initiated video in-service education to all licensed nurses regarding medication error prevention and following physician orders. Expected completion date is 3/23/24. Any staff member not receiving this education by 03/23/2024, will be educated prior to next scheduled shift. An employee roster and schedule will be used to validate education compliance. Director of Nursing/Designee will: On 3/22/24, initiated re-education to all licensed nurses regarding notifying physician of change in resident condition, including notifying physician when holding resident's insulin, and documentation of the notification, resident change of condition, in-service on scope of practice decision making module, nursing scope of practice as related to medication administration, med error policy, policy on nursing care of older adult with diabetes. Expected completion date is 3/23/2024. Any staff member not receiving this education by 03/23/2024, will be educated prior to next scheduled shift. An employee roster and schedule will be used to validate education compliance. Have all licensed nurses show competency upon start of next shift via competency -based training via post-test and with continued audits and skills validation.	3/25/2024	15	4/24/2024	5/9/2024
	Clinical Compliance Nurse will: On 03/23/2024, provide re-education for facility director of nursing regarding notifying physician of change in resident condition, including notifying physician when holding resident's insulin, and documentation of the notification, in-service on Scope of practice decision making module, Nursing scope of practice as related to medication administration, med error policy, policy on nursing care of older adult with diabetes. Director of Nursing/Designee will: On 3/22/24, initiated re-education to all licensed nurses regarding notifying physician of change in resident condition, including notifying physician when holding resident's insulin, and documentation of the notification, resident change of condition, in-service on scope of practice decision making module, nursing scope of practice as related to medication administration, med error policy, policy on nursing care of older adult with diabetes. Expected completion date is 3/23/2024. Any staff member not receiving this education by 03/23/2024, will be educated prior to next scheduled shift. An employee roster and schedule will be used to validate education compliance. Have all licensed nurses show competency upon start of next shift via competency-based training via post-test and with continued audits and skills validation. Competency testing initiated on 3/22/24. Expected completion date is 3/23/2024. Any staff member not receiving this education by 03/23/2024 will be educated prior to next scheduled shift. An employee roster and schedule will be used to validate education compliance. Facility per diem nurses, new hires, and agency nurses will receive this re-education prior to reporting for duty. Physician was contacted for hold parameters for all six residents. Nurses will be in-serviced on asking for hold parameters for new insulin orders on 3/23/2024. If nurse is not available they will be educated before starting their next shift. 6 diabetic residents identified medication administration records were audited for failures related to following physician orders. Audit initiated on 3/22/24. Audit completed on 3/23/24. Negative findings will be reviewed with physician. Findings from the audit were reviewed with physician on 3/22/24 and 3/23/24. Monitoring insulin medication document records for accuracy of following physician orders initiated on 3/22/24. Monitoring will continue 3 X week for four weeks and then review findings with QAPI team. If the physician notification was required, we will ensure it is documented in resident medical record.				
WHISPERING OAKS REHAB & NURSING	-	-	-	-	-

Attachment C: Jack Shelby Affiliated Entities Owned Facilities Deficiencies and Survey Results

Source: ProPublica Nursing Home Inspection/Survey Results

List facilities that are required for review under 10.24.20.05(8)	SFF	Date of the Survey	Deficiencies	Deficiencies (Cont.)	Description	Seriousness
White Settlement Nursing Center	-	2/15/2025	Resident Rights Deficiency — F0580	Failure to: Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.	Facility failed to immediately consult with the resident's physician and notify the resident representative when there was a significant change in the resident's physical or mental status or need to alter treatment significantly for one (Resident #1) of eight residents reviewed for change of condition.	J
			Quality of Life and Care Deficiency — F0684	Failure to: Provide appropriate treatment and care according to orders, resident's preferences and goals.	Facility failed to ensure the residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices for one (Resident #1) of eight residents reviewed for quality of care.	J
		4/4/2024	Freedom from Abuse, Neglect, and Exploitation Deficiency — F0600	Failure to: Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.	Facility failed to ensure residents had the right to be free from abuse, neglect, misappropriation of resident property, and exploitation for 1 of 21 residents (Resident #47) reviewed for abuse. The facility failed to ensure Resident #47 was free from abuse when LVN F sent the resident a mentally/emotionally abusive text message, which caused the resident to experience fear for her personal safety.	J

Attachment C: Jack Shelby Affiliated Entities C

Source: ProPublica Nursing Home Inspection/Survey

		Medicare			
List facilities that are required for review under 10.24.20.05(8)	**Action Taken**	**Penalty Date**	**Payment Denial Length in Days**	**Payment Denial Start Date**	**Payment Denial End Date**
White Settlement Nursing Center	The Administrator and DON were notified of an Immediate Jeopardy (IJ). The facility's Plan of Removal (POR) was accepted on 02/15/25 at 12:46 PM and included:I. Resident Specific Staff nurse completed a clinical assessment of Resident # 1 on 2/4/25 at 5:00pm including blood pressure. Physician was immediately notified of previous high blood pressures on 2/4/25 at 5:06pm. On 2/4/25 all residents with a diagnosis of Hypertension had a clinical assessment completed by the DON and ADON including blood pressure. There were no residents identified requiring physician notification. On 2/15/25 all residents with a diagnosis of Hypertension will have a clinical assessment completed by the DON and Designee including blood pressure. Any resident identified with any abnormal findings the DON and designee will notify the physician immediately. Staff nurses will continue to monitor and report any changes to the physician. II. System Changes Each nurse will review vital signs prior to the end of their shift to ensure all abnormalities are addressed and will be ongoing. DON/ADON will review the previous days vital signs in morning meeting to ensure all abnormalities are addressed and will be ongoing. The weekend Supervisor will review previous days vital signs at the beginning of her shift to ensure all abnormalities are addressed and will be ongoing. III. Education On 2/4/25 medication aides were in-serviced by the ADON on reporting all abnormal vital signs to the nurse immediately and then documenting who they notified. On 2/15/25 DON completed education with all medication aides on reporting all abnormal vital signs to the nurse immediately and then documenting who they notified. This education will be ongoing to include any new staff and staff not yet trained. Identified medication aide received disciplinary action for failure to notify nurse of abnormal blood pressure. On 2/4/25 all nurses were in-serviced by DON on notifying the physician of all vital signs out of the documented parameters and documenting who they notified and what new orders were given. On 2/15/25 DON completed education with all nurses on notifying the physician of all vital signs out of the documented parameters and documenting who they notified and what new orders were given. This education is ongoing to include any new staff and staff not yet trained. IV. Monitoring DON/ADON will randomly pull 3 residents with hypertension weekly x 4 weeks and review their blood pressure for appropriate follow-up and interventions if required. Results of the random audits will be reviewed in QAPI meeting monthly x 3 months.	-	-	-	-
	The facility corrected the noncompliance 1/17/2024, before the survey began. The Provider Investigation Report reflected the provider response to the incident included notifying the police department and the physician, LVN F was terminated, a complaint was filed with the Board of Nursing, and the resident was assessed. Additionally, the Administrator provided staff with in-service training regarding reporting abuse, verbal and mental abuse, forms of abuse, and the Abuse Coordinator.				

Attachment C: Jack Shelby Affiliated Entities Owned Facilities Deficiencies and Survey Results

Source: ProPublica Nursing Home Inspection/Survey Results

List facilities that are required for review under 10.24.20.05(8)	SFF	Date of the Survey	Deficiencies	Deficiencies (Cont.)	Description	Seriousness
WHITNEY NURSING AND REHABILITATION CENTER	-	3/19/2024	Resident Rights Deficiency — F0580	Failure to: Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.	Failed to ensure the physician was consulted for a change of condition for 1 of 7 residents reviewed for notification of changes. (Resident #1) The facility failed to ensure a UA was collected, notify the physician, family, and provide treatment to Resident #1 died of sepsis and complications of a urinary tract infection because of her change in condition. The facility failed to identify a change in condition and notify her physician including a decline in cognitive status and a fall.	J
			Freedom from Abuse, Neglect, and Exploitation Deficiency — F0600	Failure to: Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.	Facility failed to ensure a UA was collected and provide treatment to Resident #1 who subsequently died of sepsis and complications of a urinary tract infection. The facility failed to identify a change in condition and notify her physician including a decline in cognitive status and a fall.	J
			Quality of Life and Care Deficiency — F0684	Failure to: Provide appropriate treatment and care according to orders, resident's preferences and goals.	Facility failed to ensure a UA was collected and provide treatment to Resident #1 who subsequently died of sepsis and complications of a urinary tract infection.	J
			Administration Deficiency — F0770	Failure to: Provide timely, quality laboratory services/tests to meet the needs of residents.	Facility failed to ensure a UA was collected and provide treatment to Resident #1 who subsequently experienced a change in condition, died of sepsis and complications of a urinary tract infection.	J

Attachment C: Jack Shelby Affiliated Entities C

Source: ProPublica Nursing Home Inspection/Survey

		Medicare			
List facilities that are required for review under 10.24.20.05(8)	**Action Taken**	**Penalty Date**	**Payment Denial Length in Days**	**Payment Denial Start Date**	**Payment Denial End Date**
WHITNEY NURSING AND REHABILITATION CENTER	The DON and the ADON will review 24-hour reports, nursing documentation, incidents and accidents, all new orders, and labs daily to ensure change of conditions are handled appropriately. If labs are found missing, the physician will be notified, and labs will be collected per physician orders. This will be an ongoing process. Lab audit was conducted for all residents last 3 months. 1 resident was found that had not received a lab collection due to lab technician quitting without notice. Physician notified and a new req was made. Lab collected and awaiting results. The DON and the ADON will audit orders, labs, documentation and 24-hour reports to ensure no labs are missed for all residents, both long term, and short stay (respite) for the last 3 months and will be an ongoing process.The DON and the ADON have been in-serviced on change of condition upon hire, through The Facility Meeting, QRM, and TMF . In-service all staff about change of condition, notifying the residents attending physician or physician on call, RP and documenting in the medical record when there has been a: Accident or incident involving the resident, Significant change in the residents physical/emotional/mental condition, Need to alter the resident's medical treatment significantly, Need to transfer the resident to a hospital/treatment center. Ensure PCP orders were followed including, PRN , agency, new hires, and staff not currently in the facility before the start of their next shift. The Facility had a QAPI meeting held with the DON, the Administrator, the DM, the MR, the VP of Operations and the ADON. Medical Director notified. The DON and the ADON have been in-serviced on Incidents and Accidents upon hire, through the Facility, QRM, and TMF throughout the year. In-service all staff about incidents and accidents and ensure responsible party and PCP notified, including PRN, agency, new hires, and staff not currently in facility before the start of their next shift. The DON and the ADON have been in-serviced on Falls, Fall Management, definitions of Falls, upon hire, through the facility Meetings, QRM, and TMF (last one on [DATE]). In-service all staff including, PRN, agency, new hires, and staff not currently in facility before the start of their next shift about falls, fall management, definitions of falls and incidents & accidents completion. All staff were also educated about change in conditions related to falls and notification to on call nurse, physician, and resident's responsible party.The DON and the ADON have been in-serviced on respite care through the National Institute on Aging. In-service all staff including PRN, agency, new hires, and staff not currently in facility before the start of their next shift about respite care and treating them the same as all other residents. Physician will be notified of all changes in condition and physician orders will be followed with notification to resident's responsible party as well as on call nurse. This will be monitored by the DON and the ADON as each respite is admitted for the next 3 months. Both the DON and the ADON have been in-service through Texas Board of Nursing on documentation. In-service all staff including PRN, agency, new hires, and staff not currently in facility before the start of their next shift about documentation and it is to be completed during shift. This will be monitored by the DON and the ADON Monday - Friday for the next 3 months.	-	-	-	-

Attachment C: Jack Shelby Affiliated Entities Owned Facilities Deficiencies and Survey Results

Source: ProPublica Nursing Home Inspection/Survey Results

List facilities that are required for review under 10.24.20.05(8)	SFF	Date of the Survey	Deficiencies	Deficiencies (Cont.)	Description	Seriousness
WILLOW REHAB & NURSING	-	12/12/2024	Resident Rights Deficiency — F0624	Failure to: Prepare residents for a safe transfer or discharge from the nursing home.	Facility failed to provide and document sufficient preparation and orientation to residents to ensure safe and orderly discharge from the facility for 2 of 5 residents (Resident #1 and Resident #2) reviewed for discharge rights, in that: The facility failed to ensure Resident #1 had a safe and orderly discharge to a home environment on 9/12/2024. Resident #1 was discharged from the facility with no place to go and made to sit outside and found approximately 7 hours later on the ground behind the facility and transported to the hospital with A-fib and high blood pressure. The facility failed to ensure Resident #2 had a safe and orderly discharge to a home environment on 11/14/2024. Resident #2 who needed supervision and assistance with some ADL's and was a moderate fall risk was discharged to a motel and had multiple falls.	K

Attachment C: Jack Shelby Affiliated Entities C

Source: ProPublica Nursing Home Inspection/Survey

		Medicare			
List facilities that are required for review under 10.24.20.05(8)	**Action Taken**	**Penalty Date**	**Payment Denial Length in Days**	**Payment Denial Start Date**	**Payment Denial End Date**
WILLOW REHAB & NURSING	The failures esulted in the identificaiton of an Immediate Jeapardy on 12/10/24. The IJ was removed on 12/12/24 but the removal plan is not listed in this survey	-	-	-	-

Attachment C: Jack Shelby Affiliated Entities Owned Facilities Deficiencies and Survey Results
Source: ProPublica Nursing Home Inspection/Survey Results

List facilities that are required for review under 10.24.20.05(8)	SFF	Date of the Survey	Deficiencies	Deficiencies (Cont.)	Description	Seriousness
WILLOW REHAB & NURSING	-	12/12/2024	Quality of Life and Care Deficiency — F0689	Failure to: Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.	Facility failed to respond to door alarm that resulted in Resident #3 elopement on 9/20/2024. Resident #3, who had dementia, left the facility through an alarmed door on 9/20/2024 at 5:05 PM. The resident wandered approximately 200 yards down the road from the facility driveway and was intercepted by Medical Records and returned to the facility.	J

Attachment C: Jack Shelby Affiliated Entities C

Source: ProPublica Nursing Home Inspection/Survey

		Medicare			
List facilities that are required for review under 10.24.20.05(8)	**Action Taken**	**Penalty Date**	**Payment Denial Length in Days**	**Payment Denial Start Date**	**Payment Denial End Date**
WILLOW REHAB & NURSING	The facility's plan of removal was accepted on 12/12/2024 at 1:37 p.m. and included: 1. Immediate Action Taken: G. Resident #3 is no longer in the facility as of September 23, 2024. H. On 12/11/2024 The Maintenance Director/Designee completed environmental assessments to include checks on all doors. I. On 12/11/2024 The ADON and/or designee completed elopement assessments on all facility residents with no changes noted.J. On 12/11/2024 The ADON and/or designee completed in-service education with facility direct care nursing staff on the missing resident policy which ensures that residents who exhibit wandering behavior and/or are at risk for elopement receive adequate supervision to prevent accidents. The facility RNC completed in-service education with the facility Admin and ADONs. Facility direct care nursing staff were trained prior to their next shift. The Missing Resident Policy Inservice Education included Residents will be assessed within 4 hours for risk of elopement and unsafe wandering upon admission, quarterly, and as needed throughout their stay at the facility. K. On 12/11/2024 The ADON and/or designee completed a Missing Resident Drill with facility direct care staff to ensure staff know the proper procedure for locating missing residents to include when a staff member hears the alarm sound they will initiate the code silver alert to notify all other staff members of the missing resident. Facility direct care staff completed a missing resident drill prior to their next shift. This was completed on 12/11/2024 by 10:00 pm. L. On 12/12/24 The facility RNC completed in-service education with the facility Administrator regarding do not take a resident to their room without notifying the admitting nurse and providing the admission paperwork to them.2. Identification of Residents Affected or Likely to be Affected: C. No other residents identified , on 12/11/24 the facility ADON and/or Designee completed elopement assessments on all facility residents with no new changes noted. This will be completed on 12/11/24 by 10:00 pm. 3. Actions to Prevent Occurrence/Recurrence: D. As of 12/11/2024, any staff member hired for direct nursing staff the following will be completed during orientation by the facility DON and/or designee: In-service education with facility direct care nursing staff on the missing resident policy which ensures that residents who exhibit wandering behavior and/or are at risk for elopement receive adequate supervision to prevent accidents.The DON and/or designee will complete a Missing Resident Drill with facility direct care staff during orientation to ensure staff know the proper procedure for locating missing residents to include when a staff member hears the alarm sound they will initiate the code silver alert to notify all other staff members of the missing resident. E. The ADON/Designee will conduct weekly random missing resident drills two (2) times a week for six (6) weeks to ensure facility staff know the proper procedure for locating missing residents to include when a staff member hears the alarm sound they will initiate the code silver alert to notify all other staff members of the missing resident. F. Results of weekly observations will be reviewed in the morning meeting by the Administrator or designee. On 12/11/2024 the facility's Administrator notified the Medical Director to conduct an AdHOC QAPI meeting regarding the Immediate Jeopardy the facility received related to Free of Accidents/ Hazards/ Supervision and reviewed plan to sustain compliance On 12/12/2024 the Surveyor confirmed the facility implemented their plan of removal sufficiently to remove the IJ.	-	-	-	-

Attachment C: Jack Shelby Affiliated Entities Owned Facilities Deficiencies and Survey Results

Source: ProPublica Nursing Home Inspection/Survey Results

List facilities that are required for review under 10.24.20.05(8)	SFF	Date of the Survey	Deficiencies	Deficiencies (Cont.)	Description	Seriousness
WILLOWCREEK REHAB AND NURSING	-	2/27/2025	Quality of Life and Care Deficiency — F0689	Failure to: Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.	Facility failed to maintain hot water below 110 F for 5 of 8 (Resident #60's sink, RM17 E sink, East Hall shower room sink, Resident #168, Resident #167, and Resident # 14's shared sink and RM 24 E sink) bathroom reviewed for water temperature.	K

Attachment C: Jack Shelby Affiliated Entities C

Source: ProPublica Nursing Home Inspection/Survey

		Medicare			
List facilities that are required for review under 10.24.20.05(8)	**Action Taken**	**Penalty Date**	**Payment Denial Length in Days**	**Payment Denial Start Date**	**Payment Denial End Date**
WILLOWCREEK REHAB AND NURSING	1. Immediate Action Taken A. On 2/25/2025 the maintenance director turned off all hot water in all resident rooms B. On 2/25/2025 all shower rooms were secured by the Maintenance Director with key codes/or pad locks and do not enter signs were placed on the door taking them out of service until further notice. C. On 2/25/2025 all staff were in-serviced that hot water was turned off in resident rooms, and all shower rooms were secured and out of service D. On 2/26/2025 the hot water issues were fixed by the Plumbing company at 4:30 pm. The issues were fixed by adding 2 new recirculating pumps, by re-routing the plumbing to the mixing valve, and by adding 2 new thermostats (1 to the water coming into the mixing valve, and 1 coming out of the mixing valve). The Maintenance Director completed testing all hot water in all resident rooms and shower rooms at 7:00 pm with no hot water temperatures found to be above 110 degrees. E. On 2/26/2025 the DON/Designee completed head-to-toe skin assessment for residents 60, 168, 167, and residents #14 and no skin issues identified F. On 2/27/2025 at 7:09 am, while testing hot water Temps. It was noted that the facility had hot water temps. Above 110 degrees, so all hot water was again immediately turned off. The Plumbing Company was immediately notified. G. On 2/27/2025 all staff were alerted that hot water would again be shut off to the facility. 2. Identification of Residents Affected or Likely to be Affected: A. On 2/26/2025 the DON/Designee completed head-to-to-toe skin assessment for all other residents throughout the facility, and no issues identified. This was completed on 2/26/2025 at 5:43pm. 3.Actions to Prevent Occurrence/Recurrence: A. On 2/25/2025 the DON/Designee began in-service education with all staff on: This training was completed at 7:00 pm on 2/25/2025 and no staff were allowed to work until they complete this training. Hot water is being turned off on all resident sinks, shower rooms are not to be used, do not turn on hot water in resident rooms. This was completed on 2/25/2025, and no staff were allowed to work until they completed this education. Ensure doors to shower rooms are kept closed at all times to prevent residents from entering unattended. This was completed on 2/25/2025, and no staff were allowed to work until they completed this education. Starting 2/26/2025 This education will be provided for all new hires and any agency staff going forward as part of new hire orientation. B. On 2/26/2025 The Regional Nurse consultant provided 1:1 in-service with the Maintenance Director regarding the hot water system and taking and recording hot water temperatures: Every hour x 4 hours, then twice daily x 3 days, then daily x 7 days then resume the weekly water temp. testing. If at any time the hot water temp. exceeds 110 degrees, the hot water will be turned off, The Plumber will be notified for repairs/services, and the monitoring process above will continue until the hot water temperatures remain between 100 and 110 degrees. On Schedule of checking hot water temps. Weekly, rotating rooms, bathrooms etc., ensuring that all rooms and shower room hot water temps are taken and recorded during the month and hot water temperatures remain between 100 and 110 degrees. C. On 2/26/2025 DON/Designee start in-service training with all staff related to: a. Hot water is being turned off on all resident sinks, shower rooms are not to be used, do not turn on hot water in resident rooms. This was completed on 2/26/2025, and no staff were allowed to work until they completed this education. b. Ensure doors to shower rooms are kept closed at all times to prevent residents from entering unattended. This was completed on 2/26/2025, and no staff were allowed to work until they completed this education. c. To turn hot water off immediately and notify charge nurse if at any time water temps. Feel too hot. The nurse in charge will immediately contact the facility administrator so this issue can be addressed immediately. This was completed on 2/26/2025 and no staff were allowed to work until they complete this education. D. All hot water temperature logs will be reviewed daily by the Facility administrator/Designee in the morning meeting to validate facility remains in compliance and no residents are affected related to water temperatures being too hot. E. If at any time during hot water temperature monitoring, any temperature reading is above 110 degrees, the hot water will be shut off to all resident rooms and shower rooms, a plumbing company will be notified to address the issue, and the facility will then monitor hot water temps. Again, every hour x 4 hours, then twice daily x 3 days, then daily x 7 days then resume the weekly water temp. testing.	-	-	-	-

Attachment C: Jack Shelby Affiliated Entities Owned Facilities Deficiencies and Survey Results

Source: ProPublica Nursing Home Inspection/Survey Results

List facilities that are required for review under 10.24.20.05(8)	SFF	Date of the Survey	Deficiencies	Deficiencies (Cont.)	Description	Seriousness
WINDCREST HEALTH & REHABILITATION	-	2/14/2024	Pharmacy Service Deficiency — F0760	Failure to: Ensure that residents are free from significant medication errors.	Facility failed to prevent significant medication error for 1 of 33 residents (Resident #77) reviewed for pharmacy services. The facility failed to follow physician's order by not administering Lasix 20mg (diuretic medication to reduce swelling) as needed every 24 hours for Resident #77.	H
			Quality of Life and Care Deficiency — F0684	Failure to: Provide appropriate treatment and care according to orders, resident's preferences and goals.	Facility failed to ensure residents received treatment and care in accordance with professional standards of practice and the comprehensive person-centered care plan for 1 of 6 residents (Resident #77) reviewed for quality of care. The facility failed to follow physician's order for daily weights for Resident #77 for 01/26/2024 and 01/27/2024.	G
WINDSOR HEALTHCARE RESIDENCE	-	11/20/2023	Quality of Life and Care Deficiency — F0689	Failure to: Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.	Facility failed to provide adequate supervision and assistive devices to prevent accidents for 1 (Resident # 1) of 9 reviewed for falls. The facility failed to provide adequate supervision for Resident # 1 , by ensuring all staff were awake while on duty, which resulted in Resident # 1 falling on 11/14/2023 and sustaining a right superior and inferior pubic rami fracture.	G
		9/15/2023	Quality of Life and Care Deficiency — F0678	Failure to: Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident's advance directives.	Facility failed to ensure personnel provided basic life support, which included CPR, to a Resident requiring such emergency care prior to the arrival of emergency medical personnel and subject to related physician orders and the Resident's advance directives for 1 of 6 Residents (Resident #1) reviewed for cardio-pulmonary resuscitation. RN A and LVN B failed to continue to perform CPR, until the arrival of emergency medical personnel, to Resident #1 who was a full code status.	J

Attachment C: Jack Shelby Affiliated Entities C

Source: ProPublica Nursing Home Inspection/Survey

		Medicare			
List facilities that are required for review under 10.24.20.05(8)	**Action Taken**	**Penalty Date**	**Payment Denial Length in Days**	**Payment Denial Start Date**	**Payment Denial End Date**
WINDCREST HEALTH & REHABILITATION	No action taken	-	-	-	-
	No action taken				
WINDSOR HEALTHCARE RESIDENCE	Interview on 11/20/2023 at 1:00 pm with the ADM revealed his expectation were that when staff member reports to work, they perform their job duties which always includes supervision of residents. He stated that the failure of a staff member to supervise a resident can have a potential negative outcome. He stated that sleeping while on duty is unacceptable and against policy and grounds for immediate termination. He stated sleeping on the job can cause potential harm due to lack of supervision. Record review on 11/20/2023 at 130 pm of CNA A employee record revealed employee was terminated per company policy on 11/15/2023. Record Review on 11/20/2023 at 130 pm of Inservice records revealed the following in-services were completed on 11/15/2023 for all staff. Rounding, Staff tips on staying awake at night, Fall Prevention, Abuse, neglect and exploitation, and Company policy regarding sleeping while on the clock. Provider investigation report on 11/20/2023 revealed that the Staff assigned to the unit that Resident #1 resided completed an in-service on 11/15/2023 that stated incontinent rounds every 2 hours for the resident. Investigated revealed resident did not utilize the call light, a bed alarm was ordered by the facility with anticipation of delivery on 11/21/2023. MD order and care plan will be updated when equipment is delivered. Plan in place for frequent rounds and offer the resident the restroom every 2 hours until equipment is in place.	-	-	-	-
	Re-Education of Abuse/Neglect Policy to all staff (staff not present, agency, and PRN staff will be re-educated prior to working their next scheduled shift, newly hired staff will be educated within their first 3 days of employment) Training: the facility will train through orientation and on-going in-services on issues related to abuse/neglect prohibition practices regularly. New Employee orientation will consist of educational resources to identify abuse, neglect, exploitation, and misappropriation of resident property. Ongoing in-services (Staff not present, PRN, agency staff will be re-educated prior to the start of their next shift, this will be tracked by the Administrator/Director of Nursing/Designee beginning [DATE]) will be conducted to educate staff Prevention: the facility will provide the residents, families, and staff an environment free from abuse and neglect. The facility will post in a public area easily accessible to residents, visitors, and staff members information on how to report concerns, incidents, and grievances without fear of retribution. The facility will post the Abuse Preventionist/Task 5G Coordinator and Co-Coordinator of the facility. All reports of abuse or suspicion of abuse/neglect or potentially criminal behavior will be investigated as per facility protocol. Investigations will be reviewed by the facility administrator and/or Abuse Preventionist within 24 hours of complaint. Appropriate notification to state and home office will be the responsibility of the administrator and per policy. The facility will be responsible to identify, correct, and intervene in situations of possible abuse/neglect. The facility has in place a method to identify events such as suspicious bruising of residents, occurrences, patterns, and trends that may constitute abuse. All occurrences of potential abuse or criminal behavior will be investigated by the Abuse Preventionist and/or designee. The facility will identify and investigate events that may constitute abuse/neglect. This Plan of Removal will be monitored by the Director of Nursing or designee beginning [DATE] by two code status audits to include accurate orders, accurate care plans weekly x4 weeks any issues will be addressed at time of discovery and reviewed with the QAPI team monthly during the center monthly scheduled QAPI team meeting. This plan of removal will be reviewed with the QAPI team monthly x3 and re-evaluated if needed. Director of Nursing or designee will perform two 1:1 documented coaching conversations with a nursing staff member regarding CPR process weekly x4 weeks and any issues will be addressed at time of discovery and reviewed with the QAPI team. This plan of removal will be reviewed with the QAPI team monthly x3 and re-evaluated if needed. A QAPI meeting was held on [DATE] to discuss Plan of Removal and the incident. A QAPI meeting was held [DATE] with Administrator, Director of Nursing, and the Medical Director to review the incident and to discuss how the plan of removal will be monitored.	-	-	-	-

Attachment C: Jack Shelby Affiliated Entities Owned Facilities Deficiencies and Survey Results

Source: ProPublica Nursing Home Inspection/Survey Results

List facilities that are required for review under 10.24.20.05(8)	SFF	Date of the Survey	Deficiencies	Deficiencies (Cont.)	Description	Seriousness
WINFIELD REHAB & NURSING	-	5/1/2025	Freedom from Abuse, Neglect, and Exploitation Deficiency — F0604	Failure to: Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment.	Failed to ensure that residents were free from physical and chemical restraints imposed for purposes of discipline or convenience and were not required to treat the resident's medical symptoms for 1 of 11 residents (Resident #8) reviewed for restraints.	J

Attachment C: Jack Shelby Affiliated Entities C

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		Medicare			
List facilities that are required for review under 10.24.20.05(8)	**Action Taken**	**Penalty Date**	**Payment Denial Length in Days**	**Payment Denial Start Date**	**Payment Denial End Date**
WINFIELD REHAB & NURSING	The facility corrected the noncompliance on 4/28/2025 by the following: CNA A was immediately removed from resident care and suspended then terminated. Appropriate notifications to abuse coordinator, RP and providers were made Began ongoing in-service on 4/27/25 for all staff which covered abuse/neglect and required reporting to the facility abuse coordinator. Began ongoing in-service for all staff dated 4/27/25 which covered using no force or minimal force with residents and reporting any pain during personal care to charge nurse . The in-service was provided to all-staff members. Completed QAA Resident Questionnaires, dated 4/28/25, indicated 10 of 10 residents interviewed had not experienced any physical or verbal mistreatment, were treated with dignity and respect, and felt safe in the facility. Staff interviews conducted with staff of varying disciplines on two separate shifts including LVN (3), RN (1), CNA (7), CMA (1), LCSW (1) revealed all staff interviewed were had received abuse and neglect training upon hire, annually, and had additional in-services covering abuse, neglect, mandatory reporting, and using minimal force with residents.	-	-	-	-

Attachment C: Jack Shelby Affiliated Entities Owned Facilities Deficiencies and Survey Results
Source: ProPublica Nursing Home Inspection/Survey Results

List facilities that are required for review under 10.24.20.05(8)	SFF	Date of the Survey	Deficiencies	Deficiencies (Cont.)	Description	Seriousness
WINFIELD REHAB & NURSING	-	5/1/2025	Quality of Life and Care Deficiency — F0689	Failure to: Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.	Failed to ensure residents received adequate supervision and assistance devices to prevent accidents for 1 of 11 residents (Resident #1) reviewed for accidents.	J
		9/11/2024	Quality of Life and Care Deficiency — F0689	Failure to: Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.	Failed to ensure residents received adequate supervision and assistance devices to prevent accidents for 1 of 24 residents reviewed for accidents. (Resident #20)	J

Attachment C: Jack Shelby Affiliated Entities C

Source: ProPublica Nursing Home Inspection/Survey

		Medicare			
List facilities that are required for review under 10.24.20.05(8)	**Action Taken**	**Penalty Date**	**Payment Denial Length in Days**	**Payment Denial Start Date**	**Payment Denial End Date**
WINFIELD REHAB & NURSING	Resident #1 placed on 1-to-1 supervision pending psychiatric evaluation to determine safe placement. Resident head counts conducted on 4/24/25 following elopement accounted for all residents. New elopement assessments completed for all residents and placed in elopement binder located at nurse's station. All exit doors locks and alarms were checked by facility maintenance staff and verified to be functioning. Each exit door had a sign posted, prominently displayed at eye-level, indicating a resident could attempt to follow visitors out. An associate disciplinary memo dated 4/25/25 indicated LVN G was suspended pending investigation. QAA Staff questionnaire dated 4/25/25 concerning resident's following staff out of building. Ad Hoc QAPI meeting held to develop a performance improvement plan and ensure safety of resident's going forward. Performance Improvement Plan, dated 4/24/25, titled Exit Seeking/Missing Resident indicated the following action items: 1.) The facility maintenance director and/or designee completed environmental assessments to include checking the function of all the facility exit doors to ensure proper function. 2.) Complete head to toe physical assessment performed by facility staff nurse and telehealth physician assistance, no injuries noted. 3.) Educate facility direct care staff on Missing Resident Policy. Document education using in-service sign in sheet so that compliance can be validated. 4.) Complete a missing resident drill with facility direct care staff. Document drill using drill sign in sheet so that compliance can be validated.5.) All facility residents were reassessed using the Elopement/Wandering Risk Assessments. No other like residents were identified. 6.) The DON /Designee will conduct weekly random missing resident drills two (2) times a week for six (6) weeks to ensure facility staff know the proper procedure for locating missing residents. Results of weekly observations will be reviewed in the facility morning meeting by the Administrator and/or designee. 7.) Review findings monthly at QAPI meeting for three months to ensure compliance. 8.) Conduct an AdHOC QAPI meeting regarding the facility resident exiting the facility and the facility's plan to follow up to sustain compliance. All staff members said they attended in-service training after the elopement and topics covered not allowing residents to exit the facility without permission from the charge nurse and missing resident response. All staff were all able to verbalize appropriate action to take in the event of a missing resident including identifying exit-seeking behavior, immediately responding to door alarms, looking for missing resident inside the building, outside the building, and notifications including to local police. Staff were able to verbalize to be wary of residents following staff or visitors out of the building and not to allow residents to exit the building without permission from the charge nurse. Staff interviews included LVN (3) RN (1) CNA (7) CMA (1) LCSW (1).	-	-	-	-
	1. Immediate Action Taken A. Resident # 20 was sent to the ER for evaluation/treatment on 8/30/2024 B. Resident #20 returned to facility on 9/1/2024; head to toe physical assessment was completed upon return to the facility and documented; new diagnosis Acute Right Subdural Hematoma, no midline shift; Left Shoulder Separation Grade 1 C. On 9/10/2024 The DON and/or designee trained all facility nurses and nurse aides on the use of mechanical lift. All facility nurses and nurse aides were trained prior to their next shift. D. On 9/10/24 The DON and/or designee completed a skills validation with return demonstration on all facility nurses and nurse aides on the use of Hoyer lifts to ensure knowledge and understanding of training. All facility nurses and nurse aides were trained prior to their next shift. E. The MDS Coordinator and/or designee reviewed the care plans for each resident who requires the use of a mechanical lift to ensure resident specific interventions were present. F. On 9/10/2024, the facility discarded the mechanical lift sling that was faded in color without a manufacturer's tag. G. On 9/10/24, CNA A was suspended pending retraining and will not be reinstated until CNA A is able to demonstrate competency with Hoyer lift skills validation. H. On 9/10/24, CNA B was suspended pending retraining and will not be reinstated until CNA B is able to demonstrate competency with Hoyer lift skills validation. 2. Identification of Residents Affected or Likely to be Affected: A. No other residents identified, on 9/10/24 the DON/Designee completed an audit on all facility resident's requiring Hoyer lift transfers to ensure interventions currently in place are appropriate for resident's receiving required care and transfer interventions. This will be completed on 9/10/24 by 10:00 pm. 3.Actions to Prevent Occurrence/Recurrence: A. As of 9/10/2024, any staff member hired for facility nurse and/or nurse aide positions will be provided the following by the facility DON and/or designee: o In-service education on the Mechanical Lift will be completed by the facility DON and/or designee during orientation. o Skills Validation with Return Demonstration will be completed by facility DON and/or designee during orientation. B. The DON/Designee will conduct weekly random observations two (2) times a week for eight (8) weeks to ensure staff are transferring residents who require Hoyer lift properly. C. Results of weekly observations will be reviewed in the morning meeting by the Administrator or designee On 9/10/2024 the facility's Administrator notified the Medical Director to conduct an Ad Hoc QAPI meeting regarding the Immediate Jeopardy the facility received related to Accidents/Hazards/Supervision and reviewed plan to sustain compliance.				

Attachment C: Jack Shelby Affiliated Entities Owned Facilities Deficiencies and Survey Results

Source: ProPublica Nursing Home Inspection/Survey Results

List facilities that are required for review under 10.24.20.05(8)	SFF	Date of the Survey	Deficiencies	Deficiencies (Cont.)	Description	Seriousness
WINFIELD REHAB & NURSING	-	7/1/2024	Freedom from Abuse, Neglect, and Exploitation Deficiency — F0600	Failure to: Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.	Failed to ensure residents had the right to be free from abuse, neglect, misappropriation of resident property, and exploitation for 11 of 18 residents reviewed for abuse and neglect.	K
			Freedom from Abuse, Neglect, and Exploitation Deficiency — F0607	Failure to: Develop and implement policies and procedures to prevent abuse, neglect, and theft.	Failed to develop and implement written policies and procedures that prohibited and prevented abuse, neglect, and exploitation of residents and misappropriation of resident property for 11 of 18 residents reviewed for abuse policies.	K
			Quality of Life and Care Deficiency — F0686	Failure to: Provide appropriate pressure ulcer care and prevent new ulcers from developing.	Failed to ensure the necessary treatment and services, in accordance with comprehensive assessment and professional standards of practice, to prevent development of pressure injuries was provided for	K
			Quality of Life and Care Deficiency — F0689	Failure to: Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.	Failed to ensure residents received adequate supervision and assistance devices to prevent accidents for 1 of 14 residents reviewed for accidents.	J
		6/12/2024	Resident Rights Deficiency — F0580	Failure to: Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.	Failed to notify and consult with the resident's physician when there was a need to alter treatment for 1 of 8 residents reviewed for notification of changes.	J
			Quality of Life and Care Deficiency — F0684	Failure to: Provide appropriate treatment and care according to orders, resident's preferences and goals.	Failed to provide residents treatment and care in accordance with professional standards of practice and the comprehensive person-centered care plan for 1 of 8 residents reviewed for quality of care.	J

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		Medicare			
List facilities that are required for review under 10.24.20.05(8)	**Action Taken**	**Penalty Date**	**Payment Denial Length in Days**	**Payment Denial Start Date**	**Payment Denial End Date**
WINFIELD REHAB & NURSING	Employees at fault of physical/verbal abuse to a resident were suspended, received a formal verbal and written warning and re-educated on professionalism, inappropriate languages, and inappropriate behaviors. Residents at fault of physical/verbal abuse to another resident were either moved to another facility, had changes made to their care plan, seperated from the conflicting residents, or received behavioral health solutions	-	-	-	-
	No action taken				
	A. Resident # 12 is currently out of the facility on 6/20/2024 B. The facility's van immediately stopped all van transport on 6/26/2024 at 8:00am C. The Regional Director of Operations or designee completed the following with the three facilities designated van drivers: o In-service education on the Transportation Policy which provides direction on duties of driver, driving of the van, how to operate the wheelchair lift and the wheelchair securement system, how to transport more than 1 wheelchair o In-service education on weekly maintenance log that van drivers complete and provides to administrator/designee o Completed a skills validation check list on van drivers to acknowledge skills competence on how to operate the wheelchair lift and the wheelchair securement system. Completed a return demonstration. o All van drivers sign job description duties o Facility will decline transport to any resident who refuses to comply with Texas laws to wear a seat belt. The expectation is that all residents riding in facility van will wear a seat belt and have proper wheelchair securement if applicable. Facility will assist with alternate methods of transportation (ambulance, community ride and share vans, family members etc.) o In-service education on the Transportation Policy which provides direction on duties of driver, driving of the van, how to operate the wheelchair lift and the wheelchair securement system, how to transport more than 1 wheelchair prior to driving the van o In-service education on weekly maintenance log that van driver completes and provides to administrator/designee o Completed a skills validation check list on van driver to acknowledge skills competence on how to operate the wheelchair lift and the wheelchair securement system. Completed a return demonstration. o Have van driver sign job description duties o Understand that in the event a resident refuse to wear a seatbelt or have wheelchair securement if applicable, that the administrator or designee will be notified immediately to schedule alternate transportation o Understand, that in the event of an emergency, pull over immediately as soon as it is safe to do so and call 911which is stated in the facility's Van Transportation policy				
	During an interview on [DATE] at 5:23 PM, the Administrator requested an IJ PNC and provided additional information to include a QAPI meeting and in-service documentation. Review of Performance Improvement Project Report, titled Bowel Movement Monitoring, start date of [DATE] revealed the following: .Goal: Establish a procedure for to avoid constipation or fecal impaction in order to achieve evacuation of the bowel that optimizes therapeutic benefits and minimizes associated risks . 4.) DON/Designee to pull no BM x 3 days report; resident is to be monitored for signs/symptoms of constipation and notify MD of any abnormal symptoms. 5.) Results of no BM x 3 days report will be discussed with admin/DON during morning clinical start up meeting. 6.) review findings monthly at QAPI meeting for three months to ensure compliance. Review of Clinical and Order Alerts Listing Report, dated [DATE] through [DATE], revealed bowel movement report was gerenated. Review of Daily Census Report, dated [DATE] and signed by the DON, revealed a bowel assessment validation was completed on all facility residents and no residents were identified [with] no bowel movements for 3 days				

Attachment C: Jack Shelby Affiliated Entities Owned Facilities Deficiencies and Survey Results

Source: ProPublica Nursing Home Inspection/Survey Results

List facilities that are required for review under 10.24.20.05(8)	SFF	Date of the Survey	Deficiencies	Deficiencies (Cont.)	Description	Seriousness
WOODWAY REHABILITATION AND HEALTHCARE CENTER	-	3/14/2025	Quality of Life and Care Deficiency — F0684	Failure to: Provide appropriate treatment and care according to orders, resident's preferences and goals.	Facility failed to ensure that residents received treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices reviewed for 1 (Resident #1) of 5 residents reviewed for quality of care. The facility nurses failed to hold Resident #1s health shakes and administered them through a 60ML syringe by mouth while she was not responsive on 3/10/25 at 10:20pm and 3/11/25 at 12:10pm.	J
			Nursing and Physician Services Deficiency — F0726	Failure to: Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being.	Facility failed to assure that all nursing staff possess the competencies and skill sets necessary to provide nursing and related services to meet the residents' needs safely and in a manner that promotes each resident's rights, physical, mental, and psychosocial well-being for 1 (Resident #1) of 5 residents reviewed. The facility nurses failed to hold Resident #1's health shakes and administered them through a 60 ML syringe by mouth while she was not responsive on 3/10/25 at 10:20pm and 3/11/25 at 12:10pm.	J
		1/23/2025	Freedom from Abuse, Neglect, and Exploitation Deficiency — F0600	Failure to: Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.	Facility failed to ensure residents had the right to be free from abuse for one (Resident #1) of five residents reviewed for abuse. The facility failed to protect Resident #1 from physical abuse when CNA A was slapped by Resident #1 across the face and CNA A slapped Resident #1 back across their face on 1/5/2025.	J
			Freedom from Abuse, Neglect, and Exploitation Deficiency — F0607	Failure to: Develop and implement policies and procedures to prevent abuse, neglect, and theft.	Facility failed to implement their written policies and procedures regarding investigating abuse for one (Resident #1) of five residents reviewed for abuse and neglect. The facility failed to ensure CNA A was suspended/terminated or removed from working with all residents after she slapped a resident in the memory care unit, potentially causing additional abuse and/or emotional distress.	J
			Freedom from Abuse, Neglect, and Exploitation Deficiency — F0610	Failure to: Respond appropriately to all alleged violations.	Facility failed to, in response to allegations of abuse, prevent further potential abuse for one (Resident #1) of five residents reviewed for abuse and neglect while the investigation of alleged abuse was in progress. The facility failed to ensure CNA A was suspended/terminated or removed from working with all residents while the investigation of alleged abuse was ongoing.	J

Attachment C: Jack Shelby Affiliated Entities C

Source: ProPublica Nursing Home Inspection/Survey

		Medicare			
List facilities that are required for review under 10.24.20.05(8)	**Action Taken**	**Penalty Date**	**Payment Denial Length in Days**	**Payment Denial Start Date**	**Payment Denial End Date**
WOODWAY REHABILITATION AND HEALTHCARE CENTER	1. As soon as the DON was made aware of the situation on 3/11/25 she immediately removed the syringe from the resident's room. 2. CNA #1 was given a one-on-one education by ADON on 3/11/25 that a resident should never be syringe fed. Our investigation revealed that an overnight nurse instructed the CNA to administer the resident ensure through a syringe. A telephone call was placed to the night nurse & a message left for her to call the facility. The night nurse had not returned our phone call. A message was left that she could not return to the facility until she spoke with the DON. 3. DON started In-servicing facility & agency licensed nurses & CNAS on 3/11/25 at 1300 that residents were never to fed via a syringe. All 6-2 & 2-10 nursing staff on duty were educated. In-services for facility licensed nurses & CNAS will be completed on 3/13/25. Any agency staff that has not previously been in-serviced will be required to complete the in-services prior to starting their shift. 4. DON/ADON started In-servicing on 3/12/25 with agency staff to ensure they were educated on where to find the residents plan of care. 5. DON/ADON started In-servicing on 3/12/25 with all CNAs both facility & agency on the importance of not attempting to feed a resident that is unresponsive. Any new facility or agency CNA will be provided the education prior to working. 6. The agency binder was reviewed to ensure that agency staff know where to look to review the residents plan of care. Interventions 1. Any new agency staff will be in-serviced by nurse management on how to find the residents plan of care prior to starting their shift. The education started on 3/12/25 & will be ongoing when new facility or agency staff are scheduled. 2. Shift Key will download the process of where to find the residents plan of care prior to accepting a shift. The ADON will be responsible for the communication to Shift Key. 3. Nurse management will review the residents' care plan to ensure that it reflects the resident's needs. The care plan review will be completed by 3/14/25. 4. When a resident experiences a change of condition the care plan will be updated to reflect the resident's current needs. The DON/ADON/ Unit Manager will be responsible for updating resident care plan when a change of condition is identified. Ongoing Projected completion 3/13/25 for facility nursing staff. Care Plan review will be completed by 3/14/25. Any staff member who was not present during initial in-servicing/training will not be allowed to assume their duties until in-service was completed. The DON/ADON/WC NURSE will complete Ongoing In-service/or weekend nurse supervisor, until all staff, weekend, prn, and agency staff in completed. Monitoring 1. Nurse management will question random CNAs 3 X's a week to ensure they understand Resident #1s plan of care. Nurse management will perform random questions 3 X's a week for 6 weeks. 2. Staff will complete a questionnaire related to providing care that reflects the resident's needs. 3. On 3/13/25 The DON/designee began a questionnaire to validate the effectiveness of the training. The questionnaire is conducted with facility staff. Immediate re-education will be completed by the DON/designee if any staff is unable to answer appropriately to the questions on the questionnaire. Staff will not be allowed to work until after completion of the questionnaire. Projected completion 3/14/25. 4. On 3/12/25 An impromptu QAPI meeting was conducted with the facility's Medical Director to notify of the potential for non-compliance and the action plan implemented for approval.	-	-	-	-
	1. On 1/22/25 The facility IDON/ADON/Designee immediately initiated skin assessments to ensure no s/s of physical injuries were present in all residents currently residing at the facility- no issues noted. Completed 1/23/25 2. On 1/22/25 The facility Adm/IDON/Designee initiated Life safety rounds with interviewable residents, interviews revealed no negative outcomes. Non-interviewable residents' responsible parties will also be interviewed. Any issues identified will be addressed immediately. Completed 1/23/2 3. On 1/22/25 The VPO conducted a 1:1 in-service with the facility administrator on the company abuse and neglect policy focusing on immediately suspending employees pending allegations of abuse and neglect. This included returned verbalized understanding of the process. This was documented on a signed in-service sheet. Any reportable incidents will also be reported to the corporate VP of Operation and or VP of Clinical to ensure an appropriate investigation, interventions and follow-up takes place. Any issues identified with this process will be addressed through further education and or disciplinary action 4. On 1/22/25 The Adm initiated an in-service with the facility management staff on expectations to assure residents safety, abuse and neglect policy and reporting incidents immediately, this includes removing/suspending any staff members involved with any allegations or suspicion of abuse. Comprehension was verified by successfully completing a questionnaire on the subject, Completed 1/23/25 5. On 1/22/25 The facility Adm/IDON/Designee initiated an in-service with the staff on the corporate compliance hot line to report unusual events. Comprehension was verified by successfully completing a questionnaire on the subject, Completed 1/23/25. 6. On 1/22/25 The facility Adm/DON/Designee initiated in-service with the facility staff on Abuse and Neglect focusing on ensuring residents safety and immediately reporting suspected abuse or neglect to the abuse prevention coordinator and or the corporate compliance hot line. The Abuse prevention coordinator contact information is posted throughout the facility. The abuse prevention coordinator will suspend, investigate, rule out, or report any allegation of abuse and neglect within the allotted time frame.				

ATTACHMENT D

Palo Pinto Nursing Center
PERFORMANCE IMPROVEMENT PROJECT (PIP) WORKSHEET
Root Cause Analysis and the Plan Do Study Act (PDSA) Cycle

Project Title: Star Rating	**Team Leader:** Administrator
Start Date: 9/1/2025	**Completion Date:** 2/28/2026
Data we reviewed: Facility is a 1 Star facility related to poor survey outcomes in August 2024. Facility will achieve 2 Star rating by 3/1/2026	
PLAN	**Conduct a Root Cause Analysis and Develop the Approach to the Problem**

During the PIP subcommittee investigation, the "Four Whys" method was utilized to identify the root cause of the problem so that appropriate approaches can be planned.

Why did this occur? 3 New MDS nurses over the last year and a half

- Lack of job knowledge in role to perform duties

Why did this occur? 3 New Director of nurses over the last year and a half

- Lack of qualified applicants for the position
- Hiring applicants with little to no prior DON experience

Why did this occur? Facility failed to review quality measures weekly and identify trends and interventions prior to ARD date

- Lack of follow up to ensure that Quality measures are reviewed weekly
- Lack of follow up to ensure accuracy of MDS's

Why did this occur? Facility failed to follow policies and procedures that resulted in negative survey outcome

- New DON's

The PIP Subcommittee has concluded that the root cause of this problem is:

- Lack of qualified staff to perform job duties
- Lack of oversight and monitoring
- Lack of survey management

DO	Implement the approaches for the Plan

Approaches:

1. The center will conduct weekly Quality Measure meetings to identify any issues early

2. The RNC will conduct weekly visits to the facility for continued training and monitoring of clinical systems

3. The Regional Reimbursement nurse will conduct weekly visits to the facility for continued training and monitoring of Tracking, completion and accuracy of MDS's

4. The Regional Reimbursement nurse and Designee will ensure weekly Quality measure meeting is being conducted with appropriate interventions

5. The V.P. of Operations will visit monthly to validate that performance plan is implemented and being

followed

6. The V.P. of Clinical Services will monitor the progress of 5 Star to validate that the facility is making progress toward being a 2 Star facility

7. This PIP will be reviewed monthly in QAPI to maintain compliance

Name	Title	Responsibility (see above)
Lauron McKish	Administrator	1. 1, 7
Regional Reimbursement Nurse	Regional Reimbursement Nurse	2. 3, 4
Regional Nurse Consultant	Regional Nurse Consultant	3. 2
V.P. of Operations	V.P. of Operations	4. 5
V. P. of Clinical Services	V. P. of Clinical Services	5. 6

Project Goal

To be a 2 Star facility by 3/1/2026, and no negative survey outcomes

☐ Goal Met ☐ Goal Not Met ☐ Revision ☐ Abandon ☐ In Progress ☐ Adopt Plan

Plan if goal not met:

Summary Note

Background information on the problem:

What we did about it:

The results: Summarize Results

Date:

Date:

Date: **Date:**
What we'll do in the future to sustain improvement:

1. **Issues**: When Ruby Healthcare took the Region over in 2023(October) within 2 months we had our State Survey where we received 16 deficiencies. A month later, we had a Federal Survey where we received 21 deficiencies with 3 IJ's included in that survey. Within a month after the Federal Survey all tags were cleared, and we were in substantial compliance. There were little to no systems in place along with a sever need of capital expenses that had not been obtained by the previous Region Team.

Corrections: I spent the next 9 months at Parkview for 2-3 days a week training staff and assuring that capital expenses and systems were in place to assure compliance. . The RNC was in the facility weekly for 2-3 days during this time as well. I had the remainder of my region team also conduct weekly visits to the facility to review and establish systems and trainings. As a Team, we spent a significant amount of time reviewing Department Heads and team members to assure that we had the correct personnel in place. We replaced 50-60% of the staff at Parkview including the Director of Nursing, MDS, Food Service Director, Activities Director and contract EVS. The VP of Clinical did almost daily reviews of all QMs along with working with the RNC to assure that all clinical systems were in place. By making these changes, the State went from almost a weekly visit and weekly deficiencies due to complaints from families and residents to monthly and at times every 1.5- 2months visit with no Deficient issues being found. From a capital standpoint, I replaced, flooring, the roof, call light system and many other capital items that were in desperate need.

2. In December of 2024, we had our annual survey and received 8 low scope and severity tags with nothing over a "E"

3. **Issue**: In September of 2024, the Administrator was fired for verbal abuse with a resident which caused an additional IJ.

Correction: I replaced this Administrator with a seasoned Administrator.

4. The Region Team continues to be in the facility weekly with the RNC spending 2-3 days a week reviewing systems, QM and Nursing Staffing needs. I continue to go every other week to the facility to review all of the above along with continues capital and staffing needs. Ruban and I visit at least every 2 months as a team to assure continued compliance. VPOC continues to review QM's and Clinical systems weekly to assure compliance and monthly visits to the facility.

Whitehall Rehab & Nursing

QAPI Performance Improvement Project (PIP) Charter & Report

Title: *Click a PIP Topic Below*

☐ Resident Centered Culture Change

☐ Staff Retention

☒ IMPROVE CMS 5 STAR RATING

Start Date: _11-01-2025

Est. End Date: 01-1-2026

Problem/ Opportunity for Improvement Summary

Facility will focus on each component of the CMS 5 star rating in order to improve rating and resident quality of care. This includes staffing, Health Inspection and Quality Measures.

Supportive Data

What prompted you to believe this was a problem? (Include hard data like percentage comparisons, trends, number of incidents, etc. if applicable).

Overall Star Rating is a 2. We have improved staffing rating to a 4 from a 2. Facility continues to maintain high level of RN on staff and a low turnover. Health inspection has remained a 2. Quality Measures has dropped from a 4 to a 3.

Root Cause Analysis* (Include things like probable causes and the scope of the problem)

WHY?. Quality Measures dropped from a 4 to a 2

WHY?. Survey Results were negative in 2023 impacting the overall Health inspection rating
Admitted several residents on antipsychotics impacting this QM

WHY?. Multiple falls with injury that remained on our QM impacting this rating

WHY?. Pressure Ulcer was not met b/c resident went out to hospital prior to healing wound and then expired.

Conclusion(s): We have had ups and downs with the Quality Measure portion of the 5 star rating. As of now it is predicted to go to a 4 star this quarter and the staffing will remain a 4. Survey portion remains a 2 from some negative results that occurred in 2024. We will increase the overall rating to a 4 star by the first quarter of 2026.

** Note: there are many methods for conducting a Root Cause Analysis, please use your preferred method and then complete the "Conclusions" portion of this section*

Measurable Goals

State your goal(s) - must be Measurable Goals*.
What data/ results will indicate that the goal(s) has been reached (measurable progress)? Are there allowable deviations?.
Facility will raise QM overall rating to a 4 star by first quarter of 2026.

What tools will you utilize to track your progress? (Feedback surveys, types of data points, data trend breakdowns, etc.). QIPP measures, QM in Simple LTC, Resident Satisfaction, Incident Reports, Trends on all QM, Resident Surveys, Medicare Meetings, QAPI meeting

When will the PIP Subcommittee make a report to the QAPI Committee? (Every month, only when the progress goal(s) are not met, etc.).

Subcommittee will report to QAPI committee monthly and as needed. Progress will be reported and updated as changes occur.

Whitehall Rehab & Nursing

**Note: a "Measurable Goal" is a SMART goal - Specific, Measurable (can quantifiably measure progress over time), Attainable, Relevant, Time-bound*

Barriers

What could get in the way of success?	What can you do about it?
Negative result on State Survey or Complaint Investigation	Diligent with patient care, system monitoring, follow up on resident concerns
Staffing not meeting predicted levels	Daily monitoring of RN scheduling, as well as Direct care to ensure at proper level
QM not meeting predicted increase to a 4	Communication with MDS as far as timely review of submissions to max score

Team Members Assigned to PIP Subcommittee

Person's Name (Print)	Title/Position	Person's Name (Print)	Title/Position
Hillary Armstrong	Director of Nursing	Margaret Rothrock	Administrator
Keshia Elem	ADON	Lisa Saxon	MDS
Brittany Gillebrand	Therapy Director		
Team Leader(s):			

Interventions/ Action Items

	Action Item (What will be done?)	Person(s) Responsible	Timeline/ Est. Completion	What is being used to track the indicator/ measure?
1)	Implement Exercise/ Restorative for Fall Prevention	DON / Therapy	11-15-2025	Written Plan / Report to QAPI
2)	Investigate low staffing times and monitor for res safety	DON / Admin	11-30-2025	Staffing patterns, time sheets, sign in log
3)	Ensure Pressure Ulcers are healed on MDS timely	Tx Nurse / MDS	11-15-2025	Weekly Skin Meeting, Skin Sheets
4)	Staffing levels set to remain a 4 – ensure maintained	DON/ Admin	11-15-2025	Daily staffing, monthly schedule, sign in sheets
5)	Continue to be proactive on hiring RN & Direct Care	Admin/ DON	11-1-2025	Application log, Staffing assign per shift
6)	Antipsychotic Review for proper Dx and dose reduction	DON/ Pharm Consultant	11-15-2025	Pharmacy Consult Review, DON weekly audits
7)	Training of CNA for completion of ADL's in PCC	DON / MDS	11-30-2025	PCC ADL charting, Care Plans
8)	Continue PBJ calls monthly for accurate staff data reporting	Admin	11-15-2025	PBJ data tracking, Apex PBJ site, staffing sheets
9)				
10)				
11)				

Progress Evaluation

Date:____/___/____

What is the current status of the PIP and Action Items? Include a breakdown of all relevant data/ quality measures and state if you attached supporting documentation.

Have you identified any additional barriers? (If yes, provide an explanation below then add/ edit the Barrier section above. Do not delete original content in the section).

Are there any changes or additions to the Action Items? If so, why? (If yes, add/ edit the Action Item section above. Do NOT delete the original, use strikethrough on prior versions or discontinued Items).

Date: ___/____/_____

What is the current status of the PIP and Action Items? Include a breakdown of all relevant data/ quality measures and state if you attached supporting documentation.

Have you identified any additional barriers? (If yes, provide an explanation below then add/ edit the Barrier section above. Do not delete original content in the section).

Are there any changes or additions to the Action Items? If so, why? (If yes, add/ edit the Action Item section above. Do NOT delete the original, use strikethrough on prior versions or discontinued Items).

Date: ___/___/____

What is the current status of the PIP and Action Items? Include a breakdown of all relevant data/ quality measures and state if you attached supporting documentation.

Have you identified any additional barriers? (If yes, provide an explanation below then add/ edit the Barrier section above. Do not delete original content in the section).

Are there any changes or additions to the Action Items? If so, why? (If yes, add/ edit the Action Item section above. Do NOT delete the original, use strikethrough on prior versions or discontinued Items).

Date: ___/____/_____

Whitehall Rehab & Nursing

Date: ____/____/_____

What is the current status of the PIP and Action Items? Include a breakdown of all relevant data/ quality measures and state if you attached supporting documentation.

Have you identified any additional barriers? (If yes, provide an explanation below then add/ edit the Barrier section above. Do not delete original content in the section).

Are there any changes or additions to the Action Items? If so, why? (If yes, add/ edit the Action Item section above. Do NOT delete the original, use strikethrough on prior

Results (Do *NOT* complete this section until the end of the PIP)

Date Completed: ___/___/_____

What is the final status of your Goal(s) and Action Items? Address them on an individual level.

Did you achieve everything you wanted to? If not, why? Identify the barriers that prevented you from reaching your Goals. Could these barriers have been overcome and how?.

Were the interventions/ Action Items effective? Use measurable/ quantifiable data to support your answer. Note: effectiveness is not the same as achieving your Goal(s).

*** Based on the findings this PIP will be: Adopted xx Adapted (significant goal revision) Abandoned ***

Provide details and rationale for your decision. If you achieved your goals and selected "Abandoned", explain why you believe there will not be a decline or reversal after efforts have ceased. *(Examples: Will all Actions Items be Adopted? If not, provide details on your decision. If it was Abandoned, did the problem resolve itself in a manner unrelated to the efforts of the Subcommittee? Was the goal or PIP not feasible? If Adapted, what prompted the decision to make such major revisions instead of making minor adjustments to the current PIP?).*

Has the maximum potential been reached for the identified problem or identified opportunity for improvement? If not, explain. Is there anything else that can be done to reach the maximum potential?.

SIMPLE LTC **Five Star Planner**
Report Generated on 11/05/25 - 11:18am

Current

Overall Five-Star Rating

2

Health Inspection

Data through 2025-09-01

2

87.75

Cycle	Standard	Revisit	Year	Complaint/Infecti
Add Survey				
Cycle 1	64	0	Year 1	0
Cycle 2	8.00	0	Year 2	143
			Year 3	8
Total	72.00	0.00		151.00

Quality Measures

2025-Q1 Official

3

1334

Short Stay Score

489

Long Stay Score

845

Staffing

Data through 2025-Q1

4

July-Sep2025

Care Compare Five-Star Ratings of Nursing Homes

Provider Rating Report for September 2025

Ratings for Whitehall Rehab & Nursing (675624)
Crockett, Texas

Overall Quality	Health Inspection	Quality Measures	Staffing
★★	★★	★★★	★★★★

The Five-Star ratings provided above will be displayed for your nursing home on the Care Compare website on or around September 24, 2025. The health inspection rating incorporates data reported through June 30, 2025. The time periods for each of the quality measures that contribute to the Quality Measure (QM) rating can be found in the QM tables located later in this report. The staffing rating is based on payroll-based journal (PBJ) staffing data reported through the first calendar quarter of 2025.

Helpline

The Five-Star Helpline will operate Monday - Friday **September 22 - 26, 2025.** Hours of operation will be from 9 am - 5 pm ET, 8 am - 4 pm CT, 7 am - 3 pm MT, and 6 am - 2 pm PT. The Helpline number is 1-800-839-9290. The Helpline will be available again **October 27 - November 7, 2025.** During other times, direct inquiries to BetterCare@cms.hhs.gov as Helpline staff help respond to e-mail inquiries when the telephone Helpline is not operational.

Apr - June 2025

Care Compare Five-Star Ratings of Nursing Homes

Provider Rating Report for June 2025

Ratings for Whitehall Rehab & Nursing (675624)
Crockett, Texas

Overall Quality	Health Inspection	Quality Measures	Staffing
★★	★★	★★★★	★★★

The Five-Star ratings provided above will be displayed for your nursing home on the Care Compare website on or around June 25, 2025. The health inspection rating incorporates data reported through May 31, 2025. The time periods for each of the quality measures that contribute to the Quality Measure (QM) rating can be found in the QM tables located later in this report. The staffing rating is based on payroll-based journal (PBJ) staffing data reported through the fourth calendar quarter of 2024.

Helpline

The Five-Star Helpline will operate Monday - Friday **June 23 - 27, 2025.** Hours of operation will be from 9 am - 5 pm ET, 8 am - 4 pm CT, 7 am - 3 pm MT, and 6 am - 2 pm PT. The Helpline number is 1-800-839-9290. The Helpline will be available again **July 28 - August 8, 2025.** During other times, direct inquiries to BetterCare@cms.hhs.gov as Helpline staff help respond to e-mail inquiries when the telephone Helpline is not operational.

Important News

Influenza vaccination measures.

Beginning in April 2025, only the 4-quarter average value for the long-stay and short-stay influenza vaccination measures are displayed in the preview reports (the individual quarters are grayed out). These measures are found in the table containing quality measures that are not included in the QM rating (measure names: Percentage of residents assessed and appropriately given the seasonal influenza vaccine – long and short-stay).This change is intended to better reflect the specifications and timeframes for the measures, which are calculated annually for the prior year's flu season. Note that the measure specifications themselves have not changed. Also note that these measures will update annually in October beginning in 2025.

Jan-Mar 2025

Care Compare Five-Star Ratings of Nursing Homes

Provider Rating Report for March 2025

Ratings for Whitehall Rehab & Nursing (675624)
Crockett, Texas

Overall Quality	Health Inspection	Quality Measures	Staffing
★★	★★	★★★	★★★

The Five-Star ratings provided above will be displayed for your nursing home on the Care Compare website on or around March 26, 2025. The health inspection rating incorporates data reported through February 28, 2025. The time periods for each of the quality measures that contribute to the Quality Measure (QM) rating can be found in the QM tables located later in this report. The staffing rating is based on payroll-based journal (PBJ) staffing data reported through the third calendar quarter of 2024.

Your facility has been cited for abuse at harm or higher in the last survey cycle, or at least once at potential harm or higher in each of the last two survey cycles. Care Compare displays an icon for nursing homes with instances of non-compliance related to abuse and their health inspection rating is capped at two stars. For more details, please see the Five-Star Quality Rating Technical Users' Guide that is available at the link on the References page of this report.

Helpline

The Five-Star Helpline will operate Monday - Friday **March 24 - 28, 2025.** Hours of operation will be from 9 am - 5 pm ET, 8 am - 4 pm CT, 7 am - 3 pm MT, and 6 am - 2 pm PT. The Helpline number is 1-800-839-9290. The Helpline will be available again **April 28 - May 2, 2025.** During other times, direct inquiries to BetterCare@cms.hhs.gov as Helpline staff help respond to e-mail inquiries when the telephone Helpline is not operational.

Sep-Dec 2024

Care Compare Five-Star Ratings of Nursing Homes

Provider Rating Report for November/December 2024

Ratings for Whitehall Rehab & Nursing (675624)
Crockett, Texas

Overall Quality	Health Inspection	Quality Measures	Staffing
★★	★★	★★★★	★★

The Five-Star ratings provided above will be displayed for your nursing home on the Care Compare website on or around December 4, 2024. The health inspection rating incorporates data reported through October 31, 2024. The time periods for each of the quality measures that contribute to the Quality Measure (QM) rating can be found in the QM tables located later in this report. The staffing rating is based on payroll-based journal (PBJ) staffing data reported through the second calendar quarter of 2024.

Your facility has been cited for abuse at harm or higher in the last survey cycle, or at least once at potential harm or higher in each of the last two survey cycles. Care Compare displays an icon for nursing homes with instances of non-compliance related to abuse and their health inspection rating is capped at two stars. For more details, please see the Five-Star Quality Rating Technical Users' Guide that is available at the link on the References page of this report.

Helpline

The Five-Star Helpline will operate Monday - Friday **December 2 - 6, 2024.** Hours of operation will be from 9 am - 5 pm ET, 8 am - 4 pm CT, 7 am - 3 pm MT, and 6 am - 2 pm PT. The Helpline number is 1-800-839-9290. The Helpline will be available again **January 27 - 31, 2025.** During other times, direct inquiries to BetterCare@cms.hhs.gov as Helpline staff help respond to e-mail inquiries when the telephone Helpline is not operational.

ATTACHMENT E

Bernath + Rosenberg
CPAS + WEALTH ADVISORS

October 21, 2025

Ms. Jeanne-Marie Gawel, Chief
Long Term Care Policy and Planning, Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, MD 21215

Re: Laurelwood Nursing and Rehab Center LLC, Proof of Financial Feasibility

Ms. Gawel,

I am a Certified Public Accountant licensed in the State of New York and engaged by the principals of Laurelwood Nursing and Rehab Center LLC.

At the request of my client, I hereby confirm that the principals of Laurelwood Nursing and Rehab Center LLC have access to sufficient cash reserves and liquid assets to fund the capital needs of the proposed acquisition of the Maryland nursing home currently owned by CommuniCare Family of Companies, the total of which is not expected to exceed $5,000,000.

This letter is provided for the sole purpose of confirming the availability of adequate funds for the above-referenced acquisition and should not be construed as an audit, review, or opinion of financial statements in accordance with generally accepted auditing standards.

Sincerely,
BERNATH & ROSENBERG, P.C.

Benjamin Berger
Certified Public Accountant

Tel 212.221.1140 · Fax 212.221.1944
INFO@BERNATHANDROSENBERG.COM
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126 Spruce Street
Cedarhurst, NY 11516

365 Route 59, Suite 203
Airmont, NY 10952

1515 Pine Street, Suite 250
Lakewood, NJ 08701

ATTACHMENT F

Quality Assurance and Performance Improvement (QAPI) Committee

Policy Statement

This facility shall establish and maintain a Quality Assurance and Performance Improvement (QAPI) Committee that oversees the implementation of the QAPI Program.

Policy Interpretation and Implementation

1. The Administrator shall delegate the necessary authority for the QAPI Committee to establish, maintain and oversee the QAPI program.
2. The committee shall be a standing committee of the facility, and shall provide reports to the Administrator and governing board (body).

Goals of the Committee

The primary goals of the QAPI Committee are to:

1. Establish, maintain and oversee facility systems and processes to support the delivery of quality of care and services;
2. Promote the consistent use of facility systems and processes during provision of care and services;
3. Help identify actual and potential negative outcomes relative to resident care and resolve them appropriately;
4. Support the use of root cause analysis to help identify where patterns of negative outcomes point to underlying systematic problems;
5. Help departments, consultants and ancillary services implement systems to correct potential and actual issues in quality of care;
6. Coordinate the development, implementation, monitoring, and evaluation of performance improvement projects to achieve specific goals; and
7. Coordinate and facilitate communication regarding the delivery of quality resident care within and among departments and services, and between facility staff, residents, and family members.

Committee Authority

1. The QAPI Committee advises the Administrator and owner and/or governing board (body).
2. The committee has the full authority to oversee the implementation of the QAPI Program, including, but not limited to, the following:
   a. Establishing performance and outcome indicators for quality of care and services delivered in the facility;

b. Choosing and implementing tools that best capture and measure data about the chosen indicators;

continues on next page

c. Appropriately interpreting data within the context of standards of care, benchmarks, targets and the strengths and challenges of the facility; and

d. Communicating the information gathered and their interpretation to the owner/governing board (body).

3. The QAPI Coordinator shall coordinate the activities of the QAPI Committee.

Committee Membership

1. The Administrator shall appoint both permanent and rotating members of the committee.
2. The Administrator shall appoint individuals to fill any vacancies occurring on the committee.
3. The following individuals will serve on the committee:
   a. Committee Chairperson;
   b. Administrator;
   c. Director of Nursing Services;
   d. Medical Director;
   e. Dietary Representative;
   f. Pharmacy Representative;
   g. Social Services Representative;
   h. Activities Representative;
   i. Environmental Services Representative;
   j. Infection Control Representative;
   k. Rehabilitative/Restorative Services Representative;
   l. Staff Development Representative;
   m. Safety Representative; and
   n. Medical Records Representative.

Committee Meetings

1. The committee will meet monthly at an appointed time.

2. Special meetings may be called by the coordinator as needed to address issues that cannot be held until the next regularly scheduled meeting.

Committee Reports and Records

1. The committee shall maintain minutes of all regular and special meetings that include at least the following information:
   a. The date and time the committee met;
   b. The names of committee members present and absent;
   c. A summary of the reports and findings;
   d. A summary of any approaches and action plans to be implemented;
   e. Conclusions and recommendations from the committee; and
   f. The time the meeting adjourned.
2. The QAPI Coordinator shall ensure that meeting minutes are distributed to all committee members and others as needed.

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Confidentiality of Information

1. All QAPI minutes, reports, findings, etc., are confidential and shall be filed separately from other committee documentation to maintain such confidentiality.
2. Committee members shall keep confidential all information that they obtain as a result of their participation in/on the committee.
3. The Administrator may authorize sharing of summaries or periodic evaluations of the QAPI Program with residents and/or other interested persons or organizations. These should not include confidential information.

Committee Audit Process

1. The QAPI Committee will scrutinize all department reports and summarize the findings in the committee minutes.
2. The QAPI Committee shall help various departments/ committees/ disciplines/ individuals develop and implement plans of correction and monitoring approaches. These plans and approaches should include specific time frames for implementation and follow-up.
3. The committee shall track the progress of any active plans of correction.
4. The committee shall advise the administration of the need for policy or procedural changes and, as appropriate, monitor to ensure that such changes are implemented.

Annual Review

1. The QAPI Committee shall review the QAPI Plan at least annually for necessary revisions, and shall document any such changes.

References	
OBRA Regulatory Reference Numbers	§483.75(g) Quality assessment and assurance.
Survey Tag Numbers	F868
Other References	
Related Documents	Quality Assurance and Performance Improvement (QAPI) Plan Quality Assurance and Performance Improvement (QAPI) Program
Version	1.2 (H5MAPL0696)

POLICY TITTLE: RESIDENT RIGHTS

Policy Statement

Employees shall treat all residents with kindness, respect, and dignity. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility.

Policy Interpretation and Implementation

1. Federal and state laws guarantee certain basic rights to all residents of this facility.
2. A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident.
3. The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source.
4. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.
5. The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility.
6. The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart.
7. Justice involved residents (under the care of law enforcement, under community supervision or Inmates of a public institution) are entitled to the same rights all other residents residing in the facility
8. These rights include the resident's right to:

- a dignified existence;
- be treated with respect, kindness, and dignity;
- be free from abuse, neglect, misappropriation of property, and exploitation;
- be free from corporal punishment or involuntary seclusion, and physical or chemical restraints not required to treat the resident's symptoms;
- self-determination;
- communication with and access to people and services, both inside and outside the facility without violating facility policy;
- be supported by the facility in exercising his or her rights;
- exercise his or her rights without interference, coercion, discrimination or reprisal from the facility;
- be informed about his or her rights and responsibilities;
- appoint a legal representative of his or her choice, in accordance with state law;
- revoke the delegation of a legal representative, in accordance with state law;
- exercise rights not delegated to a legal representative;
- have his or her same-sex spouse (if applicable) afforded treatment equal to that of an opposite-sex spouse;
- be notified of his or her medical condition and of any changes in his or her condition;

- be informed of, and participate in, his or her care planning and treatment;
- access personal and medical records pertaining to him or herself;
- manage his or her personal funds, or have the facility manage his or her funds (if he or she wishes);
- choose an attending physician and participate in decision-making regarding his or her care;
- privacy and confidentiality;
- voice grievances to the facility, or other agency that hears grievances, without discrimination or reprisal and without fear of discrimination or reprisal;
- have the facility respond to his or her grievances;
- examine survey results;
- communicate with outside agencies (e.g., local, state, or federal officials, state and federal surveyors, state long-term care ombudsman, protection or advocacy organizations, etc.) regarding any matter;
- work or not work;
- perform services for the facility if he or she chooses, or refuse to perform services for the facility;
- visit and be visited by others from outside the facility following facility policy and without jeopardizing safety or rights of other residents;
- be informed of safety or clinical restriction or limitations of visitation;
- access to a telephone, mail and email;
- communicate in person and by mail, email and telephone with privacy;
- retain and use personal possessions to the maximum extent that space and safety permit;
- share a room with a spouse, if that is mutually agreeable;
- share a room with his or her roommate of choice when practicable, both residents live in the same facility and both residents agree;
- self-administer medication, if the interdisciplinary care planning team determines it is safe;
- refuse a transfer from a distinct part within the institution; and
- equal access to quality care, regardless of source of payment.

2. Copies of our resident rights are posted throughout the facility. In addition, staff will have appropriate in-service training on resident rights prior to having direct-care responsibilities for residents.

3. The unauthorized release, access, or disclosure of resident information is prohibited. All release, access, or disclosure of resident information must be in accordance with current laws governing privacy of information issues. All inquiries concerning the release of resident information should be directed to the HIPAA compliance officer/Medical Records/Administrator.

4. Orientation and in-service training programs are conducted to assist our employees in understanding our residents' rights.

5. Inquiries concerning residents' rights should be referred to the social services personnel.

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Critical Element Pathways (CMS Survey Tools)

CMS-20131 Resident Assessment

Guidelines

Guidelines for Notifying Practitioners of Clinical Problems

Sample Documentation

Interdisciplinary Care Plan (CP3131)

Vital Signs and Weight Record (MP5439)

24 Hour Report/Change of Condition (MP5419)

Tools

Care Area Assessment (CAA) Resources (MDS RAI – Appendix C)

Clinical Problem Solving and Decision Making Process Steps and Objectives

Crosswalk – MDS Care Area Assessments (CAAs) and MED-PASS/Heaton Clinical Protocols

Resident Census and Conditions of Residents (CMS-672)

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Critical Element Pathways (CMS Survey Tools)

CMS-20067 Behavioral and Emotional Status

CMS-20077 Physical Restraints

CMS-20133 Dementia Care

Sample Documentation

Antipsychotic Medication Review/Abnormal Involuntary Movement Scale (AIMS) (MP5562)
Behavior/Intervention Monthly Flow Record (MP5945)
Behavior Monitoring/Intervention Flow Record (MP5942)
Consent for Use of Psychoactive Medications (MP5563)
Dyskinesia Identification System – Condensed User Scale (DISCUS) (MP5671)
Elopement/Wandering Monitoring Form (MP5473)
Functional Assessment for Persons with Alzheimer's Disease (MP5350)
Geriatric Depression Scale (GDS) (MP5480)
Informed Consent for Use of Restraints (MP5469)
Mood/Behavior Monitoring (CP3007)
Neurological Evaluation Flow Sheet (MP5435)
Physical Restraint Elimination Review (MP5471)
Pre-Restraining Evaluation (MP5470)
Psychoactive Medication Use Reference Card (MP5944)
Risk – Benefit Acknowledgement Form (MP5540)
Risk of Elopement/Wandering Review (MP5472)

Tools

24-Hour Restraint Observation Record
Care Area Assessment #2 Cognitive Loss/Dementia
Care Area Assessment #9 Behavioral Symptoms
Emergency Use of Restraints
Review of Care and Services for a Resident with Dementia Checklist

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Healthcare Preparedness Capabilities – National Guidelines

Tools

Emergency Contact Information and Recall Roster
Introduction: National Incident Management and Incident Command Systems
Line Listing Report, Influenza-Like Illness
Long-Term Care and Other Residential Facilities Pandemic Influenza Planning Checklist
Pandemic Influenza Planning Committee Roster

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Sample Documentation

PT/INR/Coumadin (Warfarin) Flowsheet (MP5583)

Tools

AHA Pacemaker Identification – Wallet Card

Know Stroke (NIH Stroke Scale Booklet)

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Guidelines

CDC Campaign to Prevent Antimicrobial Resistance in Healthcare Settings

Clinical Practice Guidelines for *Clostridium difficile* Infection in Adults and Children

Facility Guidance for Control of Carbapenem-resistant Enterobacteriaceae (CRE)

General Recommendations for Routine Prevention and Control of MDROs in Healthcare Settings

NHSN Protocol: Laboratory-identified Multidrug-Resistant Organism (MDRO) & Clostridium difficile Infection (CDI) Events for Long-term Care Facilities (LTCFs)

NHSN Protocol: Urinary Tract Infection Event for Long-Term Care Facilities

Recommendations for Intensified MDRO Control Efforts

TB Elimination — Infection Control in Health-Care Settings

Tools

HIV/HBV Antibody Testing – Exposed Individual Consent/Refusal Form

HIV/HBV Antibody Testing – Source Individual Consent/Refusal Form

Infection Treatment/Tracking Report

Infection Treatment/Tracking Report (Example)

Long-Term Care (LTC) Respiratory Surveillance Line List

Procedural Observation Checklists: Placing and Reading Tuberculin Skin Tests

Resources for HIV PEP Consultation

Risk Classifications and Recommendations for Screening Frequency

State TB Statistics on the Internet

Tuberculosis Cases and Case Rates per 100,000 Population: States, 2004 and 2003

Tuberculosis Cases, Case Rates per 100,000 Population, Deaths, and Death Rates Per 100,000 Population, and Percent Change: United States, 1953-2004

Tuberculosis (TB) Risk Assessment Worksheet

Tuberculosis (TB) Risk Assessment Worksheet (Example)

Tuberculosis Summary Record

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Guideline

Standards of Medical Care in Diabetes – 2015: Summary of Revisions

Sample Documentation

Diabetes: Injectable Medications (A96969RCK)

Diabetic Record (MP5581)

Foot Evaluation (MP5459)

Tools

CDC Clinical Reminder - Use of Fingerstick Devices on More than One Person Poses Risk for Transmitting Bloodborne Pathogens

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Tools

Defibrillation Event Report

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Guidelines

Categories of Procedures According to Level of Risk for Transmission of Bloodborne Pathogens

Functions of the Infection Prevention Review Panel

Immunization of Healthcare Personnel – Summary of Recommendations of the Advisory Committee on Immunization Practices

Sample Documentation

Associate/Employee TB Screening Record (CP1807)

Employee Informed Consent for Influenza Vaccine (CP1816)

Hepatitis B Vaccine – Acceptance/Declination and Hepatitis B Vaccination Record (CP1815)

Tools

Bloodborne Pathogens Exposure Report

Employee Health – Role of the Medical Director

Employee Health Survey/Immunization Status

Employee Medical Treatment Record

Employee Orientation Checklist, Infection Control Program

Employee Record of Vaccination

Employee's Notice of Reportable Conditions

Health Care Personnel (HCP) Baseline Individual TB Risk Assessment

Hepatitis B General Information

Hepatitis B Vaccine Information Statement

Sample Contract between the Infection Prevention and Control Committee and Healthcare Worker

Sharps Injury Record

Standard Precautions Barrier Checklist

Standard Precautions Barrier Checklist (Example)

Task Evaluation and Classification Record

Task Evaluation and Classification Record (Example)

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Critical Element Pathways (CMS Survey Tools)

CMS-20073 Hospice and End of Life

CMS-20074 Death

Guideline

Clinical Practice Guideline for Quality Palliative Care

Sample Documentation

Record of Death and Mortician's Receipt (MP5409)

Tool

Hospice Services Agreement

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Sample Documentation

Evaluation of Bowel (CP1700)

Tools

Be Alert - Practice Safe Enteral Feeding

Be Aware - Practice Safe Enteral Medication Delivery

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Sample Documentation

Associate/Employee TB Screening Record (CP1807)

Infection Control Log (CP1905)

Infection Report Form (CP1817)

TB Screening and Immunization Record (CP1801)

Tuberculosis Surveillance Summary Record (CP1812)

Guidelines

Clinical Practice Guidelines by the Infectious Diseases Society of America for the Treatment of Methicillin-Resistant Staphylococcus Aureus Infections in Adults and Children

Prevention Strategies for Seasonal Influenza in Healthcare Settings

Protocol for Public Health Agencies to Notify CDC about the Occurrence of Nationally Notifiable Conditions, 2018

Updated Norovirus Outbreak Management and Disease Prevention Guidelines

Tools

Tuberculosis (TB) Risk Assessment Worksheet

Tuberculosis (TB) Risk Assessment Worksheet (Example)

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Sample Documentation

Joint Mobility Screen (MP5478)

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Critical Element Pathways (CMS Survey Tools)

CMS-20075 Nutrition
CMS-20092 Hydration
CMS-20093 Tube Feeding

Sample Documentation

Calorie Count Record (CP1728)
Data Collection/Evaluation – Nutritional (CP1708)
Dietary Enteral Review (CP1713)
Dietary Intake Record (CP1719)
Enteral Flow Record (MP9211)
Enteral Protocol (MP-EFP)
Food and Beverage Preference List (CP1711)
Hydration Risk Evaluation (MP5474)
Intake/Output Record (Shift) (MP5429)
Monthly Intake and Output Flow Sheet (MP5443)
Nutritional Evaluation of Tube Fed Resident (CP1714)
Nutritional Review (CP1718)

Tools

Complications of Parenteral Nutrition Chart
Nutrition and Hydration Care – What Nursing Assistants Can Do

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Sample Documentation

Physician/Prescriber Telephone Orders (MP5013)

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Critical Element Pathways (CMS Survey Tools)

CMS-20065 Activities

CMS-20066 Activities of Daily Living

CMS-20069 Communication and Sensory Problems

CMS-20070 Dental Status and Services

Sample Documentation

Activities Evaluation (MP5450)

Resident Care Flow Record (MP4111)

Sleep Evaluation (MP5486)

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CMS-20062 Sufficient and Competent Nurse Staffing

Sample Documentation

Record of In-Service (CP1808)

Tools

Employee Orientation Checklist
Nursing Staff Directly Responsible for Resident Care
Nursing Staff Directly Responsible for Resident Care (Example)
Payroll-Based Journal Manual Log (Worksheet)
Payroll-Based Journal Manual Log (Worksheet – Example)
Payroll-Based Journal Manual Log (Worksheet – E-Version)
State Nurse Aide Registry List

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Critical Element Pathways (CMS Survey Tools)

CMS-20081 Respiratory Care

Sample Documentation

Documentation for Nebulizer Treatment - Scheduled or PRN (MP4780)

Documentation for Oxygen Therapy - Continuous or PRN (MP4781)

Tools

Assessment of Resident on Mechanical Ventilation

Mechanical Ventilation - Interventions

Modes of Ventilation (Adult)

Oxygen Safety

Responding to Ventilator Warning Signals

Types of Mechanical Ventilators for Adults

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Guidelines

Guidelines for Reporting Abnormal Test Results to Physicians

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Critical Element Pathways (CMS Survey Tools)

CMS-20068 Urinary Catheter

CMS-20071 Dialysis

CMS-20125 Bladder and Bowel Incontinence

Sample Documentation

Bowel and Bladder Elimination Pattern Evaluation (CP1703)

Bowel and Bladder Toileting Record (CP1704)

Dialysis Communication Record (CP1697)

Urinary Continence Evaluation (CP1699)