STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455278	A. Building B. Wing	09/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Knopp Healthcare and Rehab Center Inc	1208 N Llano Fredericksburg, TX 78624

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48366 Based on interviews and record reviews, the facility failed to ensure that all alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of unknown source and misappropriation of resident property, were reported immediately, but not later than 2 hours after the allegation was made, if the events that cause the allegation involve abuse or serious bodily injury for 1 (Resident #4) of 4 residents reviewed for freedom from abuse, neglect, and exploitation. The nursing staff of the facility failed to report an allegation of resident abuse made by Resident #4, which occurred on 09/10/24, to the administrator immediately, per facility policy. This failure could place all residents at increased risk for potential neglect due to unreported allegations of neglect. The findings included: Record review of Resident #4's admission record, dated 09/20/24, reflected a [AGE] year-old male who was readmitted on [DATE] with no relevant diagnoses. Record review of Resident #4's quarterly MDS assessment, dated 07/20/24 reflected no BIMS score and had modified independence (some difficulty in new situations only) with cognitive skills for daily decision making. Record review of a late entry for a Health Status Note, dated 09/09/24 at 10:45 PM, authored by LVN B, reflected, This nurse went to check on [Resident #4], he had drank water and had no blood in mouth at present. [Resident #4] has trouble with canker sores and bad teeth. Asked him if he said the CNAs hit him and he said No I was joking, informed him that was not something to joke about and to not make False statements like that unless it really happened he said okay. (continued on next page)

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

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

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Behavior Note, dated 09/09/24 at 10:55 PM, authored by LVN B, reflected, [10:30 PM]- [CNA D] went into room for last round and resident asked for a drink of water, [CNA D] handed him his water and noticed he had a little blood in mouth, so [CNA D] asked resident what happened, and he replied you hit me, [CNA D] said no I didn't, don't say that because I can get in trouble for you lying about something like that, resident Laughed then [CNA D] made sure he had his call light and said if you need something just call. Resident then said your going to leave when I have blood in my mouth, [CNA D] stated she was going to report it to this nurse. He then said oh my gosh and laughed. [CNA D] exited room. Record review of Behavior Note, dated 09/09/24 at 11:03 PM, authored by LVN B, reflected, [10:35 PM] - [CNA D] went and asked [CNA C] to go in room with her to check on resident status. [CNA C] said resident has canker sores a lot. They both went into resident's room, [CNA C] asked him what happened in Spanish, he then told [CNA C] you hit me and [CNA C] replied no I didn't, don't say stuff like that because we can get into trouble for stuff that's not true. He then replied well who hit me then, CNA's said no one, he stated well I'm going to tell them in the morning then. During an interview on 09/19/24 at 01:20 PM, Resident #4 revealed he was joking around when he said a CNA hit him. He revealed he feels safe at this facility and had never experienced any abuse at this facility. During an interview on 09/19/24 at 03:11 PM, LVN B revealed she worked shift 6PM to 6AM for a couple of years. She said she did not want to bother anyone about the abuse allegation involving Resident #4. She revealed it was important to report allegations according to protocol for resident safety. During an interview on 09/19/24 at 04:30 PM, the DON revealed CNA D reported to DON that Resident #4 accused CNA D and CNA C of hitting him . The DON was told Resident #4 said he was joking, and the nurse found the resident was bleeding due to a canker sore. The DON revealed she learned about this at about 06:00AM on 09/10/24 from CNA D. The DON further revealed this did not need to be reported to the administrator because it was not an abuse allegation because they found the source of why Resident #4 was bleeding. The DON further revealed after reading LVN B's progress note she thought this incident needed to be reported because of how it was documented. The DON revealed the documentation did not include the nursing staff found why the resident was bleeding and the progress note read as an abuse allegation. She revealed she reported this abuse allegation at around 03:00 PM on 09/10/24. During an interview on 09/19/24 at 04:43 PM, the administrator revealed the incident where Resident #4 accused 2 CNAs of hitting him should have been reported to the administrator immediately. She revealed she let staff know that she didn't care when they contact her or how many people contact her. She revealed this would allow her to decide if this would be something to report to state. She revealed because the resident accused someone of hitting him, even if he was joking, the CNAs, nurse, and DON should've reported this incident to her. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 09/19/24 at 05:18PM, CNA D revealed Resident #4 was bleeding in his mouth. CNA D asked Resident #4 why he was bleeding and he accused her of hitting him. CNA D requested CNA C to speak with Resident #4 to confirm or deny Resident #4's accusations. CNA D said CNA C was now accusing CNA C of hitting him. CNA D revealed she should have reported this incident to the administrator. CNA D revealed she told LVN B before she left the facility because her shift ended. CNA D further revealed she was going to call the DON because it was an abuse allegation, however, CNA D was told by LVN B not to bother the DON. CNA D revealed she listened to her coworkers as they worked at the facility longer than her. CNA D revealed it was important to report right away even though Resident #4 was joking about being hit, because it could be a possibility, he was remembering someone else at the facility was hitting him. She further revealed she made a mistake and realized it the next day. She further revealed she should've called the administrator because I know better. Record review of the facility's policy Resident Abuse, Neglect or Mistreatment, undated, reflected Any alleged violation involving mistreatment, misappropriation of property, abuse, exploitation or neglect of a resident shall be reported to the administrator immediately.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48366 Based on observation, interview, and record review the facility failed to review and revise Resident Care Plans after each assessment for 2 of 4 Residents (Resident #1 and Resident #3) whose records were reviewed for care plan revision/timing, in that:. 1. Resident #1's Care Plan was not updated after her annual MDS assessment reflected she was dependent on staff for ADL care . 2. Resident #3's Care Plan was not updated after she had a significant change and required a mechanical lift for transfers. These deficient practices could affect any resident and contribute to Residents not receiving the care and services they needed. The findings were: 1. Record review of Resident #1's admission record, dated 09/18/24, reflected a [AGE] year-old female who was admitted on [DATE] with diagnoses to include Alzheimer's disease (a brain disorder that slowly destroys memory and thinking skills and, eventually, the ability to carry out the simplest tasks) and weakness. Record review of Resident #1's annual MDS assessment dated [DATE] reflected a BIMS score of 6 out of 15, indicating severely impaired cognition. It further reflected Resident #1 required dependent (helper does all the effort) for lying to sitting on side of bed, sit to lying, sit to stand, and chair/bed-to-chair transfer. Record review of Resident #1's care plan, undated, reflected [Resident #1] has an ADL self-care performance deficit r/t confusion, dementia with an intervention TRANSFER: [Resident #1] is totally dependent on x1 staff for transferring., revised 10/08/22. 2. Record review of Resident #3's admission record, dated 09/19/24, reflected a [AGE] year old female who was admitted on [DATE] with diagnoses to include dementia (a group of symptoms affecting memory, thinking and social abilities), weakness, cognitive communication deficit, unsteadiness on feet, and other lack of coordination. Record review of Resident #3's quarterly MDS assessment, dated 08/24/24 reflected no BIMS score with a short-term and long-term memory problem. It further reflected resident #1 required dependent (helper does all the effort) for lying to sitting on side of bed, sit to lying, sit to stand, and chair/bed-to-chair transfer. Record review of Resident #3's care plan, undated, reflected there was no section in her care plan that reflected ADLs or transfers. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview and observation on 09/19/24 at 05:49 PM, CNA H revealed Resident #1 required a mechanical lift for transfers. CNA H revealed she was not able to access resident care plans from her POC screen. When CNA H clicked on the care plan tab, which would show a resident's care plan, there was a blank window with no care plan shown. CNA H revealed she knew how to transfer residents from other CNAs' verbal report and POC documentation. She further revealed she adjusted her transfers based on how the resident responded to assistance or what was needed due to resident's possible physical limitations. CNA H revealed Resident #3 did not require a mechanical lift and she was able to transfer Resident #3 without a mechanical lift. She further revealed the morning shift liked to use a mechanical lift for Resident #3. CNA H further revealed there was no note that Resident #1 or Resident #3 required a mechanical lift for transfers on her POC screen or Kardex report. During an interview on 09/20/24 at 10:25 AM, Physical Therapist G revealed Resident #1 and Resident #3 needed the mechanical lift for transfers. She revealed the nursing staff were in charge of updated the residents' care plans for type of transfers. During an interview with CNA I on 09/20/24 at 10:35 AM revealed Resident #1 and Resident #3 were transferred by Mechanical lifts and required 2 people. She revealed she knew this information from the DON or other nursing staff that shared this information. She did not look at care plans for this information. She revealed it was important to lift resident appropriately for resident safety. During an observation and interview on 09/20/24 at 10:45 AM, the MDS nurse revealed when Resident #1 came back from 09/08/24 hospitalization , Resident #1's care plan should have been updated to reflect resident #1 needed to be transferred by a Mechanical lift. She further revealed any nurse had access to the care plan and could have updated how the resident got transferred. She further revealed there were no details on how Resident #3 was transferred. She further revealed there was not a section in Resident #3's care plan that explained the ADL care for Resident #3. The MDS nurse further revealed a lot of staff were involved in the care plans. The DON or the admitting nurse oversaw the initial care plan which would include details on how a resident was to be transferred. She revealed the DON or the MDS nurse oversaw ensuring care plans are updated as needed. She revealed CNAs had access to the Kardex report, where data came from the residents' care plan, to see if a resident required a Mechanical lift for transfers. She revealed the CNAs should have access to resident care plans to give appropriate resident care. She reviewed the Kardex report and care plans for Resident #1 and Resident #3 and confirmed Resident #1 did not have a Mechanical (2-person) transfer in her care plan but had a 1-person transfer and Resident #3 did not have an ADL section in her care plan that specified any transfers. She further revealed care plans needed to be updated with an ADL section, so the nursing staff knew how to take care of resident. She further revealed if the transfers in the care plans were not updated appropriately, this could lead to an injury or fall. During an interview on 09/20/24 at 01:46 PM, the DON revealed Resident #1 and Resident #3's care plans should be updated to include they needed to be transferred via Mechanical lifts with 2 people. She revealed they worked with physical therapy to update transfers because of safety issues for staff and residents. She further revealed this information was exchanged verbally in between all nursing staff. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record Review of facility's policy Care plan/comprehensive interdisciplinary, dated 2005, reflected, The comprehensive care plan will periodically be reviewed and revised by the interdisciplinary team after each resident assessment, assessment review, or significant change in condition. The care plan will be otherwise updated as warranted by changes in medication, treatment or other changes in condition.