STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455429	A. Building B. Wing	05/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rose Trail Nursing and Rehabilitation Center	930 S Baxter Tyler, TX 75701

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 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41093 Based on observation, interview and record review, the facility failed to ensure residents had the right to be free from abuse, neglect, misappropriation of resident property, and exploitation for 1 (Resident #1) of 7 residents reviewed for abuse and/or neglect. The facility failed to prevent CNA B from physically abuse abusing Resident #1 when she slapped her arm and left a bruise. This failure could place residents at risk of abuse and neglect. Findings included: Record review of the Resident #1's face sheet, dated 5/17/24, indicated she was readmitted to the facility on [DATE] with diagnoses including, hypothyroidism (abnormally low activity of the thyroid gland), dysphagia (difficulty swallowing), diabetes, mild protein-calorie malnutrition, high blood pressure, muscle weakness, lack of coordination, heart failure and anxiety. Record review of the Resident #1's MDS, dated [DATE], reflected Resident #1 usually made herself understood and usually understood others. Resident #1 had severe cognitive impairment with a (BIMS of 7). Resident #1 had no physical or verbal behaviors symptoms directed towards herself or others. Resident #1 had no behavior of rejecting care. Resident #1 used a manual wheelchair for locomotion and required supervision or touch assistance with eating and oral hygiene. Resident #1 required patrial/moderate assistance with dressing her upper/lower body, personal hygiene, rolling side to side in the bed, moving from a sitting position to lying flat in the bed, and lying to sitting on the side of the bed. The MDS indicated Resident #1 required substantial/maximal assistance with showers/bathing, putting on/taking off footwear, the ability to stand from a sitting position, chair to bed/ bed to chair transfers, toilet transfers, and tub/shower transfers. The MDS indicated Resident #1 was dependent on staff for toileting. Record review of Resident #1's care plan dated 3/12/24, reflected Resident #1 had a risk for bruising and bleeding due to anticoagulant therapy. The care plan interventions included encourage resident to be aware of extremities in relation to environment. The care plan also indicated Resident #1 reported alleged mistreatment by staff and was at risk for increased anxiety. (continued on next page)

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

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Record review of the facility's provider investigation report dated 5/17/24, reflected Resident #1 reported CNA B struck her arm. The police were notified. CNA B was terminated, detained and placed under arrest by the police. Record review of CNA B's signed statement, dated 5/13/24, reflected I'm not the only one that hits them . (Resident #1) was just mad because we didn't have a diaper that would fit her. She got mad and pulled the yellow diaper off. She hit me. I never hit anybody . During an observation and interview on 5/17/24 at 12:50 p.m., Resident #1 said she called for help in the early morning hours of 5/13/24 because her brief was coming off. Resident #1 demonstrated and described she pulled at the brief showing the CNA the brief did not fit and was coming off. Resident #1 then demonstrated and described that as she was doing this (pulling at the brief) CNA B slapped her arm and indicated she slapped her left arm hard while she (CNA B) stood on the left side of her bed. Resident #1 had a large bruise (approximately 7 inches in length and 3 inches in width) to the posterior aspect of her left forearm. Resident #1 said the bruise was where CNA B hit her. During an interview on 5/17/24 at 1:00 p.m., CNA C said it was not acceptable to hit a resident under any circumstances. CNA C said even if they (the residents) hit us (the staff), we the staff do not hit them back. CNA C said this was abuse. During an interview on 5/17/24 at 2:15 p.m., LVN D said Resident #1 was very descriptive and named CNA B as the aide who slapped her arm. LVN D said CNA B slapping Resident #1 no matter the reason was abuse. During an interview on 5/17/24 at 2:30 p.m., The Corporate RN said she was the acting DON. The Corporate RN said Resident #1 was consistent with her details of the event and had bruising to her left arm where she said a nurse had hit her. The Corporate RN said because of Resident #1's description of the staff member and her (Resident #1's) report that the staff member worked double almost every night- CNA B was identified. The Corporate RN said the Resident #1 had reported the incident happened sometime in the early morning hours. The Corporate RN said when the facility was made aware of the allegation they promptly reported the incident to the state agency and began their investigation. The Corporate RN said safety surveys were completed with no additional findings. The Corporate RN said the CNA B was not at work when they were notified of the allegation (she had worked 10:00 p.m. to 6:00 a.m.) so she was called to facility for interview and they kept here there until the police arrived and detained her. The Corporate RN said the police were notified and walked CNA B out in handcuffs. The Corporate RN said what CNA B did (slapping Resident #1's arm) was abuse and would not be tolerated. The Corporate RN said all staff were in-serviced over ANE. During an interview on 5/17/24 at 2:50 p.m., the Administrator said CNA B was immediately terminated and all other staff were in-serviced over abuse, neglect and exploitation. The Administrator said abuse of residents would not be tolerated at the facility. Record review of CNA B's personnel action form, dated 5/13/24, indicated she was terminated for misconduct regarding allegations of Abuse and was not eligible for rehire. The personnel action form also indicated criminal charges had were filed. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Actual harm Residents Affected - Few	Record review of the facility's policy and procedure, dated July 2022, titled Abuse, Neglect and Exploitation, stated It is the policy of this facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse . Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish, It includes verbal abuse, sexual abuse, physical abuse, and mental abuse .

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41093 Based on observation, interview, and record review, the facility failed to have evidence that all alleged violations were thoroughly investigated for 1 of 7 residents (Resident #2) reviewed for abuse and neglect. The facility failed to conduct a thorough investigation when Resident #2 alleged LVN A slapped at her hand and cursed at her during wound care. This failure could place residents at risk of abuse and neglect. Findings included: Record review of Resident #2's face sheet, dated 5/17/24, reflected she was a [AGE] years old admitted to the facility on [DATE], with diagnoses which included COPD (chronic obstructive pulmonary disease is a group of lung diseases that block airflow and make it difficult to breathe), dysphagia (difficulty swallowing foods or liquids, arising from the throat or esophagus), heart disease, muscle weakness and atrophy (wasting or thinning of muscle mass) unspecified open wound of the abdominal wall, chronic pain and depression. Record review of the MDS dated [DATE] indicated Resident #2 had clear speech, understood others and made herself understood. The MDS indicated she had moderate cognitive impairment (BIMS of 11). The MDS indicated Resident #2 had no physical or verbal behaviors towards others and had no behavior of rejecting care. The MDS indicated Resident #2 required supervision or touching assistance with oral hygiene, and eating. The MDS indicated she required partial/moderate assistance with dressing the upper body and personal hygiene. The MDS indicated Resident #2 required substantial/maximal assistance with toileting, showering/bathing and dressing the lower body. The MDS indicated she was dependent on staff for the putting on ad taking off of footwear and all transfers. The MDS indicated she required staff assistance for locomotion in her manual wheelchair. The MDS indicated she had an ostomy (urostomy, ilestomy or colostomy) present. The MDS indicated she was always incontinent of bowel and bladder. Record review of the care plan for Resident #2 dated 4/29/24, indicated Resident #2 had a surgical wound to her abdomen. The care plan interventions included wound protocol. The care plan did not indicate Resident #2 had any history of making false allegations directed toward staff. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the provider investigation report dated 5/9/24 indicated Resident #2's family member reported to the facility on [DATE] LVN A slapped Resident #2's hand away and cursed at her (Resident #2) during wound care. The investigation report indicated Resident #2 was assessed on 5/8/24 and was found without injury. The investigation report indicated Resident #2 denied the allegation against LVN A had occurred. The investigation report indicated LVN A denied the allegation and that she (LVN A) stated she never slapped or even moved Resident #2's hand away and certainly did not curse at Resident #2. The investigation report stated Alleged perpetrator was immediately suspended, pending investigation. Statements were obtained from resident, alleged perpetrator, Director of Nurses interviewed resident, as well as Administrator, at two separate times. Resident complained of pain during wound care, but denied the allegation made by .(Resident #2's family member). LVN [LVN A] was in-serviced by Director of Nurses regarding procedure, if resident complains of pain with wound care. Abuse and Neglect in-service provided by Director of Nurses. Safe Surveys completed by social worker. Physician and RP[Resident Representative] informed of allegation. Assessment performed by Director of Nurses, no physical or emotional harm was reported by resident. Record review of LVN A's employee file found that all appropriate trainings regarding abuse, neglect and exploitation had been completed by LVN A. The employee file revealed all appropriate background checks (criminal history, LVN licensure verification, NAR and EMR) had been conducted prior to hire. The employee file review found no disciplinary actions against LVN A related to abuse, neglect and exploitation or attitude towards residents/other staff. During an interview on 5/10/24 at 10:00 a.m., Resident #2's family member said Resident #2 called her on the evening of 5/7/24 and told her LVN A had performed wound care. Resident #2's family member said during the care LVN A had slapped at her hand and told her to get her motherfing hand down. The family member said Resident #2 was very with it and was only [AGE] years old and that she could tell me exactly what occurred. During an observation on 5/10/24 at 10:30 a.m., LVN A provided a breathing treatment to Resident #2. During the care, Resident #2 smiled and talked with the LVN A. Resident #2 displayed no signs of fear during the interaction. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and interview on 5/10/24 at 11:00 a.m., Resident #2 lay in her bed. Resident #2 had no scratches, bruising or marks to her hands or lower arms. Resident #2 said in the evening on 5/7/24, LVN A came into her room and performed wound care. Resident #2 said LVN A ripped off the old bandage and it hurt. Resident #2 said and demonstrated she had a tendency to hold her hands in fist shape with hands up to her shoulders during wound care because the wound care was uncomfortable. Resident #2 said when she held her hands up to her shoulders in the shape of fists, LVN A slapped at her hand and told her to get her motherfing hand away from there. Resident #2 said she told her family member about the situation on the phone that night (5/7/24). Resident #2 said LVN A came back later in the shift and apologized to her and said she was frustrated with another staff member. Resident #2 said she did not feel LVN A being frustrated with another staff member was a reason to treat her like that. Resident #2 said the incident made her mad, but she was not scared of LVN A. Resident #2 said LVN A had not provided wound care to her since the incident and that was fine with her because she felt LVN A could have been more careful when taking of her bandage. Resident #2 said wound care was provided by other nurses but not LVN A. Resident #2 said LVN A had not actually hit her hand but slapped at her hand. Resident #2 said the next day the Administrator did come ask her about the situation. Resident #2 said she reported to him just want she told the surveyor. Resident #2 said she absolutely did not deny that LVN A had slapped at her hand and cursed at her. Resident #2 said the DON came in and asked about the situation as well. Resident #2 said she told the DON the same thing she told the Administrator, LVN A had slapped at her hand and told her to get her motherfing hand away. Resident #2 said at no point when she was asked about the situation she denied that LVN A had cursed at her and slapped at her hand. During an interviews on 5/10/24 from 11:10 a.m. to 12:50 p.m., Residents #'s 3, 4, 5, 6, 7, 8, 9, and 10 were interviewed and asked specifically if they had received rough car, were abused/neglected, or treated disrespectfully by LVN A. All of Residents (#3, #4, #5, #6, #7, #8, #9, #10) said they received regular care from LVN A but had not been abused, neglected, treated roughly, or disrespected by LVN A. During an interview on 5/10/24 at 1:00 p.m., an unidentified staff member said she cared for Resident #2 on 5/8/24. The unidentified staff member said he/she entered Resident #2's room and family member #2 was at her (Resident #2's) bedside. The unidentified staff member said Resident #2's family member said tell (him/her) what happened. The unidentified staff member said Resident #2 then said LVN A performed wound care last night (5/7/24) and when LVN A ripped off the bandage, she (Resident #2) raised her hands up in shape of fists. The unidentified staff member said Resident #2 said while she (Resident #2) had her hands raised LVN A slapped at her hand and told her to move her motherfing hand. LVN A said she believed the DON and Administrator asked her (Resident #2) about the situation but was not present in the room at the time so she could not say what was said during their conversations. During an observation on 5/10/24 at 1:50 p.m., LVN A provided responded to Resident #2's call light. During the interaction, Resident #2 smiled and talked with the LVN A. Resident #2 displayed no signs of fear during the interaction. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/10/24 at 2:57 p.m., LVN A said she provided wound care to Resident #2 in the evening of 5/7/24. LVN A said she did not have to move Resident #2's hand out of the way during the wound care because Resident #2 did not put her hands in the way. LVN A said she did not slap at Resident #2's hand during the wound care. LVN A said she did not curse at Resident #2 during the wound care. LVN A said Resident #2 voiced no complaints during the wound care and did not complain of pain during the wound care. LVN A said she did not apologize to Resident #2 for anything on the evening of 5/7/24 because there had been nothing to apologize about. LVN A said the following day (5/8/24) she had been called into the conference room sometime around 3:00 pm in the afternoon. LVN A said she was notified Resident #2's family member reported she (LVN A) had slapped at Resident #2's hand and cursed at her. LVN A said she was told she would be suspended the investigation. LVN A said she turned over her keys and clocked out. LVN A said on her way to her car she was called back into the building and asked to sit in the conference room. LVN A said she was told by the DON to get her keys and go back to the floor. LVN A said she clocked out at 3:22 p.m. and clocked back in at 3:29 p.m. During an interview on 5/17/24 at 9:45 a.m., the former facility social worker on 5/8/24 said she was instructed to complete safety surveys as a result of Resident #2's allegation against LVN A. LVN A said while she was completing the safety surveys several residents had negative responses. The former social worker said a negative response meant residents reported they were not being treated with respect/dignity or they did not feel safe or they weren't getting the care they needed. The former social worker said she was told she did not have to finish the safety surveys because the investigation was over about 30 minutes later. The former social worker said she told the DON about the negative safety survey findings and left them on her (the former social worker's) desk when she walked out on the morning of 5/9/24. The social worker said she was really upset about all the complaints from the safety surveys and felt a good investigation was not completed because LVN A was back on the floor within 30 minutes of being suspended. During an interview on 5/17/24 at 12:00 p.m., the former DON said when she interviewed Resident #2 she denied LVN A slapped at her hand or cursed at her. The DON said the social worker had not come to her with any negative findings regarding the safety surveys but believed she (the social worker) said something to the Administrator because she overheard something to that effect. The former DON said she could not specifically say what was said or reported. During an interview on 5/17/24 at 2:50 p.m., the Administrator said the investigation was terminated because the complaint came from a family member but when Resident #2 was interviewed she (Resident #2) denied LVN A had slapped at her hand or cursed at her. The Administrator said he had interviewed Resident #2 himself. The Administrator said he felt LVN A's length of suspension was appropriate because the investigation had been terminated due to the Resident denying it occurred. The Administrator said the former social worker was instructed initially to complete safety surveys but because the investigation was terminated, he was not sure they were completed. The Administrator said the social worker was very upset about Resident #2's allegation and because she was so upset he sent her home late in the afternoon on 5/8/24. The Administrator said the social worker reported to him that there were a lot of complaints (from the safety surveys). The Administrator said he was never told any of the complaints were related to abuse or neglect. The Administrator said he did not ask the social worker if any of the complaints were about abuse or neglect. The Administrator said he would expect the social worker to communicate that directly and would not expect he would have to ask that specifically. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the facility's policy and procedure dated July 2022 titled Abuse, Neglect and Exploitation, stated . V. Investigation of Alleged Abuse, Neglect and Exploitation .An immediate investigation is warranted when suspicion of abuse, neglect or exploitation, or reports of abuse, neglect or exploitation occur. Written procedures for investigations included: Identifying staff responsible for the investigation; .Investigating different types of alleged violations; . Identifying and interviewing all involved persons, including the alleged victim, alleged perpetrator, witnesses, and others who might have knowledge of the allegations; .Focusing the investigation on determining if abuse, neglect, exploitation, and/or mistreatment has occurred, the extent, and cause; and Providing complete and thorough documentation of the investigation .