STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455486	A. Building B. Wing	03/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ennis Care Center	1200 S Hall St Ennis, TX 75119

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 - Minimal harm or potential for 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** 51181 Based on observations, interviews and record reviews, the facility failed to ensure that residents were free from abuse for one (Resident #29) of three residents reviewed for abuse and neglect. The facility failed to protect Resident #29 from abuse on 01/05/2025 when CNA E was witnessed calling Resident #29 an asshole. The noncompliance was identified as Past non-compliance. The noncompliance began on 1/5/25 and ended on 1/7/25. The failure placed residents at risk for abuse, neglect, and emotional and psychological harm. Findings included: Review of Resident #29's Face Sheet, dated 03/12/25, reflected he was a [AGE] year-old male who originally admitted to the facility on [DATE] and a subsequent admitted following a hospital stay on 09/30/2024, with diagnoses including: anxiety disorder (a mental health disorder characterized by feelings of worry, anxiety, or fear that are strong enough to interfere with one's daily activities), and post-traumatic stress disorder (is a mental health condition that can develop after exposure to a traumatic event. It is characterized by symptoms such as: distressing memories or flashbacks of the trauma, feelings of hopelessness or negative thoughts about oneself or others). Review of Resident #29 ' s MDS reflects a BIM ' s (Brief Interview of Mental Status) score of 10. A score of 10 indicates moderate cognitive impairment. Review of Resident #29 ' s Comprehensive Care Plan dated 07/05/2024 reflected he had an ADL (Activities of Daily Living) self-care performance deficit due to dementia and limited mobility. The plan also reflected Resident #29 was at risk of falls, and elopement. The plan does not indicate any areas of concerns for behavioral issues or concerns. Review of Resident #29 ' s nurses notes reflect RN F entered a note on 01/05/2025 that stated resident had an altercation with staff; resident verbally abused staff and attempted to assault staff member. Resident was redirected and is now calm. Administration notified. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455486	A. Building B. Wing	03/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ennis Care Center	1200 S Hall St Ennis, TX 75119

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 - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #29 ' s nurses note reflect a note entered on 01/06/2025 that stated [NAME] alerted that CNA E asked resident to stop being an a##hole due to resident attempting to hit CNA E as well as cursing and yelling at CNA E. Director of Operations made aware of event. DON to contact physician and make medical doctor aware as well as psychiatry. DON to ask that resident been seen my provider at next visit. Psychiatrist states that she saw resident yesterday and thought resident was doing better. DON to inform of resident behaviors. Psychiatrist states she will see resident at next visit. DON to ask that charge nurse alert Reporting Party of concern. Facility social worker also made aware of everything. Resident was asked about the event and resident did not recall this happened. At current time no concerns noted with resident nor voiced by resident. Review of Resident #29 ' s nurses note reflect a note entered on 1/6/2025 that stated Reporting Party notified of incident involving a CNA E over the weekend of 1/4 - 1/5. RP was informed of the disciplinary action taken to ensure this type of incident would not happen again. Reporting Party was in agreement of action taken and had no further complaints at this time. Review of Resident #29 ' s nurses note reflected a note entered on 1/6/2025 that stated Director of operations to call and speak with charge nurse as well as CNA E in 2 separate calls regarding occurrence with resident over the weekend. CNA E as well as charge nurse both state that resident was being very aggressive with male CNA D and was accusing male CNA D of abusing other residents. Both CNA E as well as charge nurse state that this never occurred and that no one was abused, and that resident was having a moment of paranoia/confusion/and possibly sundowning. Per charge nurse resident was hitting CNA E with clip board cursing CNA E out and had stood up and was very aggressive with CNA E to where charge nurse had to intervene. Charge nurse states that CNA E did slip up and tell resident to please stop being an as*hole but states that CNA E was also being hit. Per charge nurse resident was eventually redirected from nurse station with no further occurrence. Charge nurse states that when CNA E checked on resident shortly thereafter that resident didn ' t even seem to know anything had even occurred. Observation of Resident #29 on 03/11/25 at 1:35PM revealed he was clean, well-groomed, and appropriately dressed. He was free from any odors. There were no visible marks or bruises noted on his person. Resident #29 was alert and oriented; he was resting in his bed. During an interview with Resident #29 on 03/11/25 at 1:35PM, he stated facility staff treated him well and he felt safe at the facility. He had no concerns regarding the facility, or the care received; he reported he just returned from his mother ' s funeral today and was feeling sad. Resident #29 could not recall the specific incident between him and CNA E but said that CNA E talks to people rudely. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455486	A. Building B. Wing	03/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ennis Care Center	1200 S Hall St Ennis, TX 75119

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 - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with CNA E on 3/11/25 at 11:45AM he revealed he was gathering people to have coffee and snacks before dinner. He stated there was one resident that was combative during care, and she was amped up already. He stated hours at a time she will sit there crying. He stated he brought her to dining and Resident #29 went over to try to console her. CNA E stated Resident #29 then rolled down the hall to the nurse ' s station accusing CNA E of hurting the female resident. He stated Resident #29 stood up and started coming toward him while he was in med room (behind nurse station). CNA E stated he closed the door and Resident #29 was trying to get in the room and then Resident #29 put his weight on the door so CNA E could not get out and this lasted a few seconds. CNA E said he asked RN F for help and to make sure other residents are not around for their safety. CNA E said this happened for about an hour that Resident #29 was following him around and saying he would call the cops. CNA E stated Resident #29 was cussing at him, and CNA E said he told Resident #29 to stop acting like an asshole. CNA E said it was very heated in the moment he said that to Resident #29. CNA E said he realized he should not have said that and could have used another word or term. CNA E said Resident #29 came back and apologized about the incident. During an interview with RN F on 3/12/25 at 5:46 PM she revealed she was at the nurse desk during the incident. She stated CNA E was prepping snacks for residents and Resident #29 rolled up to the desk and was upset. She stated Resident #29 thought CNA E was abusing the residents. RN F stated Resident #29 stood up and he and CNA E were yelling at each other, and CNA E told Resident #29 to stop being an asshole. She stated they were arguing back and forth. She stated Resident #29 lunged forward pushing the door shut locking CNA E in the med room. RN F stated CNA E and Resident #29 continued going back and forth and she tried to deescalate the situation. RN F stated Resident #29 tried to hit CNA E with a clipboard. RN F stated Resident #29 tried hitting CNA E again and CNA E grabbed Resident #29 ' s hand and pushed it away. She stated Resident #29 left the nurse station and later came back and tried to call 911 to report CNA E and they took the phone away from him. RN F stated prior to this incident she had not seen signs of aggression in Resident #29 before, possibly just depression. RN F stated she immediately reported the incident to the ADON. During an interview with the social worker 01/13/25 at 10:30 AM, she revealed she completed Safe Surveys after the incident. She reported she spoke to Resident #29 who told her Oh that is the way he (CNA E) talks. She stated Resident #29 said he did not like the tone that CNA E used toward him. She said she did not know what CNA E said to the resident exactly. She said after the incident she ensured the resident was on psych services. During an interview with LVN G on 3/12/25 at 11:00 AM, she reported she had worked at the facility for 7 days and had worked with CNA E twice. She reported she had heard CNA E cussing in general conversation and to where residents were able to hear him swearing. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455486	A. Building B. Wing	03/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ennis Care Center	1200 S Hall St Ennis, TX 75119

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 - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the Operations Manager on 1/13/25 at 2:00 PM, he stated he was informed by RN F about the incident involving Resident #29. He stated the results of his investigation were confirmed. He stated there were consistent stories given by individuals interviewed. He stated CNA E was suspended and required to take assigned trainings regarding abuse/neglect prevention, etc. prior to returning to work. The Operations Manager stated he had a one-on-one staffing with CNA E who was given a written warning. The Operations Manager reported there have been no complaints since about CNA E prior to the incident that he is aware of. The Operations Manager stated he sees CNA E often in the hallways and people have said good things about him. He stated Safe Surveys were completed throughout the entire facility. He stated Resident #29 was back to himself after the incident. The Operations Manager did not have any concerns for CNA E to continue to provide care to Resident #29 or other Residents in the facility. Review of Facility Provider Investigation Report dated 01/06/2025 reflected the following: Incident date occurred on 01/05/2025 at 3:45 p.m. At approximately 3:30 p.m. RN [NAME] witnessed CNA [NAME] using inappropriate language towards resident [NAME]. Resident [NAME] is routinely seen by psych services. Facility immediately launched investigation into the matter. Residents MD, RP, and VA notified. Alleged Perpetrator suspended pending investigation. Safe Surveys initiated. Staff in service on abuse and neglect initiated. Should be noted that the alleged victim has a diagnosis of cognitive communication deficit, altered mental status, unspecified, depressive disorder, recurrent, mild, dementia in other diseases classified elsewhere, mild, with other 07/02/2024 other diagnosis behavioral disturbance, bipolar disorder, unspecified, major depressive disorder, single episode, unspecified mild cognitive impairment of uncertain or unknown etiology. It should also be noted that alleged victim resides on the facility ' s memory care unit. In an interview with Operations Manager [NAME] and Director of Nursing [NAME] on 1/7/25, witness [NAME] (RN) was able to provide the same details of the event that the alleged perpetrator [NAME] (CNA) provided. Resident safe surveys brought forth no further concerns. (surveys attached). It is my reasonable conclusion that the allegation was confirmed. The alleged perpetrator has been consistent with his story on what happened, and the witness as well. As a result, the alleged perpetrator was suspended and assigned several healthcare academy modules (E-learning) (Certs are attached). Staff in-service completed on abuse and neglect. Alleged perpetrator was educated on appropriate topics and issued final written warning from supervisor before returning to work. Review of the following E-learning courses completed by CNA E: Completion date of 01/07/25 titled Abuse Prevention in Persons with Dementia. Completion date of 01/07/25 titled Abuse, Neglect, and Exploitation: Mandatory Reporter Completion date of 01/07/25 titled Residents ' Rights Completion date of 01/07/25 titled Mental Health: Caring for the Older Adult in Long Term Care Review of In-Service Training Report dated 01/07/2025, of all staff and departments, topic of Abuse Neglect Resident Rights. The report indicates 5 types of abuse, the abuse coordinator, and reporting abuse protocols. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455486	A. Building B. Wing	03/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ennis Care Center	1200 S Hall St Ennis, TX 75119

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 - Minimal harm or potential for actual harm Residents Affected - Few	Review of 5 Safe Survey ' s indicated one resident responded to question #4 Have you ever heard a staff member yell at another resident? The resident responded No not really, just correction. Not abusive. Everything is being addressed the right way. Resident #29 ' s response to question #4 on the safe survey stated, just me, me and CNA E had a couple of words, but it was a misunderstanding. Review of the facilities Abuse and Neglect - Clinical Protocol, Revised March 2018, reflected Abuse is defined at S483.5 as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. Abuse also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. 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 including abuse facilitated or enabled through the use of technology.