STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455522	A. Building B. Wing	05/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Tlc West Nursing and Rehabilitation	1700 Marlandwood Rd Temple, TX 76502

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 - Immediate jeopardy to resident health or safety Residents Affected - Some	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** 42949 Based on observation, interview, and record review, the facility failed to ensure the residents had the right to be free from psychosocial abuse and neglect for one (Resident #1) of four residents reviewed for abuse and neglect. The facility failed to ensure staff were not willfully abusing and neglecting Resident #1 as they did not assist her out of bed at a reasonable time which caused her to miss breakfast and lunch and remain in a soiled brief for long periods of time on a regular basis (no specific time frame), causing her to feel hungry and neglected. Resident #1 was consistently neglected and left in her bed for most of the day. An IJ was identified on 04/30/25. The IJ template was provided to the facility on [DATE] at 4:19 PM. While the IJ was removed on 05/01/25, the facility remained out of compliance at a scope of pattern and a severity level of no actual harm with the potential for more than minimal harm that is not immediate jeopardy. This failure placed residents at risk of abuse, neglect, trauma, and psychosocial harm. Findings included: Review of Resident #1's face sheet reflected an [AGE] year-old female who was admitted to the facility on [DATE] with diagnoses of rheumatoid arthritis (condition that causes inflammation in the joints), dysphagia (difficulty swallowing), acquired deformity of neck, and adult failure to thrive. Review of Resident #1's quarterly MDS assessment, dated 01/27/25, reflected a BIMS score of 15, indicating she had no cognitive impairment. Section GG (Functional Abilities) reflected she was dependent on transferring and needed partial/moderate assistance with eating. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of Resident #1's quarterly care plan, dated 02/13/25, reflected a problem of staff guidelines with an intervention of getting her out of bed and into her wheelchair between 6:00 AM and 7:30 AM daily and to remain up to eat breakfast, lunch, and dinner. It further reflected she was at risk for aspiration pneumonia with an intervention of having her in her motorized wheelchair for all meals. It further reflected she had an ADL self-care performance deficit with an intervention of her requesting to feed herself and refusing to be fed by staff. Furthermore, it reflected she had a swallowing problem related to a diagnosis of dysphagia with an intervention of being up in her motorized wheelchair for all meals. Review of Resident #1's quarterly IDT Care Conference notes, dated 02/12/25, reflected Resident #1, FM A, FM B, the DON, the ADON, the ADM, the SW, the DOR, the SW, the OMB and the MDSC were in attendance. The daily plan for Resident #1 reflected the following: Day staff: Staff to provide ADL care and get [Resident #1] up out of bed and into motorized W/C between 6:00 AM and 7:30 AM daily. Breakfast: Staff to have [Resident #1] remain up in MWC to eat breakfast Lunch: Staff to have [Resident #1] remain up in MWC to eat lunch Dinner: Staff to have [Resident #1] remain up in MWC to eat dinner Bedtime: [Resident #1] to be placed in bed around 8:00 PM nightly Review of Resident #1's progress notes, dated 04/22/25 at 1:31 PM and documented by the SW, reflected the following: [Resident #1]'s light on when SW entered room. [FM D] was standing at [Resident #1]'s bedside. SW asked what [Resident #1] needed since light was on. [FM D] stated that [Resident #1] has been lying in bed in feces since this morning and no one has come into room . [Resident #1] asked to speak with SW once they were done. [Resident #1] stated her light had been on all morning and no one came into her room. Review of an email, dated 04/30/25 at 11:40 AM from the OMB, reflected she had been advocating for Resident #1 for months. She stated they isolate her, refuse to service her, and tell her to leave. She stated she was fragile and missing breakfast and lunch on a regular basis. She stated she believed it had caused Resident #1 physical and psychosocial harm. Review of Resident #1's weights in her EMR, on 04/30/25, reflected a 5.4% weight loss for the last three months indicating a significant weight loss: 01/24/25 - 95.6 Lbs. 02/10/25 - 94.2 Lbs. 03/06/25 - 92.6 Lbs. 04/09/25 - 91.2 Lbs. (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 - Immediate jeopardy to resident health or safety Residents Affected - Some	04/18/25 - 90.2 Lbs Review of video footage provided by Resident #1's FM A, on 04/30/25, reflected the following: - On 04/13/25, she was not assisted out of bed until 1:59 PM. - On 04/16/25, she was not assisted out of bed until 1:15 PM. - On 04/21/25, she was assisted to bed at 6:45 PM and not assisted out of bed on 04/22/25 until 2:03 PM. During an interview on 04/30/25 at 10:12 AM, the SW stated they had Resident #1's care plan meeting approximately three months ago. She stated Resident #1, her family members, the OMB, and facility leadership were there. She stated it was decided she needed to be gotten up before breakfast. She stated due to her arm/hand contractures, she was unable to eat in bed and needed to be in her wheelchair to feed herself. She stated Resident #1 refused to be fed by staff. She stated for the first couple weeks (getting her up before breakfast) it happened and then it stopped. She stated Resident #1 had been labeled as a difficult resident because Resident #1 was demanding and there were a lot of aides who refused to go into her room, including CNA C. She stated CNA C had been assigned her hall on 04/22/25. She stated she and the MDSC noticed her light had been on for a while around 1:30 PM and went to see what she needed. She stated Resident #1 had not had her brief changed or gotten up that entire day and did not eat breakfast or lunch. She stated Resident #1 was very upset and angry and felt like they (staff) did not take care of her. She stated Resident #1 did not want to move to another facility because she believed she deserved to be taken care of. SW stated she believed Resident #1 had lost weight but was unsure of how much. She stated this was an on-going problem. SW stated that day (04/30/25) they had gotten her up around 8:45 AM, so she had not eaten breakfast. She stated the ADM let the staff choose if they were going to give her care and she believed it was neglectful. During an interview on 04/30/25 at 10:30 AM, RN E stated she worked Resident #1's hall on 04/22/25 and had heard around 1:15 PM she had still not been assisted out of bed, which meant she did not have breakfast or lunch. She stated that was not typical, but sometimes they just fell behind. RN E stated she knew that there were some staff members that did not like to go in her room because she could be difficult. During a telephone interview on 04/30/25 at 10:41 AM, Resident #1's FM A stated she just wanted her (Resident #1) to be treated with dignity and respect. She stated on the videos she sent were just three instances of her being left in bed during the day, she stated it happened all the time. She stated around 12:10 PM on 04/22/25, Resident #1 called her and told her she was not doing too good and had been laying in her poop for quite some time. She stated FM D walked into her room around 1:06 PM and her call light was still on. She stated he went to go find someone for assistants and two aides came in at 1:17 PM, and she was not in her wheelchair until 2:03 PM. She stated a few months ago, they agreed in a care plan meeting that they would be getting her out of between 6:30 AM and 7:00 AM. She stated that lasted a whole two weeks. FM A stated she knew Resident #1 had a tongue on her, but she was in her right mind and deserved to be cared for. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an observation and interview on 04/30/25 at 11:01 AM, revealed Resident #1 in her wheelchair in her room watching television. She stated she did not get breakfast that day and never did because the staff would not get her up. She stated when she was in bed all day, she felt like she was starving and empty. She stated they (staff) knew she wanted to be out of bed no later than 8:00 AM. Resident #1 stated she was tired of being covered in poop, was tired of being neglected, and did not know what to do anymore. During an interview on 04/30/25 at 11:44 AM, the MDSC stated she spoke with Resident #1 that morning (04/30/25) around 9:30 AM and she was out of bed but had missed breakfast due to being assisted out of bed late. She stated she was not able to eat laying down and must be in her wheelchair to feed herself. She stated she had heard of staff members refusing to go into her room because they had their own opinions of her. She stated Resident #1 could be difficult at times but that did not mean they could just neglect and not take care of her. She stated there had been occasions where she had witnessed her being in bed for long periods of time. She stated her expectation was that every resident would be up and out of bed by the time she got there each morning at 8:00A AM. MDSC's expectations were that every resident was checked on/changed every two hours and when they (Residents) asked for something they got it. During an interview on 04/30/25 at 11:53 AM, CNA C stated he was always assigned Resident #1's hall but he barely went into her room because she used to accuse him of stuff like poisoning her or stealing her stuff. He stated those were very serious allegations and he was not going to go through that. He stated other staff had to go into her room to take care of her. CNA C stated he knew she requested to get up early, but she usually was gotten out of bed around 1:00 PM. During an interview on 04/30/25 at 12:08 PM, the ADM stated Resident #1 was one of the toughest residents he had ever been part of caring for. He stated she threatens nurses and aides. He stated they have tried bending over backwards for her. He stated they did have a care plan and the OMB was present and they tried to get her up at the time she requested but she would sometimes refuse. He stated it was always a moving target with Resident #1. He stated she will keep staff in there for over an hour when there are other residents that need to be cared for. ADM stated she called staff names, berated them, and talked to them like dogs. During an interview on 04/30/25 at 12:48 PM, CNA F stated she was a floater, and floaters were not assigned a hall, but assigned to residents that were more high-demanding, such as Resident #1. She stated she knew of a few staff members that refused to go into her room. She stated she had no problems with Resident #1. She stated her shift was from 8:00 AM - 2:30 PM and when she got to work, she would go assist another resident who required assistance with feeding and then straight to Resident #1's room to get her up for the day. She stated it was after breakfast and often missed breakfast because no one would get her up. She stated she could not answer why no one got her up before she did around 9:00 AM on her days she worked. She stated she believed it was an issue. CNA F stated Resident #1 could be cranky, but it did not mean she should be neglected. During a telephone interview on 04/30/25 at 1:17 PM, Resident #1's NP stated it did not meet her expectations for residents to not get assisted out of bed until 1:00 PM unless they refused to. She stated it did not meet her expectations for residents to go without meals or to not provide care for more difficult residents. She stated that was absolutely not okay. NP stated that could lead to pressure wounds, skin breakdown, and weight loss. NP stated even though Resident #1 had her preferences and was able to voice them, that did not mean she should be neglected. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During a telephone interview on 04/30/25 at 1:40 PM, Resident #1's FM D stated he went to visit her on 04/22/25 but could not remember the time. He stated he was so upset when he got there and saw the state she was in. He stated she had not eaten or been changed all day long. She stated she was starving and laying up in her own mess. He stated he went and asked CNA C to assist her, but he refused to go into her room. He stated that was straight-up neglect. He stated he then went and spoke to the ADM who told him, (Resident #1) just plays games. He stated he became so upset he had to walk out of the facility to calm down. FM D stated he would never in his life treat an elderly person the way they (staff) do. During an observation and interview on 04/30/25, this Surveyor along with the MDSC asked Resident #1 if it would be okay for her to get weighed, and she agreed. The MDSC went into the hall to find someone to assist them utilize the scale on the mechanical lift. CNA C was in the hall and the MDSC walked right by him. She was asked why she did not ask CNA C for assistance, and she stated that he did not like Resident #1 or going into her room. The MDSC, RN A, and CNA G utilized the mechanical lift and it reflected Resident #1's current weight was 89.6 pounds. During an interview on 04/30/25 at 4:01 PM, the ADM stated his expectations were that residents received every meal to get the full intake they needed. He stated he did not see why Resident #1 could not eat in her bed like other residents did. He stated he had never heard she had to be out of bed to eat due to a physical disability or that she had been missing meals. He stated he was aware there had been days she had been gotten up late but there could be a variety of reasons, such as her sending them away, or since they needed two people for transferring, a staff member could be waiting for someone else to be available. He stated she had threatened staff with their lively hood, and it was bullying on her part. He stated he was aware there were staff that did not like to go into Resident #1's room but he would tell them they still had to go in there and care for her. He stated they have been instructed to always have someone with them, so they had a witness. He stated floaters were assigned differently. He stated they were normally assigned to Resident #1 because she took up so much of their time. He stated missing meals and not getting out of bed could cause weight loss or skin breakdown. Review of the facility's CNA Job Description, dated 02/11/20, reflected the following: JOB SUMMARY: Responsible for assisting resident with activities of daily living in order to promote resident independence and dignity. Review of the facility's Abuse, Neglect, and Exploitation Policy, revised April 2021, reflected the following: Residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation. Establish and maintain a culture of compassion and caring for all residents and particularly those with behavioral, cognitive or emotional problems. The ADM and ADON were notified on 04/30/25 at 4:19 PM that an IJ had been identified and an IJ template was provided. The following POR was approved on 05/01/25 at 11:01 AM: (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Corrective Action 1. Facility team members were immediately in serviced on Abuse/Neglect and prior to next shift worked for those team members who are new hires, PRN, vacation, Agency and Leave of Absence. Education will be provided through verbal in servicing and post- test will be given to ensure retention of education. DON/ADON were provided training on Abuse/Neglect on 4/30/25 by RDO/RDCS. Responsible Party: DON/ADON Target Date: 4/30/25 and ongoing Follow-up: Team member roster will printed to ensure all team members on assignment sheet have been in-serviced each shift. Provide ongoing education to all new hires, agency, prn, leave of absence prior to first shift worked. Corrective Action 2. Skin assessment was completed on Resident #1. Skilled Wound Care Physician will conduct an onsite visit 05/01/25. Responsible Party: DON/ADON Target Date: 4/30/25 and ongoing Corrective Action 3. Interviewable residents were interviewed by IDT team to inquire if residents had any concerns with any basic care not being met. No concerns identified. Responsible Party: IDT Team Target Date: 4/30/25 Corrective Action 4. April weight loss summary report was reviewed for all significant weight losses for those residents who are not able to be interviewed to validate that residents who need assistance with meals did not sustain weight loss due to lack of required assistance with meal service and review meal intake documentation. No concerns noted. Responsible Party: IDT Team Target Date: 4/30/25 and ongoing Follow-up: Significant weight losses will be reviewed in (EMR) weekly by IDT Corrective Action 5. In serviced clinical team on importance of Q2 hour rounding on residents requiring assistance to ensure their needs are being met. Responsible Party: DON/ADON Target Date: 4/30/25 Follow-up: Follow the morning meeting process to ensure compliance. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Corrective Action 6. One on one education completed with CNA C regarding assisting residents or finding assistance to provide care for residents in need. In serviced all staff assigned to resident hall that they cannot refuse to go into resident room as assigned. Administrator trained by Regional Director of Operations. Responsible Party: Administrator Target Date: 4/30/25 Corrective Action 7. Daily rounding will be conducted by the IDT team for all assigned residents to address any concerns and identify any issues for those residents unable to communicate. Responsible Party: IDT Team Target Date: 4/30/25 Follow-up: Follow morning meeting process to ensure compliance Corrective Action 8. Ad HOC QAPI meeting with MD conducted to discuss the plan of correction for compliance. Responsible Party: IDT Team Target Date: 4/30/25 and ongoing Follow-up: Review any compliance issues in QAPI meeting for 3 months The Surveyor monitored the POR on 05/01/25 as followed: During an observation and interview on 05/01/25 at 3:28 PM revealed Resident #1 in her wheelchair in her room. She stated she was gotten up before breakfast and was able to eat breakfast and lunch that day. During an observation and interview on 05/01/25 at 4:19 PM revealed a resident who required a mechanical lift transfer laying in her bed. She stated she opted to stay in bed yesterday and today because she had been tired. She stated the staff had offered to get her up before each meal. During interviews on 05/01/25 from 1:39 PM - 4:30 PM, one MA, two CNAs, and two RNs stated they were in-serviced before their shifts on abuse and neglect, checking on residents every two hours, getting all residents out of bed before all meals (if they desired), notifying the charge nurse of refusals, and they could not refuse to go in any resident rooms. They all knew who their abuse and neglect coordinator was and could name several types of abuse such as sexual, emotional, and psychosocial. During an interview on 05/01/25 at 2:20 PM, the ADM stated he was in-serviced on abuse and neglect on 04/30/25 and residents should always be free from any abuse or neglect while in the facility. Review of the facility's Ad HOC QAPI meeting agenda, dated 04/30/25, reflected the ADM, the MD, the RDO, and RDCS were in attendance. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of Resident #1's skin assessment, dated 04/30/25, reflected she had no new skin issues. Review of an in-service dated 04/30/25 and conducted by the RDO, reflected the ADM and ADON were in-serviced on their Abuse and Neglect Policy. Review of an in-service, dated 04/30/25 and conducted by the RDO, reflected all staff were in-serviced on how they were not allowed to refuse care or refuse going into a resident room they were assigned to. Review of an in-service, dated 04/30/25 and conducted by the ADON, reflected all staff were in-serviced on rounding on residents every two hours to ensure their needs were being met. Review of an in-service, dated 04/30/25 and conducted by the ADON, reflected al staff were in-serviced on their Abuse and Neglect Policy. Review of Abuse and Neglect Prohibition Quizzes, dated 04/30/25, reflected staff completed the quizzes with no concerns. Review of Resident Surveys, dated 04/30/25 and conducted by the ADON, reflected all residents were interviewed (resulting in no concerns) the following questions: Do you get the care you need? Do you get out of bed when you need or want to? Do you receive 3 meals daily at the appropriate time of day? Review of documentation, dated 05/01/25 and documented by the ADM, reflected the following: Our ADON scheduled an in-person in-service for nurses and CNA's the evening of 4/30/25. There were multiple topics in the in-service, including a resident's right to refuse care. Within that context, she stated that employees cannot refuse to provide care for any resident in this building. This administrator was present throughout the in-service and reiterated that point. The ADM, RDO, and RDCS were notified on 05/01/25 at 5:58 PM that the IJ had been removed. While the IJ was removed, the facility remained at a level of no actual harm at a scope of pattern that was not immediate jeopardy due to the facility's need to evaluate the effectiveness of the corrective systems.

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Administer the facility in a manner that enables it to use its resources effectively and efficiently. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42949 Based on observation, interview, and record review, the facility failed to be administered in a manner that enabled it to use its resources effectively and efficiently to maintain the highest practicable well-being of each resident for one (Resident #1) of four residents reviewed for administration. The facility Administrator failed to ensure staff were not willfully abusing and neglecting Resident #1 as they did not assist her out of bed at a reasonable time which caused her to miss breakfast and lunch on a regular basis (no specific time frame). She was consistently neglected and left in her bed for most of the day. An IJ was identified on 04/30/25. The IJ template was provided to the facility on [DATE] at 4:19 PM. While the IJ was removed on 05/01/25, the facility remained out of compliance at a scope of pattern and a severity level of no actual harm with the potential for more than minimal harm that is not immediate jeopardy. This deficient practice could place residents at risk for abuse, neglect, injury, harm, serious impairment, and death. Findings included: Review of Resident #1's face sheet reflected an [AGE] year-old female who was admitted to the facility on [DATE] with diagnoses of rheumatoid arthritis (condition that causes inflammation in the joints), dysphagia (difficulty swallowing), acquired deformity of neck, and adult failure to thrive. Review of Resident #1's quarterly MDS assessment, dated 01/27/25, reflected a BIMS score of 15, indicating she had no cognitive impairment. Section GG (Functional Abilities) reflected she was dependent on transferring and needed partial/moderate assistance with eating. Review of Resident #1's quarterly care plan, dated 02/13/25, reflected a problem of staff guidelines with an intervention of getting her out of bed and into her wheelchair between 6:00 AM and 7:30 AM daily and to remain up to eat breakfast, lunch, and dinner. It further reflected she was at risk for aspiration pneumonia with an intervention of having her in her motorized wheelchair for all meals. It further reflected she had an ADL self-care performance deficit with an intervention of her requesting to feed herself and refusing to be fed by staff. Furthermore, it reflected she had a swallowing problem related to a diagnosis of dysphagia with an intervention of being up in her motorized wheelchair for all meals. Review of Resident #1's quarterly IDT Care Conference notes, dated 02/12/25, reflected Resident #1, FM A, FM B, the DON, the ADON, the ADM, the SW, the DOR, the SW, the OMB and the MDSC were in attendance. The daily plan for Resident #1 reflected the following: Day staff: Staff to provide ADL care and get [Resident #1] up out of bed and into motorized W/C between 6:00 AM and 7:30 AM daily. (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Breakfast: Staff to have to have [Resident #1] remain up in MWC to eat breakfast Lunch: Staff to have [Resident #1] remain up in MWC to eat lunch Dinner: Staff to have [Resident #1] remain up in MWC to eat dinner Bedtime: [Resident #1] to be placed in bed around 8:00 PM nightly Review of Resident #1's progress notes, dated 04/22/25 at 1:31 PM and documented by the SW, reflected the following: [Resident #1]'s light on when SW entered room. [FM D] was standing at [Resident #1]'s bedside. SW asked what [Resident #1] needed since light was on. [FM D] stated that [Resident #1] has been lying in bed in feces since this morning and no one has come into room . [Resident #1] asked to speak with SW once they were done. [Resident #1] stated her light had been on all morning and no one came into her room. Review of an email, dated 04/30/25 at 11:40 AM from the OMB, reflected she had been advocating for Resident #1 for months. She stated they isolate her, refuse to service her, and tell her to leave. She stated she was fragile and missing breakfast and lunch on a regular basis. She stated she believed it had caused Resident #1 physical and psychosocial harm. Review of Resident #1's weights in her EMR, on 04/30/25, reflected a 5.4% weight loss for the last three months indicating a significant weight loss: 01/24/25 - 95.6 Lbs. 02/10/25 - 94.2 Lbs. 03/06/25 - 92.6 Lbs. 04/09/25 - 91.2 Lbs. 04/18/25 - 90.2 Lbs. Review of video footage provided by Resident #1's FM A, on 04/30/25, reflected the following: - On 04/13/25, she was not assisted out of bed until 1:59 PM. - On 04/16/25, she was not assisted out of bed until 1:15 PM. - On 04/21/25, she was assisted to bed at 6:45 PM and not assisted out of bed on 04/22/25 until 2:03 PM. (continued on next page)

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	455522	A. Building B. Wing	05/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Tlc West Nursing and Rehabilitation	1700 Marlandwood Rd Temple, TX 76502

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 04/30/25 at 10:12 AM, the SW stated they had Resident #1's care plan meeting approximately three months ago. She stated Resident #1, her family members, the OMB, and facility leadership were there. She stated it was decided she needed to be gotten up before breakfast. She stated due to her arm/hand contractures, she was unable to eat in bed and needed to be in her wheelchair to feed herself. She stated Resident #1 refused to be fed by staff. She stated for the first couple weeks it happened and then it stopped. She stated Resident #1 had been labeled as a difficult resident because she was demanding and there were a lot of aides who refused to go into her room, including CNA C. She stated CNA C had been assigned her hall on 04/22/25. She stated she and the MDSC noticed her light had been on for a while around 1:30 PM and went to see what she needed. She stated Resident #1 had not had her brief changed or gotten up that entire day and did not eat breakfast or lunch. She stated Resident #1 was very upset and angry and felt like they did not take care of her. She stated Resident #1 did not want to move to another facility because she believed she deserved to be taken care of. She stated she believed she had lost weight but was unsure of how much. She stated this was an on-going problem. She stated that day (04/30/25) they had gotten her up around 8:45 AM, so she had not eaten breakfast. She stated the ADM let the staff choose if they were going to give her care and she believed it was neglectful. During an interview on 04/30/25 at 10:30 AM, RN E stated she worked Resident #1's hall on 04/22/25 and had heard around 1:15 PM she had still not been assisted out of bed, which meant she did not have breakfast or lunch. She stated that was not typical, but sometimes they just fell behind. She stated she knew that there were some staff members that did not like to go in her room because she could be difficult. During a telephone interview on 04/30/25 at 10:41 AM, Resident #1's FM A stated she just wanted her (Resident #1) to be treated with dignity and respect. She stated on the videos she sent were just three instances of her being left in bed during the day, she stated it happened all the time. She stated around 12:10 PM on 04/22/25, Resident #1 called her and told her she was not doing too good and had been laying in her poop for quite some time. She stated FM D walked into her room around 1:06 PM and her call light was still on. She stated he went to go find someone for assistants and two aides came in at 1:17 PM, and she was not in her wheelchair until 2:03 PM. She stated a few months ago, they agreed in a care plan meeting that they would be getting her out of between 6:30 AM and 7:00 AM. She stated that lasted a whole two weeks. She stated she knew Resident #1 had a tongue on her, but she was in her right mind and deserved to be cared for. During an observation and interview on 04/30/25 at 11:01 AM, revealed Resident #1 in her wheelchair in her room watching television. She stated she did not get breakfast that day and never did because the staff would not get her up. She stated when she was in bed all day, she felt like she was starving and empty. She stated they (staff) knew she wanted to be out of bed no later than 8:00 AM. She stated she was tired of being covered in poop, was tired of being neglected, and did not know what to do anymore. (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 04/30/25 at 11:44 AM, the MDSC stated she spoke with Resident #1 that morning (04/30/25) around 9:30 AM and she was out of bed but had missed breakfast due to being assisted out of bed late. She stated she was not able to eat laying down and must be in her wheelchair to feed herself. She stated she had heard of staff members refusing to go into her room because they had their own opinions of her. She stated Resident #1 could be difficult at times but that did not mean they could just neglect and not take care of her. She stated there had been occasions where she had witnessed her being in bed for long periods of time. She stated her expectation was that every resident would be up and out of bed by the time she got there each morning at 8:00A AM. Her expectations were that every resident was checked on/changed every two hours and when they asked for something they got it. During an interview on 04/30/25 at 11:53 AM, CNA C stated he was always assigned Resident #1's hall but he barely went into her room because she used to accuse him of stuff like poisoning her or stealing her stuff. He stated those were very serious allegations and he was not going to go through that. He stated other staff had to go into her room to take care of her. He stated he knew she requested to get up early, but she usually was gotten out of bed around 1:00 PM. During an interview on 04/30/25 at 12:08 PM, the ADM stated Resident #1 was one of the toughest residents he had ever been part of caring for. He stated she threatens nurses and aides. He stated they have tried bending over backwards for her. He stated they did have a care plan and the OMB was present and they tried to get her up at the time she requested but she would sometimes refuse. He stated it was always a moving target with Resident #1. He stated she will keep staff in there for over an hour when there are other residents that need to be cared for. He stated she called staff names, berated them, and talked to them like dogs. During an interview on 04/30/25 at 12:48 PM, CNA F stated she was a floater, and floaters were not assigned a hall, but assigned to residents that were more high-demanding, such as Resident #1. She stated she knew of a few staff members that refused to go into her room. She stated she had no problems with Resident #1. She stated her shift was from 8:00 AM - 2:30 PM and when she got to work, she would go assist another resident who required assistance with feeding and then straight to Resident #1's room to get her up for the day. She stated it was after breakfast and often missed breakfast because no one would get her up. She stated she could not answer why no one got her up before she did around 9:00 AM on her days she worked. She stated she believed it was an issue. She stated Resident #1 could be cranky, but it did not mean she should be neglected. During a telephone interview on 04/30/25 at 1:17 PM, Resident #1's NP stated it did not meet her expectations for residents to not get assisted out of bed until 1:00 PM unless they refused to. She stated it did not meet her expectations for residents to go without meals or to not provide care for more difficult residents. She stated that was absolutely not okay. She stated that could lead to pressure wounds, skin breakdown, and weight loss. She stated even though Resident #1 had her preferences and was able to voice them, that did not mean she had the right to be neglected. (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During a telephone interview on 04/30/25 at 1:40 PM, Resident #1's FM D stated he went to visit her on 04/22/25 but could not remember the time. He stated he was so upset when he got there and saw the state she was in. He stated she had not eaten or been changed all day long. She stated she was starving and laying up in her own mess. He stated he went and asked CNA C to assist her, but he refused to go into her room. He stated that was straight-up neglect. He stated he then went and spoke to the ADM who told him, (Resident #1) just plays games. He stated he became so upset he had to walk out of the facility to calm down. He stated he would never in his life treat an elderly person the way they (staff) do. During an observation and interview on 04/30/25, this Surveyor along with the MDSC asked Resident #1 if it would be okay for her to get weighed, and she agreed. The MDSC went into the hall to find someone to assist them utilize the scale on the hoyer lift. CNA C was in the hall and the MDSC walked right by him. She was asked why she did not ask CNA C for assistance, and she stated that he did not like Resident #1 or going into her room. The MDSC, RN A, and CNA G utilized the hoyer and it reflected Resident #1's current weight was 89.6 pounds. During an interview on 04/30/25 at 4:01 PM, the ADM stated his expectations were that residents received every meal to get the full intake they needed. He stated he did not see why Resident #1 could not eat in her bed like other residents did. He stated he had never heard she had to be out of bed to eat due to a physical disability or that she had been missing meals. He stated he was aware there had been days she had been gotten up late but there could be a variety of reasons, such as her sending them away, or since they needed two people for transferring, a staff member could be waiting for someone else to be available. He stated she had threatened staff with their lively hood, and it was bullying on her part. He stated he was aware there were staff that did not like to go into Resident #1's room but he would tell them they still had to go in there and care for her. He stated they have been instructed to always have someone with them, so they had a witness. He stated floaters were assigned differently. He stated they were normally assigned to Resident #1 because she took up so much of their time. He stated missing meals and not getting out of bed could cause weight loss or skin breakdown. Review of the facility's Abuse, Neglect, and Exploitation Policy, revised April 2021, reflected the following: Residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation. . 2. Develop and implement policies and protocols to prevent and identify: a. abuse or mistreatment of residents; b. neglect of residents . Establish and maintain a culture of compassion and caring for all residents and particularly those with behavioral, cognitive or emotional problems. (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	The ADM and ADON were notified on 04/30/25 at 4:19 PM that an IJ had been identified and an IJ template was provided. The following POR was approved on 05/01/25 at 11:01 AM: Corrective Action 1. Regional Director of Operations immediately in serviced Administrator on Abuse/Neglect. Responsibly Party: RDO Target Date: 4/30/25 and ongoing Follow-Up: Regional Director of Operations and Director of Clinical Services will attend (EMR) meetings 2x monthly for 3 months to ensure any resident issues identified have appropriate interventions. Corrective Action 2. Administrator in-serviced all team members on compliance 24-hour hot line where team members can report any concerns and or if administration is not taking corrective action or putting interventions in place to ensure residents are being cared for by staff appropriately. Compliance hotline notifications will be posted by time clock and breakrooms. Administrator trained by Regional Director of Operations. Responsible Party: Administrator The Surveyor monitored the POR on 05/01/25 as followed: Observation on 05/01/25 at 3:33 PM revealed the 24-hour hotline posted in the breakroom. During an observation and interview on 05/01/25 at 3:28 PM revealed Resident #1 in her wheelchair in her room. She stated she was gotten up before breakfast and was able to eat breakfast and lunch that day. During an observation and interview on 05/01/25 at 4:19 PM revealed a resident who required a mechanical lift transfer laying in her bed. She stated she opted to stay in bed yesterday and today because she had been tired. She stated the staff had offered to get her up before each meal. During interviews on 05/01/25 from 1:39 PM - 4:30 PM, one MA , two CNAs, and two RNs stated they were in-serviced before their shifts on abuse and neglect, checking on residents every two hours, getting all residents out of bed before all meals (if they desired), notifying the charge nurse of refusals, and they could not refuse to go in any resident rooms. They all knew who their abuse and neglect coordinator was and could name several types of abuse such as sexual, emotional, and psychosocial. They all knew where to find the 24-hour hotline number which was posted in the breakroom. During an interview on 05/01/25 at 2:20 PM, the ADM stated he was in-serviced on abuse and neglect on 04/30/25 and residents should always be free from any abuse or neglect while in the facility. Review of the facility's Ad HOC QAPI meeting agenda, dated 04/30/25, reflected the ADM, the MD, the RDO, and RDCS were in attendance. (continued on next page)

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