| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 455638 | A. Building<br>B. Wing | 10/30/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Greenview Nursing and Rehabilitation | 401 Owen LN<br>Waco, TX 76710 |

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<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47772<br><br>Based on observations, interviews, and record review, the facility failed to ensure its residents were free from abuse for 2 of 10 Residents (Resident #2 and Resident #3) reviewed for resident-on-resident abuse.<br><br>1. The facility failed to prevent Resident #1 from punching Resident #2, on his body, on 8/18/2024.<br><br>2. The facility failed to prevent Resident #1 from physically abusing Resident #3, with a wheelchair, on 8/22/2024.<br><br>This failure could have placed the facility residents at risk of physical harm and mental anguish.<br><br>Findings included:<br><br>Resident #1<br><br>Record review or Resident #1's AR, dated 10/29/2024, reflected a [AGE] year-old male who admitted to the facility on [DATE]. He was diagnosed with Dementia (which was a disease that affected memory, thought, and interfered with daily life).<br><br>Record review of Resident #1's Discharge MDS (unplanned), dated 10/10/2024, reflected the resident had a BIMS Score of 1. A BIMS Score of 1 indicated the resident had severe cognitive impairment.<br><br>(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 0600<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Record review of Resident #1's CCP reflected a focus area, initiated on 8/22/2024, revised on 8/22/2024, for potential to demonstrate physical behaviors related to dementia and poor impulse control. The CCP indicated on: 8/18/2024-he hit his roommate for messing with him while he was sleeping; 8/22/2024-resident to resident incident noted, resident held the arms of roommate's wheelchair slamming his wheelchair into his roommate's legs, yelling, cursing towards roommate. The Goal, initiated on 8/22/2024, revised on 8/22/2024, revealed a goal of fewer than 3 episodes per week of physical behavior. The interventions for nursing staff, initiated and revised both on 8/22/2024, revealed nursing staff was supposed to analyze key times, places, circumstances, triggers, and what de-escalated behavior and document. Assess and address for contributing sensory deficits. Assess and anticipate Resident's needs: food, thirst, toileting needs, comfort level, body positioning, pain. Cognitive assessment. Communication: provide physical and verbal cues to alleviate anxiety; give positive feedback, assist verbalization of source of agitation, assist to set goals for more pleasant behavior, encourage seeking out of staff member when agitated. Evaluate for side effects of medications. Give resident as many choices as possible about care and activities. Modify environment; adjust room temperature to comfortable level, reduce noise, dim lights, place familiar objects in room, keep door closed. Document observed behavior and attempted interventions in behavior log. Monitor/document/report to MD of danger to self and others. Psychiatric/Psychogeriatric consult as indicated. Intervene before agitation escalates; Guide away from source of distress; Engage calmly in conversation; If response is aggressive, staff walk calmly away, and approach later.<br><br>Record review of Resident #1's PN, dated 8/18/2024 at 8:12 AM, reflected: Was reported that Resident #1 had hit his roommate, Resident #2, for messing with him while he was sleeping. Resident #1 said his roommate, Resident #2, was grabbing him while he was sleeping. Resident #1 said he warned Resident #2 the first time to get away. Resident #1 said Resident #2 grabbed him, so Resident #1 hit Resident #2 to get him away. Resident #1 did not remember where he hit Resident #2. The Administrator and the NP was informed. No new orders received. Resident #1 has been calm so far this morning and has not made complaints towards his roommate, Resident #2.<br><br>Record review of self-reported incidents did not reflect a facility self-report for Resident #1 and Resident #2's altercation on 8/18/2024.<br><br>Record review of historical census information from 8/17/2024 to 8/22/2024, dated 10/29/2024, indicated Resident #1 changed rooms on 8/20/2024 to reside with Resident #3.<br><br>Record review of Resident #1's PN, dated 8/20/2024 at 11:36 AM revealed the presence of a UTI (which was the presence of bacteria in the urethra and bladder). Resident was alert and mildly confused.<br><br>Record review of Resident #1's PN, dated 8/22/2024 at 6:15 AM, reflected: This nurse was sitting at the desk and heard yelling coming from Resident #1 and Resident #3's room. Upon entering room, Resident #1 was found with Resident #3's wheelchair and Resident #3 sitting on the side of Resident #1's bed. Resident #1 was holding the arms of the wheelchair slamming it into Resident #3's legs yelling, I'm going to kill you shut your mouth. Resident #3 was yelling Mother F***** .<br><br>Record review of an intake, dated 8/22/2024, reflected a resident-on-resident abuse between Resident #1 and Resident #3 on 8/22/2024.<br><br>Record review of Resident #1's PN, dated 8/22/2024 at 1:39 PM reflected Resident #1 moved to his private room in the Memory Care Unit.<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Record review of Resident #1's PN, dated 8/22/2024 at 7:31 PM reflected an order for 50 Milligrams of Seroquel (mood regulator) at bedtime.<br><br>Record review of historical census information from 8/17/2024 to 8/22/2024, dated 10/29/2024, indicated Resident #1 changed rooms on 8/22/2024 with no assigned roommate.<br><br>Record review of Resident-to-Resident incident in Resident #1's PN, dated 8/22/2024 at 9:10 AM, reflected Resident #1 did not have any injuries. Breathing-normal; facial expression-sad; frightened; frown; body language-tensed; console needed-distracted/reassured by voice or touch. Resident alert. Predisposing psychological factors-confusion; dementia; impaired memory. Predisposing situational factor-recent room change.<br><br>Record review of Resident #1's PN, dated 8/23/2024 at 9:46 AM, reflected: IDT Event Review<br><br>Name of IDT participating in review: Administrator, DON, ADON, MDS (C)<br><br>*Event Being Reviewed: Resident #1 to Resident #3 incident on 8/22/2024.<br><br>*Root Cause Analysis for event: Resident #3 was cursing at Resident #1 because he was getting into the Resident #3's snacks and ate all of them. Per responsible party, it was noted that Resident #1 got aggressive when consuming sugary items. Resident #1, confused and aggressive, pushed a wheelchair into his roommate's legs to get him to stop cursing at him.<br><br>*Interventions initiated and residents' response / compliance with Intervention: Resident #1 and Resident #3 separated and assessed for injury.<br><br>*New Interventions suggested following current IDT review: Resident #1 room changed.<br><br>Record review of Resident #1's post event head to toe skin check PN, dated 8/23/2024 at 12:32 PM, reflected no new skin issues, no apparent injuries.<br><br>Recorded review of Resident #1's PN, dated 10/10/2024 at 2:54 PM, reflected the resident was DC to hospital. (Return not anticipated.)<br><br>Record review of the facility's incident reports from 8/22/2024 to 10/30/2024 did not reflect any resident-on-resident altercations involving Resident #1, Resident #2, and Resident #3.<br><br>Interview on 10/29/2024 at 2:39 PM with LVN A revealed she did not have an answer to why the Resident upon Resident interaction on 8/18/2024 between Resident #1 and Resident #2 was not reported to the state office.<br><br>Interview on 10/29/2024 at 2:43 PM with LVN B revealed she did not have an answer to why the Resident upon Resident interaction on 8/18/2024 between Resident #1 and Resident #2 was not reported to the state office.<br><br>Interview on 10/29/2024 at 2:45 PM with LVN C revealed she did not have an answer to why the Resident upon Resident interaction on 8/18/2024 between Resident #1 and Resident #2 was not reported to the state office.<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Interview on 10/29/2024 at 3:00 PM with NP H revealed no recall of any information having pertained to Resident #1 and Resident #2's altercation, which occurred on 8/18/2024. When asked why she was mentioned in a PN of Resident #1, she stated, I do not work on the weekends and did not take any calls, 8/18/2024 was a Sunday .<br><br>Interview on 10/29/2024 at 4:00 PM with the ADM revealed the resident-on-resident incident, which occurred on 8/18/2024, between Resident #1 and Resident #2 was not reported to the state office because there were no injuries. The incident on 8/18/2024 did not make the ADM, or the staff, feel that Resident #1 was the aggressor towards Resident #2, nor did they feel that Resident #1 was a threat to other residents. On 8/22/2024, Resident #1 engaged in a resident-on-resident altercation with Resident #3. The incident with Resident #1 and Resident #3 was reported to the state office because the situation was discovered by staff, was reported to him as possible physical contact, and resulted with no injuries. The ADM did not feel that Resident #1 was the aggressor in the incident with Resident #3. After the incident with Resident #1 and Resident #3, Resident #1 was moved to a private room on the Memory Care Unit. The ADM did not think a lack of any action, such as updating Resident #1's CCP after the incident on 8/18/2024, would have stopped the incident on 8/22/2024 .<br><br>Resident #2<br><br>Record review or Resident #2's AR, dated 10/29/2024, reflected an [AGE] year-old male who admitted to the facility on [DATE]. He was diagnosed with legal blindness and schizoaffective disorder (which was a mental illness with both psychotic and mood fluctuations.)<br><br>Record review of Resident #2's Quarterly MDS, dated [DATE], reflected the resident had a BIMS Score of 4. A BIMS Score of 4 indicated the resident had severe cognitive impairment.<br><br>Record review of Resident #2's CCP reflected a focus area, initiated 7/27/2024, revised 9/1/2024, for behavior problems evidenced by Alzheimer's Disease: up late at night, entering other people's rooms, grabbing at roommate, and taking things down from the walls. The goal, initiated on 7/27/2024, was for Resident #2 to have fewer episodes of restlessness. The intervention, revised on 9/1/2024, for nursing staff was to administer medications as ordered; anticipate and meet needs; create opportunity for positive interaction; explain procedures; monitor episodes and attempt to determine underlying cause; and provide a program of activities.<br><br>Record review of Resident #2's PN, dated 8/18/2024 at 8:36 AM, reflected: Last night, reported this morning, Resident #2 was messing with his roommate, Resident #1, and grabbing on him while he was trying to sleep. Resident #1 reported Resident #2 would not leave him alone after he told him to go away. Resident #1 resorted to hitting Resident #2 on his body.<br><br>Record review of Resident #2's PN, dated 8/18/2024 at 9:16 AM, reflected a skin assessment, with no new injuries from last night. Fading bruise to left upper arm. Skin discoloration to left elbow/forearm.<br><br>Record review of Resident #2's PN, dated 8/18/2024 at 10:57 AM, reflected hospice and RP #12 were at the facility and order received, from hospice, for 50 Milligrams of Seroquel (mood regulator) at bedtime. RP #12 saw Resident #2's bruise on left upper arm. Requested to speak to management.<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Record review of Resident #2's PN, dated 8/20/2024 at 10:56 AM reflected Resident #2 was more confused and agitated than normal. Resident stated, [my roommate beat me up last night and gave me a concussion.]<br><br>Record review of Resident #2's PN, dated 8/20/2024 at 2:19 PM reflected Resident #2 received an order, from hospice, for 50 milligrams of Trazadone (a treatment for insomnia) at bedtime to ease resident's restlessness.<br><br>Observation and interview on 10/29/2024 at 10:10 AM with Resident #2 revealed him in his wheelchair in the memory care unit having just came from an activity. He was unable to recall any injuries or harm from another resident. No distress noted. He felt safe at the facility.<br><br>Interview and record review on 10/29/2024 at 6:00 PM with Resident #2's RP, RP #11, revealed he was made aware, by staff, about the incident with Resident #1 and Resident #2 on 8/18/2024. He did not know many details, but he did learn of a bruise on Resident #2's left upper arm from another one of Resident #2's RP, RP #12. RP #11 stated he went to the facility on [DATE] to look at Resident #2's arm and take a photo. Record review of a photo, provided by a RP #11 on 10/29/2024 at 6:17 PM, reflected a baseball sized bruise on Resident #2's left upper arm.<br><br>Interview on 10/29/2024 at 6:34 PM with RP #12 revealed RP #12 went to the facility on [DATE] between 8-9 AM. She stated she was told, from staff, about an incident between Resident #1 and Resident #2 when she arrived. She was not informed it was of a physical nature. While there, she noticed a bruise on Resident #2's left upper arm. The bruise was about a quarter in diameter and was purple. She stated Resident #2 told her, My roommate hit me because I was in his bed. She stated Resident #2 pointed to his left upper arm and to his lower abdomen area. RP #12 had visited Resident #2 the day before, 8/17/2024, and did not notice a bruise on Resident #2's arm because of long sleeves, but Resident #2 did not mention, to RP #12, his arm being hurt.<br><br>Resident #3<br><br>Record review or Resident #3's AR, dated 10/29/2024, reflected a [AGE] year-old male who admitted to the facility on [DATE]. He was diagnosed with hemiplegia (which was one-sided paralysis), hemiparesis (which was one-sided muscle weakness), and speech and language deficits.<br><br>Record review of Resident #3's Quarterly MDS, dated [DATE], reflected the resident did not receive a BIMS Assessment, due to rarely/never understood. By staff assessment, cognitive skills for daily decision making were consistent and reasonable.<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Record review of Resident #3's CCP reflected a focus area, initiated on 3/29/2021, evidenced by physical aggression towards other residents. The goal, revised on 11/23/2022, was for resident to demonstrate effective coping skills and not harm self or others. The intervention, initiated on 3/29/2021, was for nursing staff to administer medications as ordered; analyze times of day and location; assess and address sensory deficits; anticipate needs; communication; provide choices; observe and document; and intervene before agitation escalates. A focus area, initiated on 4/19/2024, for potential to demonstrate physical behaviors R/T anger, history of harm to others, and poor impulse control: pushed his rollator walker into his roommate's leg on 6/28/2024. The goal, revised on 6/23/2024, was for resident to verbalize understanding of need to control physical aggressive behavior. The intervention, initiated 6/28/2024, was for nursing staff to analyze times of day and location; assess and address sensory deficits; anticipate needs; observe and document; evaluate side effects of medication; and psychiatric consult, as necessary. A focus area for potential behavior problems, initiated on 8/22/2022, R/T heart conditions and anxiety: Resident to Resident incident-resident held arms of roommate's wheelchair slamming his wheelchair into his roommate's legs-yelling and cursing. The goal, initiated on 8/22/2024, was that resident would have fewer episodes of physical behavior. The intervention, initiated on 8/22/2024, for nursing staff was to administer medications as ordered; develop appropriate methods to cope; create opportunity for positive interaction; intervene as necessary to protect others; monitor episodes and attempt to determine underlying cause; and provide a program of activities.<br><br>Record review of Resident-to-Resident incident in Resident #3's PN, dated 8/22/2024 at 9:10 AM, reflected Resident #3 did not have any injuries. Breathing-normal; facial expression-smiling, or inexpressive; body language-relaxed; console needed-no need to console. Oriented to person, place, situation. Predisposing situational factor-dislikes roommate/exhibiting behaviors.<br><br>Record review of Resident #3's PN, dated 8/23/2024 at 9:58 AM, reflected: IDT Event Review<br><br>Name of IDT participating in review: Administrator, DON, DOR, ADON, MDS (C)<br><br>*Event Being Reviewed: Resident to resident 8/22/2024<br><br>*Root Cause Analysis for event: Resident #3 started cussing at his roommate, Resident #1, because was taking and consuming all his snacks. The roommate, Resident #1, became aggressive and started pushing Resident #3's wheelchair into his legs while yelling at him.<br><br>*Interventions initiated and residents' response/compliance with Intervention: Residents were separated and assessed.<br><br>*New Interventions suggested following current IDT review: Resident #1 moved to alternate room.<br><br>Record review of Resident #3's post event head to toe skin check PN, dated 8/23/2024 at 12:25 PM, reflected no new skin issues, no apparent injuries, range of motion within normal limits, denied pain or injury to head.<br><br>Observations on 10/29/2024 at 10:39 AM with Resident #3 revealed him receiving assistance with personal hygiene. No distress noted.<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Interview on 10/29/2024 at 10:45 AM with Resident #3 revealed he could not remember any details about the resident-on-resident altercation on 8/22/2024. He did verbalize with tones and facial expressions that he was not hurt; he confirmed with tones and facial expressions that he was not harmed; they were just yelling. He confirmed with tones and facial expressions that he felt safe at the facility.<br><br>Interview on 10/30/2024 at 10:26 AM with Resident #3's RP, RP #13, revealed she was informed about the resident-on-resident altercation on 8/22/2024. RP #13 did not have concerns for Resident #3's safety. She felt Resident #3 was safe at the facility.<br><br>Interview on 10/30/2024 at 3:01 PM with RN D revealed he responded to Resident #1 and Resident #2's resident to resident altercation on the morning on 8/18/2024. He stated he separated the two residents, after learning of the incident, and then told the ADM. RN D thought the incident was abuse and should have been reported in the 2 hours requirement. RN D stated, abuse was supposed to be reported within two hours to start a timely investigation. Timely responses help people remember details and the facts of the incidents stay fresh. If reporting was not timely, residents risked the abuse continuing or lead to other medical or psychosocial problems. He had attended training on ANE, ANE reporting, and Resident-on-Resident Altercations.<br><br>Interview on 10/30/2024 at 3:21 PM with LVN E revealed she was a charge nurse at the facility. The immediate response for resident-on-resident abuse was to separate the residents, calm the residents, make sure they were safe, and perform an assessment for injuries. Staff were trained to report allegations of abuse, or actual incidents of, to the ADM as soon as possible. The ADM had a 2-hour window to report incidents of abuse. LVN E had attended training on ANE, ANE reporting, Resident-on-Resident Altercations .<br><br>Interview on 10/30/2024 at 3:32 PM with CNA F revealed she had just started work at the facility. CNA F stated, the first thing to do when witnessing a resident-on-resident altercation is to separate the resident and make sure they were safe. The altercation was supposed to be reported immediately to the charge nurse and to the ADM. She just attended an in-service training where she learned incidents of abuse needed to be reported to the state within 2 hours. She had taken training on dementia care and resident upon resident abuse. She had not witnessed any resident-on-resident altercations while at the facility .<br><br>Interview on 10/30/2024 at 3:38 PM with CNA G revealed he had been working at the facility for 3 years. He stated he had participated in in-service trainings for Abuse, Neglect, and Resident-on-Resident Altercations. Allegations of ANE, or resident harm, were supposed to be reported to the charge nurse and the ADM immediately.<br><br>Interview on 10/30/2024 at 3:49 PM with the LVN C revealed she had not attended an IDT team meeting to discuss the Resident #1 and Resident #2 incident that occurred on 8/18/2024. She stated she learned about the Resident #1 and Resident #2's incident the next day, which was Monday 8/19/2024. The incident on 8/18/2024 was a form of abuse and should have been reported to the state agency. Resident #1's CCP should have been updated as soon as possible to address negative outcomes and to keep other residents safe. If the incident on 8/18/2024 had been addressed by the IDT members and addressed Resident #1's CCP, the incident on 8/22/2024 might have been avoided. It could have been avoided by having Resident #1 already in a private room or having chosen a better roommate.<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Interview on 10/30/2024 at 4:10 PM with the ADM revealed the decision not to report the incident on 8/18/2024 with Resident #1 and Resident #2 was the ADM's choice, not of the other leadership staff. He reiterated he did not feel any intervention for Resident #1, stemming from the incident on 8/18/2024, would have had any positive effect on, or stop, the incident with Resident #1 and Resident #3 on 8/22/2024; therefore, there was no CCP update for Resident #1, post the resident-on-resident incident on 8/18/2024. CCP updates were made after Resident #1 and Resident #3's resident altercation on 8/22/2024; Resident #1 moved rooms too. There was no direction in the facility's Comprehensive Care Plan to address timeliness of updates. He did not feel there was any failure on his staff's duties to update Resident #1's CCP after the incident on 8/18/2024. He had seen to his staff's completion of in-service trainings on 8/22/2024 on ANE, Resident-on-Resident Altercations, ANE Reporting, Protecting Residents during an Abuse Investigation, and Resident Rights.<br><br>Record review of 10 resident safe surveys, dated 8/23/2024, reflected positive answers, yes, for 1. Are you happy with nursing staff. 2. Are you happy with the therapy department. 3. Do you feel safe at the facility. 4. If you did not feel safe would you tell the Administrator or the Director of Nursing.<br><br>Record review of the facility's in-service trainings, from 8/23/2024 to 8/29/2024, indicated 80 employees attended training for Coordinating/Implementing Abuse, Neglect, and Exploitation Policies and Procedures, Resident Rights, Abuse, Neglect, Exploitation or Misappropriation- Reporting and Investigating, Identifying Types of Abuse, Abuse and Neglect- Clinical Protocol, Recognizing Signs and Symptoms of Abuse, QAPI Review of Abuse, Neglect, Exploitation or Misappropriation, Protection of Residents During Abuse Investigations, Compliance and Ethics-Risk Areas for Fraud and Abuse, and Resident to Resident Altercations.<br><br>Record review of the facility's Coordinating/Implementing Abuse, Neglect, and Exploitation Policies and Procedures, dated April 2021, reflected policies were in place to prohibit and prevent resident abuse, neglect, exploitation, or misappropriation of resident property, reporting and response to investigations, the administrator having the overall responsibility for the coordination and implementation of facility policy.<br><br>Record review of the facility's Resident Right's Policy, dated February 2021, reflected residents had the right to be free from abuse, neglect, exploitation, or misappropriation of resident property.<br><br>Record review of the facility's Abuse, Neglect, Exploitation or Misappropriation- Reporting and Investigating Policy, dated September 2022, reflected if resident abuse, neglect, exploitation, misappropriation of resident property or injury of an unknown source is suspected, the suspicion must be reported immediately to the administrator and to other officials according to state law. Immediately is defined as: within two hours of an allegation involving abuse or result in serious bodily injury or within 24 hours of an allegation that does not involve abuse or result in serious bodily injury. Within 5 business days of the incident, the administrator will provide a follow-up investigation report.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 455638 | A. Building<br>B. Wing | 10/30/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Greenview Nursing and Rehabilitation | 401 Owen LN<br>Waco, TX 76710 |

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|---|---|
| F 0600<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Record review of the facility's Identifying Types of Abuse Policy, dated September 2022, reflected Physical Abuse of any kind against residents is strictly prohibited. Abuse is defined as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. Abuse toward a resident can occur as resident-to-resident abuse, staff to resident abuse, or visitor to resident abuse. Physical abuse included, but was not limited to hitting, slapping, biting, punching, or kicking. Some situations of abuse do not result in an observable physical injury, but psychosocial effects of abuse may not be immediately apparent.<br><br>Record review of the facility's Abuse and Neglect- Clinical Protocol Policy, dated March 2018, reflected abuse defined as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. Willful defined as acting deliberately, not that the individual must have intended to inflict injury or harm. The facility management and staff will institute measures to address the needs of residents and minimize the possibility of abuse and neglect.<br><br>Record review of the facility's Recognizing Signs and Symptoms of Abuse, dated April 2021, reflected all personnel are expected to report any signs and symptoms of abuse or neglect to their superior or to the director of nursing services immediately. Signs of physical abuse can be injuries that are non- accidental or unexplained.<br><br>Record review of the facility's QAPI Review of Abuse, Neglect, Exploitation or Misappropriation, dated September 2022, reflected the QAPI Team was responsible for integrating the findings of a confirmed allegation of abuse into a performance improvement initiative.<br><br>Record review of the facility's Resident-to-Resident Altercation Policy, dated September 2022, reflected occurrences of such incidents were reported to the ADM. If two residents engaged in an altercation, staff were to review the events with nursing supervisor and DON and evaluate the effectiveness of interventions meant to address distressed behaviors for one, or both, residents. The ADM, who would report in accordance with the reporting criteria, would do so within two hours of the allegation involving abuse.<br><br>Record review of the facility's CCP Policy, dated December 2016, reflected the CCP will contain measurable objectives and timeframes; describe these services that are being furnished to attain or maintain their residence highest practical physical, mental, and psychosocial well-being; and incorporate risk factors associated with identified problems, such as identify the professional services that are responsible for each element of care. The IDT must review and update the CCP when the desired outcome has not been met. |

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| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47772<br><br>Based on interviews and record review, the facility failed to ensure that all alleged violations involving abuse were reported immediately, but not later than 2 hours after the allegation is made for 2 of 10 residents (Resident #1 on Resident #2) reviewed for abuse.<br><br>1. The facility failed to report physical abuse, from Resident #1 on Resident #2 on 8/18/2024, within 2 hours.<br><br>2. The facility failed to complete a 5-day provider investigation for the Resident #1 on Resident #2 abuse, which on 8/18/2024.<br><br>This failure could have placed the facility residents at risk of physical harm and mental anguish.<br><br>Findings included:<br><br>Resident #1<br><br>Record review or Resident #1's AR, dated 10/29/2024, reflected a [AGE] year-old male who admitted to the facility on [DATE]. He was diagnosed with Dementia (which was a disease that affected memory, thought, and interfered with daily life.)<br><br>Record review of Resident #1's Discharge MDS (unplanned), dated 10/10/2024, reflected the resident had a BIMS Score of 1. A BIMS Score of 1 indicated the resident had severe cognitive impairment.<br><br>Record review of Resident #1's CCP reflected a focus area, initiated on 8/22/2024/ revised on 8/22/2024, for potential to demonstrate physical behaviors related to dementia and poor impulse control. The CCP indicated on: 8/18/2024-he hit his roommate for messing with him while he was sleeping; 8/22/2024-resident to resident incident noted, resident held the arms of roommate's wheelchair slamming his wheelchair into his roommate's legs, yelling, cursing towards roommate. The Goal, initiated on 8/22/2024, revised on 8/22/2024, revealed a goal of fewer than 3 episodes per week of physical behavior. The interventions for nursing staff, initiated and revised both on 8/22/2024, revealed nursing staff was supposed to analyze of key times, places, circumstances, triggers, and what de-escalates behavior and document. Assess and address for contributing sensory deficits. Assess and anticipate Resident's needs: food, thirst. toileting needs, comfort level, body positioning, pain. Cognitive assessment. Communication: provide physical and verbal cues to alleviate anxiety; give positive feedback, assist verbalization of source of agitation, assist to set goals for more pleasant behavior, encourage seeking out of staff member when agitated. Evaluate for side effects of medications. Give resident as many choices as possible about care and activities. Modify environment; adjust room temperature to comfortable level, reduce noise, dim lights, place familiar objects in room, keep door closed. Document observed behavior and attempted interventions in behavior log. Monitor/document/report to MD of danger to self and others. Psychiatric/Psychogeriatric consult as indicated. Intervene before agitation escalates; Guide away from source of distress; Engage calmly in conversation; If response is aggressive, staff walk calmly away, and approach later.<br><br>(continued on next page) |

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| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Record review of Resident #1's PN, dated 8/18/2024 at 8:12 AM, reflected: Was reported that Resident #1 had hit his roommate, Resident #2, for messing with him while he was sleeping. Resident #1 says his roommate, Resident #2, was grabbing him while he was sleeping. Resident #1 said he warned Resident #2 the first time to get away. Resident #1 said Resident #2 grabbed him, so Resident #1 hit Resident #2 to get him away. Resident #1 did not remember where he hit Resident #2. Administrator and NP was informed. No new orders received. Resident #1 has been calm so far this morning and has not made complaints towards his roommate, Resident #2.<br><br>Record review of self-reported incidents, did not reflect a facility self-report for Resident #1 and Resident #2's altercation on 8/18/2024.<br><br>Record review of historical census information from 8/17/2024 to 8/22/2024, dated 10/29/2024, indicated Resident #1 changed rooms on 8/20/2024.<br><br>Recorded review of Resident #1's PN, dated 10/10/2024 at 2:54 PM, reflected the resident was DC to hospital. (Return not anticipated.)<br><br>Record review of the facility's incidents report from 8/22/2024 to 10/30/2024 did not reflect any resident-on-resident altercations involving Resident #1 or Resident #2.<br><br>Interview on 10/29/2024 at 2:39 PM with LVN A revealed she did not have an answer to why the Resident upon Resident interaction on 8/18/2024 between Resident #1 and Resident #2 was not reported to the state office.<br><br>Interview on 10/29/2024 at 2:43 PM with LVN B revealed she did not have an answer to why the Resident upon Resident interaction on 8/18/2024 between Resident #1 and Resident #2 was not reported to the state office.<br><br>Interview on 10/29/2024 at 2:45 PM with LVN C revealed she did not have an answer to why the Resident upon Resident interaction on 8/18/2024 between Resident #1 and Resident #2 was not reported to the state office.<br><br>Interview on 10/29/2024 at 3:00 PM with NP H revealed no recall of any information having pertained to Resident #1 and Resident #2's altercation, which occurred on 8/18/2024. When asked how she was mentioned in a PN of Resident #1, she stated, I do not work on the weekends and did not take any calls, 8/18/2024 was a Sunday.<br><br>Interview on 10/29/2024 at 4:00 PM with the ADM revealed the resident-on-resident incident, which occurred on 8/18/2024, between Resident #1 and Resident #2 was not reported to the state office because there were no injuries. The incident on 8/18/2024 did not make the ADM, or the staff, feel that Resident #1 was the aggressor towards Resident #2, nor did they feel that Resident #1 was a threat to other residents.<br><br>Resident #2<br><br>Record review or Resident #2's AR, dated 10/29/2024, reflected an [AGE] year-old male who admitted to the facility on [DATE]. He was diagnosed with Legal Blindness and Schizoaffective Disorder (which was a mental illness with both psychotic, and mood, fluctuations.)<br><br>(continued on next page) |

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| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Record review of Resident #2's Quarterly MDS, dated [DATE], reflected the resident had a BIMS Score of 4. A BIMS Score of 4 indicated the resident had severe cognitive impairment.<br><br>Record review of Resident #2's CCP reflected a focus area, initiated 7/27/2024 / revised 9/1/2024, for behavior problems evidenced by Alzheimer's Disease: up late at night, entering other people's rooms, grabbing at roommate, and taking things down from the walls. The goal, initiated on 7/27/2024, was for Resident #2 to have fewer episodes of restlessness. The intervention, revised on 9/1/2024, for nursing staff was to administer medications as ordered; anticipate and meet needs; create opportunity for positive interaction; explain procedures; monitor episodes and attempt to determine underlying cause; and provide a program of activities.<br><br>Record review of Resident #2's PN, dated 8/18/2024 at 8:36 AM, reflected: Last night, reported this morning, Resident #2 was messing with his roommate, Resident #1, and grabbing on him while he was trying to sleep. Resident #1 reported Resident #2 would not leave him alone after he told him to go away. Resident #1 resorted to hitting Resident #2 on his body.<br><br>Record review of Resident #2's PN, dated 8/18/2024 at 9:16 AM, reflected a skin assessment, with no new injuries from last night. On fading bruise to left upper arm. Skin discoloration to left elbow/forearm.<br><br>Record review of Resident #2's PN, dated 8/18/2024 at 10:57 AM, reflected hospice and RP #12 were at the facility and order received, from hospice, for 50 Milligrams of Seroquel (mood regulator) at bedtime. RP #12 saw Resident #2's bruise on left upper arm. Requested to speak to management.<br><br>Record review of Resident #2's PN, dated 8/20/2024 at 10:56 AM reflected Resident #2 was more confused and agitated than normal. Resident stated, [my roommate beat me up last night and gave me a concussion.]<br><br>Record review of Resident #2's PN, dated 8/20/2024 at 2:19 PM reflected Resident #2 received an order, from hospice, for 50 milligrams of Trazadone (a treatment for insomnia) at bedtime to ease resident's restlessness.<br><br>Observation and interview on 10/29/2024 at 10:10 AM with Resident #2 revealed him in his wheelchair in the memory care unit having just came from an activity. He was unable to recall any injuries or harm from another resident. No distress noted. He felt safe at the facility.<br><br>Interview and record review on 10/29/2024 at 6:00 PM with Resident #2's RP, RP #11, revealed he was made aware, by staff, about the incident with Resident #1 and Resident #2 on 8/18/2024. He did not know many details, but he did learn of a bruise on Resident #2's left upper arm from another one of Resident #2's RP, RP #12. RP #11 stated he went to the facility on [DATE] to look at Resident #2's arm and take a photo. Record review of a photo, provided by a RP #11 on 10/29/2024 at 6:17 PM, reflected a baseball sized bruise on Resident #2's left upper arm.<br><br>(continued on next page) |

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| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Interview on 10/29/2024 at 6:34 PM with RP #12 revealed RP #12 went to the facility on [DATE] between 8-9 AM. She stated she was told, from staff, about an incident between Resident #1 and Resident #2 when she arrived. She was not informed it was of a physical nature. While there, she noticed a bruise on Resident #2's left upper arm. The bruise was about a quarter in diameter and was purple. She reported Resident #2 told her, My roommate hit me because I was in his bed. She stated Resident #2 pointed to his left arm and to his lower abdomen area. RP #12 had visited Resident #2 the day before, 8/17/2024, and did not notice a bruise on Resident #2's arm because of long sleeves, but Resident #2 did not mention his arm being hurt.<br><br>Interview on 10/30/2024 at 3:01 PM with RN D revealed he responded to Resident #1 and Resident #2's resident to resident altercation on the morning on 8/18/2024. He stated he separated the two residents, after learning of the incident, and then told the ADM. RN D thought the incident was abuse and should have been reported in the 2 hours requirement. RN D stated, abuse was supposed to be reported within two hours to start a timely investigation. Timely responses help people remember details and the facts of the incidents stay fresh. If reporting was not timely, residents risked the abuse continuing or lead to other medical or psychosocial problems. He had attended training on ANE, ANE reporting, and Resident-on-Resident Altercations.<br><br>Interview on 10/30/2024 at 3:21 PM with LVN E revealed she was a charge nurse at the facility. The immediate response for resident-on-resident abuse was to separate the residents, calm the residents, make sure they were safe, and perform an assessment for injuries. Staff were trained to report allegations of abuse, or actual incidents of, to the ADM as soon as possible. The ADM had a 2 hour window to report incidents of abuse. LVN E had attended training on ANE, ANE reporting, Resident-on-Resident Altercations.<br><br>Interview on 10/30/2024 at 3:32 PM with CNA F revealed she had just started work at the facility. CNA F stated, the first thing to do when witnessing a resident-on-resident altercation is to separate the resident and make sure they were safe. The altercation was supposed to be reported immediately to the charge nurse and to the ADM. She just attended an in-service training where she learned incidents of abuse needed to be reported to the state within 2 hours. She had taken training on dementia care and resident upon resident abuse. She had not witnessed any resident-on-resident altercations while at the facility.<br><br>Interview on 10/30/2024 at 3:38 PM with CNA G revealed he had been working at the facility for 3 years. He stated he had participated in in-service trainings for Abuse, Neglect, and Resident-on-Resident Altercations. Examples of abuse were physical, emotional, and sexual; physical abuse examples were hitting or pushing; Emotional abuse examples were being rude, not being respectful, or discounting feelings; sexual abuse examples were inappropriately touching private parts, unwanted sex, unwanted touching. Allegations of ANE, or resident harm, were supposed to be reported to the charge nurse and the ADM immediately.<br><br>Interview on 10/30/2024 at 4:10 PM with the ADM revealed the decision not to report the incident on 8/18/2024 with Resident #1 and Resident #2 was the ADM's choice, not of the other leadership staff. He reiterated he did not feel any intervention for Resident #1 would have had any positive effect on Resident #1's behaviors. He did not feel there was any failure on his staff to have not updated Resident #1's CCP with a behavior intervention after 8/18/2024 .<br><br>(continued on next page) |

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| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Record review of the facility's Coordinating/Implementing Abuse, Neglect and Exploitation Policies and Procedures, dated April 2021, reflected policies were in place to prohibit and prevent resident abuse, neglect, exploitation, or misappropriation of resident property, reporting and response to investigations, the Administrator having the overall responsibility for the coordination and implementation of facility policy.<br><br>Record review of the facility's Abuse, Neglect, Exploitation or Misappropriation- Reporting and Investigating Policy, dated September 2022, reflected if resident abuse, neglect, exploitation, misappropriation of resident property or injury of an unknown source is suspected, the suspicion must be reported immediately to the administrator and to other officials according to state law. Immediately is defined as: within two hours of an allegation involving abuse or result in serious bodily injury or within 24 hours of an allegation that does not involve abuse or result in serious bodily injury. Within 5 business days of the incident, the administrator will provide a follow-up investigation report.<br><br>Record review of the facility's Identifying Types of Abuse Policy, dated September 2022, reflected Physical Abuse of any kind against residents is strictly prohibited. Abuse is defined as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. Abuse toward a resident can occur as resident to resident abuse, staff or resident abuse, or visitor to resident abuse. Physical abuse includes, but is not limited to hitting, slapping, biting, punching, or kicking. Some situations of abuse do not result in an observable physical injury for the cycle social effects of abuse may not be immediately apparent.<br><br>Record review of the facility's Abuse and Neglect- Clinical Protocol Policy, dated March 2018, reflected abuse defined as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. Willful defined as acting deliberately, not that the individual must have intended to inflict injury or harm. The facility management and staff will institute measures to address the needs of residents and minimize the possibility of abuse and neglect.<br><br>Record review of the facility's Protection of Residents During Abuse Investigations, dated April 2021, reflected the victim is evaluated for his, or her, feelings of safety. If he or she communicates fear or insecurity, measures are taken to alleviate. Examples are changing the room assignment or providing more supervision. If the alleged abuse involved another resident, there may be restrictions on the accused resident's freedom to visit other resident's rooms unattended.<br><br>Record review of the facility's Resident-to-Resident Altercation Policy, dated September 2022, reflected occurrences of such incidents were reported to the ADM. If two residents engaged in an altercation, staff were to review the events with nursing supervisor and DON and evaluate the effectiveness of interventions meant to address distressed behaviors for one, or both, residents. The ADM, who would report in accordance with the reporting criteria, would do so within two hours of the allegation involving abuse. |

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| F 0656<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47772<br><br>Based on interviews and record review, the facility failed to develop and implement a CCP for 1 or 3 residents (Resident #1) reviewed for CCP.<br><br>1. The facility failed to implement care plan interventions for Resident #1, after Resident #1's physically abused Resident #2 on 8/18/2024, to protect other facility residents.<br><br>This failure could have placed the facility residents at risk of physical harm and mental anguish.<br><br>Findings included:<br><br>Resident #1<br><br>Record review or Resident #1's AR, dated 10/29/2024, reflected a [AGE] year-old male who admitted to the facility on [DATE]. He was diagnosed with Dementia (which was a disease that affected memory, thought, and interfered with daily life.)<br><br>Record review of Resident #1's Discharge MDS (unplanned), dated 10/10/2024, reflected the resident had a BIMS Score of 1. A BIMS Score of 1 indicated the resident had severe cognitive impairment.<br><br>Record review of Resident #1's CCP reflected a focus area, initiated on 8/22/2024/ revised on 8/22/2024, for potential to demonstrate physical behaviors related to dementia and poor impulse control. The CCP indicated on: 8/18/2024-he hit his roommate for messing with him while he was sleeping; 8/22/2024-resident to resident incident noted, resident held the arms of roommate's wheelchair slamming his wheelchair into his roommate's legs, yelling, cursing towards roommate. The Goal, initiated on 8/22/2024, revised on 8/22/2024, revealed a goal of fewer than 3 episodes per week of physical behavior. The interventions for nursing staff, initiated and revised both on 8/22/2024, revealed nursing staff was supposed to analyze of key times, places, circumstances, triggers, and what de-escalates behavior and document. Assess and address for contributing sensory deficits. Assess and anticipate Resident's needs: food, thirst. toileting needs, comfort level, body positioning, pain. Cognitive assessment. Communication: provide physical and verbal cues to alleviate anxiety; give positive feedback, assist verbalization of source of agitation, assist to set goals for more pleasant behavior, encourage seeking out of staff member when agitated. Evaluate for side effects of medications. Give resident as many choices as possible about care and activities. Modify environment; adjust room temperature to comfortable level, reduce noise, dim lights, place familiar objects in room, keep door closed. Document observed behavior and attempted interventions in behavior log. Monitor/document/report to MD of danger to self and others. Psychiatric/Psychogeriatric consult as indicated. Intervene before agitation escalates; Guide away from source of distress; Engage calmly in conversation; If response is aggressive, staff walk calmly away, and approach later.<br><br>(continued on next page) |

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| F 0656<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Record review of Resident #1's PN, dated 8/18/2024 at 8:12 AM, reflected: Was reported that Resident #1 had hit his roommate, Resident #2, for messing with him while he was sleeping. Resident #1 says his roommate, Resident #2, was grabbing him while he was sleeping. Resident #1 said he warned Resident #2 the first time to get away. Resident #1 said Resident #2 grabbed him, so Resident #1 hit Resident #2 to get him away. Resident #1 did not remember where he hit Resident #2. Administrator and NP was informed. No new orders received. Resident #1 has been calm so far this morning and has not made complaints towards his roommate, Resident #2.<br><br>Record review of self-reported incidents, did not reflect a facility self-report for Resident #1 and Resident #2's altercation on 8/18/2024.<br><br>Record review of historical census information from 8/17/2024 to 8/22/2024, dated 10/29/2024, indicated Resident #1 changed rooms on 8/20/2024 to reside with Resident #3.<br><br>Record review of Resident #1's PN, dated 8/20/2024 at 11:36 AM revealed the presence of a UTI (which was the presence of bacteria in the urethra and bladder.) Resident was alert and mildly confused.<br><br>Record review of Resident #1's PN, dated 8/22/2024 at 6:15 AM, reflected: This nurse was sitting at the desk and heard yelling coming from Resident #1 and Resident #3's room. Upon entering room, Resident #1 was found with his Resident #3's wheelchair and Resident #3 sitting on the side of Resident #1's bed. Resident #1 was holding the arms of the wheelchair slamming it into Resident #3's legs yelling I'm going to kill you shut your mouth Resident #3 was yelling Mother F*****<br><br>Record review of an intake, dated 8/22/2024, reflected a resident-on-resident abuse between Resident #1 and Resident #3 on 8/22/2024.<br><br>Record review of Resident #1's PN, dated 8/22/2024 at 1:39 PM reflected Resident #1 moved to his private room in the memory Care Unit.<br><br>Record review of historical census information from 8/17/2024 to 8/22/2024, dated 10/29/2024, indicated Resident #1 changed rooms on 8/22/2024 with no assigned roommate.<br><br>Record review of Resident #1's PN, dated 8/22/2024 at 7:31 PM reflected an order for 50 Milligrams of Seroquel (mood regulator) at bedtime.<br><br>Record review of Resident to Resident incident in Resident #1's PN, dated 8/22/2024 at 9:10 AM, reflected Resident #1 did not have any injuries. Breathing-normal; facial expression-sad; frightened; frown; body language-tensed; console needed-distracted/reassured by voice or touch. Resident alert. Predisposing psychological factors-confusion; dementia; impaired memory. Predisposing situational factor-recent room change.<br><br>Record review of Resident #1's PN, dated 8/23/2024 at 9:46 AM, reflected: IDT Event Review<br><br>Name of IDT participating in review: Administrator, DON, ADON, MDS (C)<br><br>*Event Being Reviewed: Resident #1 to Resident #3 incident on 8/22/2024.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 455638 | A. Building<br>B. Wing | 10/30/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Greenview Nursing and Rehabilitation | 401 Owen LN<br>Waco, TX 76710 |

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|---|---|
| F 0656<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | *Root Cause Analysis for event: Resident #3 was cursing at Resident #1 because he was getting into the Resident #3's snacks and ate all of them. Per responsible party, it was noted that Resident #1 got aggressive when consuming sugary items. Resident #1, confused and aggressive, pushed a wheelchair into his roommate's legs to get him to stop cursing at him.<br><br>*Interventions initiated and residents' response / compliance with Intervention: Resident #1 and Resident #3 separated and assessed for injury.<br><br>*New Interventions suggested following current IDT review: Resident #1 room changed.<br><br>Record review of Resident #1's post event head to toe skin check PN, dated 8/23/2024 at 12:32 PM, reflected no new skin issues, no apparent injuries.<br><br>Recorded review of Resident #1's PN, dated 10/10/2024 at 2:54 PM, reflected the resident was DC to hospital. (Return not anticipated.)<br><br>Record review of the facility's incidents report from 8/22/2024 to 10/30/2024 did not reflect any resident-on-resident altercations involving Resident #1, Resident #2, Resident #3.<br><br>Interview on 10/29/2024 at 3:00 PM with NP H revealed no recall of any information having pertained to Resident #1 and Resident #2's altercation, which occurred on 8/18/2024. When asked how she was mentioned in a PN of Resident #1, she stated, I do not work on the weekends and did not take any calls, 8/18/2024 was a Sunday.<br><br>Interview on 10/29/2024 at 4:00 PM with the ADM revealed the resident-on-resident incident, which occurred on 8/18/2024, between Resident #1 and Resident #2 was not reported to the state office because there were no injuries. The incident on 8/18/2024 did not make the ADM, or the staff, feel that Resident #1 was the aggressor towards Resident #2, nor did they feel that Resident #1 was a threat to other residents. On 8/22/2024, Resident #1 engaged in a resident-on-resident altercation with Resident #3. The incident with Resident #1 and Resident #3 was reported to the state office because the situation was discovered quickly by staff, was reported as possible physical contact, but resulted with no injuries. The ADM did not feel that Resident #1 was the aggressor in the incident with Resident #3. After the incident with Resident #1 and Resident #3, Resident #1 was moved to a private room on the Memory Care Unit. The ADM did not think a lack of any action, such as updating Resident #1's CCP after the incident on 8/18/2024, would have stopped the incident on 8/22/2024.<br><br>Resident #2<br><br>Record review or Resident #2's AR, dated 10/29/2024, reflected an [AGE] year-old male who admitted to the facility on [DATE]. He was diagnosed with Legal Blindness and Schizoaffective Disorder (which was a mental illness with both psychotic, and mood, fluctuations.)<br><br>Record review of Resident #2's Quarterly MDS, dated [DATE], reflected the resident had a BIMS Score of 4. A BIMS Score of 4 indicated the resident had severe cognitive impairment.<br><br>(continued on next page) |

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| | 455638 | A. Building<br>B. Wing | 10/30/2024 |

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| Greenview Nursing and Rehabilitation | 401 Owen LN<br>Waco, TX 76710 |

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| F 0656<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Record review of Resident #2's CCP reflected a focus area, initiated 7/27/2024 / revised 9/1/2024, for behavior problems evidenced by Alzheimer's Disease: up late at night, entering other people's rooms, grabbing at roommate, and taking things down from the walls. The goal, initiated on 7/27/2024, was for Resident #2 to have fewer episodes of restlessness. The intervention, revised on 9/1/2024, for nursing staff was to administer medications as ordered; anticipate and meet needs; create opportunity for positive interaction; explain procedures; monitor episodes and attempt to determine underlying cause; and provide a program of activities.<br><br>Record review of Resident #2's PN, dated 8/18/2024 at 8:36 AM, reflected: Last night, reported this morning, Resident #2 was messing with his roommate, Resident #1, and grabbing on him while he was trying to sleep. Resident #1 reported Resident #2 would not leave him alone after he told him to go away. Resident #1 resorted to hitting Resident #2 on his body.<br><br>Record review of Resident #2's PN, dated 8/18/2024 at 9:16 AM, reflected a skin assessment, with no new injuries from last night. On fading bruise to left upper arm. Skin discoloration to left elbow/forearm.<br><br>Record review of Resident #2's PN, dated 8/18/2024 at 10:57 AM, reflected hospice and RP #12 were at the facility and order received, from hospice, for 50 Milligrams of Seroquel (mood regulator) at bedtime. RP #12 saw Resident #2's bruise on left upper arm. Requested to speak to management.<br><br>Record review of Resident #2's PN, dated 8/20/2024 at 10:56 AM reflected Resident #2 was more confused and agitated than normal. Resident stated, [my roommate beat me up last night and gave me a concussion.]<br><br>Record review of Resident #2's PN, dated 8/20/2024 at 2:19 PM reflected Resident #2 received an order, from hospice, for 50 milligrams of Trazadone (a treatment for insomnia) at bedtime to ease resident's restlessness.<br><br>Observation and interview on 10/29/2024 at 10:10 AM with Resident #2 revealed him in his wheelchair in the memory care unit having just came from an activity. He was unable to recall any injuries or harm from another resident. No distress noted. He felt safe at the facility.<br><br>Interview and record review on 10/29/2024 at 6:00 PM with Resident #2's RP, RP #11, revealed he was made aware, by staff, about the incident with Resident #1 and Resident #2 on 8/18/2024. He did not know many details, but he did learn of a bruise on Resident #2's left upper arm from another one of Resident #2's RP, RP #12. RP #11 stated he went to the facility on [DATE] to look at Resident #2's arm and take a photo. Record review of a photo, provided by a RP #11 on 10/29/2024 at 6:17 PM, reflected a baseball sized bruise on Resident #2's left upper arm.<br><br>Interview on 10/29/2024 at 6:34 PM with RP #12 revealed RP #12 went to the facility on [DATE] between 8-9 AM. She stated she was told, from staff, about an incident between Resident #1 and Resident #2 when she arrived. She was not informed it was of a physical nature. While there, she noticed a bruise on Resident #2's left upper arm. The bruise was about a quarter in diameter and was purple. She reported Resident #2 told her, My roommate hit me because I was in his bed. She stated Resident #2 pointed to his left arm and to his lower abdomen area. RP #12 had visited Resident #2 the day before, 8/17/2024, and did not notice a bruise on Resident #2's arm because of long sleeves, but Resident #2 did not mention his arm being hurt.<br><br>(continued on next page) |

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| F 0656<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Resident #3<br><br>Record review or Resident #3's AR, dated 10/29/2024, reflected a [AGE] year-old male who admitted to the facility on [DATE]. He was diagnosed with Hemiplegia (which was one-sided paralysis,) Hemiparesis (which was one-sided muscle weakness,) and Speech and Language deficits.<br><br>Record review of Resident #3's Quarterly MDS, dated [DATE], reflected the resident did not receive a BIMS Assessment, due to rarely/never understood. By staff assessment, cognitive skills for daily decision making were consistent and reasonable.<br><br>Record review of Resident #3's CCP reflected a focus area, initiated on 3/29/2021, evidenced by physical aggression towards other residents. The goal, revised on 11/23/2022, was for resident to demonstrate effective coping skills and not harm self or others. The intervention, initiated on 3/29/2021, was for nursing staff to administer medications as ordered; analyze times of day and location; assess and address sensory deficits; anticipate needs; communication; provide choices; observe and document; and intervene before agitation escalates. A focus area, initiated on 4/19/2024, for potential to demonstrate physical behaviors R/T anger, history of harm to others, and poor impulse control: pushed his rollator walker into his roommate's leg on 6/28/2024. The goal, revised on 6/23/2024, was for resident to verbalize understanding of need to control physical aggressive behavior. The intervention, initiated 6/28/2024, was for nursing staff to analyze times of day and location; assess and address sensory deficits; anticipate needs; observe and document; evaluate side effects of medication; and psychiatric consult, as necessary. A focus, initiated on 8/22/2022, for potential behavior problems R/T heart conditions and anxiety: Resident to Resident incident-resident held arms of roommate's wheelchair slamming his wheelchair into his roommate's legs-yelling and cursing. The goal, initiated on 8/22/2024, was that resident would have fewer episodes of physical behavior. The intervention, initiated on 8/22/2024, for nursing staff was to administer medications as ordered; develop appropriate methods to cope; create opportunity for positive interaction; intervene as necessary to protect others; monitor episodes and attempt to determine underlying cause; and provide a program of activities.<br><br>Record review of Resident to Resident incident in Resident #3's PN, dated 8/22/2024 at 9:10 AM, reflected Resident #3 did not have any injuries. Breathing-normal; facial expression-smiling, or inexpressive; body language-relaxed; console needed-no need to console. Oriented to person, place, situation. Predisposing situational factor-dislikes roommate/exhibiting behaviors.<br><br>Record review of Resident #3's PN, dated 8/23/2024 at 9:58 AM, reflected: IDT Event Review<br><br>Name of IDT participating in review: Administrator, DON, DOR, ADON, MDS<br><br>*Event Being Reviewed: Resident to resident 8/22/2024<br><br>*Root Cause Analysis for event: Resident #3 started cussing at his roommate, Resident #1, because was taking and consuming all his snacks. The roommate, Resident #1, became aggressive and started pushing Resident #3's wheelchair into his legs while yelling at him.<br><br>*Interventions initiated and residents' response/compliance with Intervention: Residents were separated and assessed.<br><br>(continued on next page) |

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| | 455638 | A. Building<br>B. Wing | 10/30/2024 |

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|---|---|
| F 0656<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | *New Interventions suggested following current IDT review: Resident #1 moved to alternate room.<br><br>Record review of Resident #3's post event head to toe skin check PN, dated 8/23/2024 at 12:25 PM, reflected no new skin issues, no apparent injuries, Range of motion within normal limits, denied pain or injury to head.<br><br>Observations on 10/29/2024 at 10:39 AM with Resident #3 revealed him receiving assistance with personal hygiene. No distress noted.<br><br>Interview on 10/29/2024 at 10:45 PM with Resident #3 revealed he could not remember and details about the resident-on-resident altercation on 8/22/2024. He did verbalize with tones and facial expressions that he was not hurt; he confirmed with tones and facial expressions that he was not harmed; they were just yelling. He confirmed with tones and facial expressions that he felt safe at the facility.<br><br>Interview on 10/30/2024 at 10:26 AM with Resident #3's RP, RP #13, revealed she was informed about the resident-on-resident altercation on 8/22/2024. RP #13 did not have concerns for Resident #3's safety. She felt Resident #3 was safe at the facility.<br><br>Observations on 10/30/2024 at 2:21 PM of a resident group activity, in the facility dining room, revealed a peaceful atmosphere with staff and resident participation. Adequate staff were present. No disturbances: residents were calm.<br><br>Interview on 10/30/2024 at 3:01 PM with RN D revealed he responded to Resident #1 and Resident #2's resident to resident altercation on the morning on 8/18/2024. He stated he separated the two residents, after learning of the incident, and then told the ADM. RN D thought the incident was abuse and should have been reported in the 2 hours requirement. RN D stated, abuse was supposed to be reported within two hours to start a timely investigation. Timely responses help people remember details and the facts of the incidents stay fresh. If reporting was not timely, residents risked the abuse continuing or lead to other medical or psychosocial problems. He had attended training on ANE, ANE reporting, and Resident-on-Resident Altercations.<br><br>Interview on 10/30/2024 at 3:49 PM with the LVN C revealed she had not attended an IDT team meeting to discuss the Resident #1 and Resident #2 incident that occurred on 8/18/2024. She stated she learned about the Resident #1 and Resident #2 incident the next day, which was Monday 8/19/2024. The incident on 8/18/2024 was a form of abuse and should have been reported to the state agency. Resident #1's CCP should have been updated as soon as possible to address negative outcomes and to keep residents safe. If the incident on 8/18/2024 had been addressed in Resident #1's CCP, the incident on 8/22/2024 could have been avoided. It could have been avoided by having Resident #1 in a private room or having chosen a better roommate.<br><br>(continued on next page) |

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| | 455638 | A. Building<br>B. Wing | 10/30/2024 |

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| F 0656<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Interview on 10/30/2024 at 4:10 PM with the ADM revealed the decision not to report the incident on 8/18/2024 with Resident #1 and Resident #2 was the ADM's choice, not of the other leadership staff. He reiterated he did not feel any intervention for Resident #1, stemming from the incident on 8/18/2024, would have had any positive effect on, or stop, the incident with Resident #1 and Resident #3 on 8/22/2024; therefore, there was no CCP update for Resident #1, post the resident-on-resident incident on 8/18/2024. CCP updates were made after Resident #1 and Resident #3's resident altercation on 8/22/2024. There was no direction in the facility's Comprehensive Care Plan to address timeliness of updates. He did not feel there was any failure on his staff to have not updated Resident #1's CCP with a behavior intervention after 8/18/2024.<br><br>Record review of the facility's CCP Policy, dated December 2016, reflected the CCP will contain measurable objectives and timeframes; describe these services that are being furnished to attain or maintain their residence highest practical physical, mental, and psychosocial well-being; and incorporate risk factors associated with identified problems, such as identify the professional services that are responsible for each element of care. The IDT must review and update the CCP when the desired outcome has not been met. |