STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455715	A. Building B. Wing	07/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Monument Rehabilitation and Nursing Center	120 State Loop 92 LA Grange, TX 78945

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30633 Based on observations, interviews, and record review the facility failed to ensure the residents were free from abuse, neglect, misappropriation of resident property, and exploitation for one (1) of five (5) residents reviewed for abuse. The facility failed to protect Resident #1 from abuse when staff yelled at her when asking for assistance via call light. The noncompliance was identified as Past Noncompliance 07/30/24. The noncompliance began on 07/22/24 and ended on 07/29/24. The facility had corrected the noncompliance before the survey began. These failures placed residents at risk of experiencing and enduring abuse by facility staff causing decreased quality of life. Findings Included: Review of the Face Sheet for Resident #1 reflected she was admitted on [DATE] with diagnosis of: Hemiplegia to left side, Metabolic encephalopathy, Hx of Traumatic Brain Injury, Muscle wasting and atrophy, epilepsy, Unspecified convulsions, need for personal care. Review of the quarterly MDS assessment for Resident #1 dated 6/11/24 reflected a BIMS score of 15 indicating normal cognitive function. Her physical assessment reflected she required substantial assistance for eating, hygiene and dressing. She could accomplish some ADLs with one person assistance. She was assessed as always incontinent of bowel and bladder. Review of the Care Plan for Resident #1 reflected interventions were in place for: Full Code status, ADL performance deficit, History of Falls/Hemiplegia, Antidepressant medication, Anticoagulant medication, Chronic Pain r/t pelvic fracture and vertebrae fractures. Review of the Face Sheet for Resident #21 reflected she was admitted on [DATE] with diagnoses of: Myopathy, Morbid Obesity, Hypothyroidism, Congestive Heart Failure, Muscle wasting and atrophy and Peripheral Vascular disease. (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: 455715	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/31/2024
NAME OF PROVIDER OR SUPPLIER Monument Rehabilitation and Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 120 State Loop 92 LA Grange, TX 78945	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the MDS assessment for Resident #21 dated 6/13/24 reflected a BIMS score of 15 indicating normal cognitive function. Her physical assessment reflected she had impairment to both arms and legs, she required one person assist for eating and grooming and extensive assistance in all other ADLs. She was assessed as always incontinent of bowel and bladder. Review of the Care Plan for Resident #21 reflected interventions were in place for: her DNR status, ADL self performance deficit, a history of falls, a UTI, Chronic back pain, Psych history related to sexual assault. In an interview on 7/29/24 at 9:10 am Resident #1 stated she felt fine, and she got along well with facility staff. She stated the one aide was the only one that had ever spoken badly to her. She stated she did not like to discuss the matter because the aide was disrespectful to her and talked to her like a child. In an interview on 7/29/24 at 9:15 am Resident #21 stated she had overheard the conversation between the CNA and Resident #1. She stated when Resident #1 first pushed her call light it was for assistance to the toilet. She stated the aide came in and said she would be right back. Resident #21 stated Resident #1 then pushed the call light about five more times. She stated the aide came back and yelled and cussed at Resident #1. She stated she didn't hear everything, but the aide was mean and warned Resident #1 not to push the call light anymore. In an interview on 7/30/24 at 1:36 pm the Administrator stated the employee named in the Abuse/Neglect allegation involving Resident #1 and her roommate Resident #21. The Administrator stated the employee was terminated for inappropriate behavior towards a resident. He stated he interviewed Resident #1, and she confirmed the staff was rude. The Administrator stated the Resident's room-mate Resident #21 stated she overheard and felt the aide had a bad attitude and was disrespectful. The Administrator stated no other reports of bad behavior were found in interviews with other residents. He stated in his interview with the can she denied speaking inappropriately or using cuss words. The Administrator stated no harm was assessed to either resident. In an interview on 7/30/24 at 3:15 pm the DON stated the incident involving Resident #1 and #21 had been investigated. She stated the facility had an aide who was not always polite with residents. She stated Resident #1 informed her the aide talked down to her like she was a child. The DON stated the roommate, Resident #21, confirmed the aide was grouchy with Resident #1. The DON stated no psychological harm was assessed. The DON stated the social worker did a Harm Survey with all able residents and no other residents had any complaints related to the allegations. In an interview on 7/30/24 at 4:00 pm LVN L stated neither Residents #1 nor #21, had any changes in behavior after the incident involving the aide. LVN L stated Resident #21 had complained about the aide stating she yelled at Resident #1 and cussed at her to stop using her call light. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the investigation report by the facility completed on 7/29/24 reflected the facility had substantiated the CNA was verbally inappropriate or abusive. The investigation started on 7/22/24 when Resident #1's family member reported via telephone that the Resident was treated ugly and disrespectfully by the CNA. The aide was suspended, and the physician, RP, and Sheriff department were notified. A head-to-toe assessment reflected no new injuries. Resident #1 denied any psychological stress. Interviews with other residents were conducted. Residents #1 and her roommate, Resident #21, were interviewed by the administrator. The interviews reflected the CNA was loud, inappropriate, and yelled at Resident #1 for putting her call light on too many times. The Administrator interviewed the alleged perpetrator who denied doing anything wrong. She stated Resident #1 put on her call light multiple times and she told her after getting her up she was going to keep her in her wheelchair. She stated she did not yell, the resident took it wrong. Review of the CNA's written statement dated 7/22/24 reflected she went to answer Resident #1's call light and she asked for a pain pill. She stated she would inform the nurse, and the nurse stated it would be 45 more minutes before she could have a pain pill per her physician's orders. The CNA stated Resident #1 put on the call light five more times asking for a pain pill. The CNA stated she took Resident #1 to the bathroom and placed her in a regular wheelchair as Resident #1's electric chair was still charging. Her statement also reflected she had informed Resident #1 the nurse wanted her to sit up in the wheelchair for a while after her lunch. Review of the Abuse Neglect and Exploitation Policy dated 8/15/22 reflected a definition of Verbal Abuse which included the use of disparaging or derogatory terms to residents. The CNA had completed training on abuse neglect at the time of her employment. Review of the facility policy Promoting Resident Dignity dated 1/13/23 reflected the employees were to protect and promote Resident rights and treat each resident with respect and dignity. Resident requests will be responded to in a timely manner. Staff were to speak respectfully to residents, discussions should not be overheard by others. The noncompliance was identified as Past Noncompliance 07/30/24. The noncompliance began on 07/22/24 and ended on 07/29/24. The facility had corrected the noncompliance before the survey began.