STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455834	A. Building B. Wing	11/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
South Place Rehabilitation and Skilled Nursing	150 Gibson Rd Athens, TX 75751

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 - 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** 19401 Based on observation, record review and interview the facility failed to ensure a resident had the right to be free from abuse for 1 of 7 residents reviewed for abuse (Resident #1). LVN E and CNA D witnessed CNA C abusing Resident #1. CNA C hit Resident #1 and was allowed to remain in the facility for over three hours with access to Resident #1 and other Residents. The noncompliance was identified as PNC (past non-compliance). The IJ (Immediate Jeopardy) began on 4/19/24 and ended 4/19/24. The facility had corrected the noncompliance before the survey began. The facility failures could have caused residents serious physical injury. Findings Included: Record review of Resident #1's face sheet indicated she was an [AGE] year-old female admitted to the facility on [DATE]. She had a diagnosis of Alzheimer's disease (progressive disease that destroys memory), and unsteadiness on feet. Record review of Resident #1's Quarterly MDS dated [DATE] indicated she was severely cognitively impaired with a BIMS score of 5. The MDS did not indicate any mood or behavior issues. The resident required substantial to maximum assist with all ADLS except eating, and oral hygiene. Record review of Resident #1's care plan indicated a problem start date of 1/7/22 of frequent incontinence of bowel and bladder. An approach was to provide peri care after each incontinent episode. The plan indicated a problem of ADL Self Care Performance Deficit. Some of the approaches were the resident required maximum assist for bathing, supervised assist for bed mobility, and one person assist for toileting. The plan indicated a problem of Cognitive loss due to dementia. One of the approaches was to provide the resident with necessary cues, stop, and return if the resident was agitated. (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 - Few	Record review a Provider Investigation Report indicated an incident occurred on 4/19/24 at 3:30 a.m. The report indicated LVN E and CNA D witnessed CNA C hit Resident #1 in the stomach area. The nurse heard Resident #1 screaming and yelling in her room. The nurse went to assess the resident in her room. When the nurse opened the door, CNA C was changing Resident #1. The resident was grabbing the blankets and yelling to get CNA C away from her and for CNA C to leave her alone. CNA C was seen balling up her fist on her right hand and to hit Resident #1 on her right side in the rib area. The nurse immediately yelled what are you doing? You cannot do that. CNA C stated, I'm tired of her pinching The investigation indicated Resident #1 was assessed by LVN E on 4/19/24 at 3:45 a.m. with no visible injuries noted and no complaints of pain. CNA C was suspended pending investigation 4/19/24 at 6:30 a.m. The resident received another head-to-toe assessment on 4/19/24 at 10:00 a.m. with no injuries noted from this morning's incident. The family, the physician and the police department were notified. LVN E and CNA D were given one on one education on 4/19 by the DON regarding the importance of reporting allegations of abuse immediately. LVN E and CNA D were issued a three-day suspension on 4/19/2024 for failing to report allegations of abuse immediately. CNA C was terminated due to abuse allegation on 4/19/24 being confirmed. All interview able residents were interviewed by the administrator and social worker regarding abuse on 4/19/24. All non-resident received head to toe assessment, to assess for any injuries or evidence of abuse, by Nurses on 4/19/24. The direct care staff were interviewed on 4/19/24 by the administrator and DON regarding abuse and reporting requirements. The Abuse/Reportable Event policy was reviewed on 4/19/24 at 11:00 a.m. by the Administrator, Regional Director of Operations, Regional Nurse, and DON no changes made to the policy at this time. The DON provided education to all staff regarding abuse/reportable events policy, including types of abuse, and reporting requirements all staff present in the facility were educated on 4/19/24. Staff that were not present for education would receive the education prior to their next shift. The social services, Director or design would continue to interview and assess Resident #1 for emotional distress. During an observation and interview on 11/25/24 at 3:10 p.m. Resident #1 was sitting in a wheelchair by the nursing station. She said she was fine; she said she was still breathing. The rest of her conversation was about her childhood. She was unable to answer any questions about the incident. Attempts were made to contact CNA C, but phone numbers for her appeared to be disconnected. During an interview on 11/26/24 at 11:40 a.m. the Administrator said after the incident with Resident #1 he did interviews with all staff available at that time. He said he was notified on 4/19/24 around 6:00 a.m. of the abuse. He said CNA C had already left, and he talked to CNA C on the phone. He said at first, CNA C denied the incident. He said he told her he had two witnesses, she seemed frustrated, and did not say much. He said she just asked if she was terminated. He said they had implemented corrective actions such as terminating CNA C immediately, calling the police, the physician and updated Resident #1's care plan. He said they monitored Resident #1 for three days after the incident from 4/19/24 through 4/22/24, and they completed safe surveys with Resident #1 on each shift to make sure she did not have any reoccurring memories of the event. He said CNA C went home that morning and she never came back. The Administrator said he received statements from LVN E and CNA D, they did specific in services with LVN E and CNA D. He said they conducted safe surveys with the residents and follow up interviews with any concerns voiced by residents and there no concerns with abuse. The Administrator said they conducted skin assessments on all the residents. He said they also talked to staff about burn out and he conducted regular training on abuse, at least once a month. (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 - Few	During a telephone interview on 11/26/24 at 10:38 a.m. CNA D said Resident #1 had never hit or scratched her. She said the incident happened on the 10 to 6 a.m. shift on 4/19/24. CNA D said it could have been the way the aide approached Resident #1 in the middle of the night to make her resistive to care. She said Resident #1 was clutching the covers and saying, Stop leave me alone. She said she did not see Resident #1 trying to strike CNA C. CNA D said she was sitting in the lounge and LVN E was sitting at the nursing station. She said they kept hearing through the door a resident grunting and saying, no and stop can D said at first, they did not know which room the noise was coming from, there were two rooms right by the nurse's station. She said they thought someone had fallen. She said she had gotten up to follow the nurse. When LVN E opened Resident #1's, she opened the door abruptly. CNA D said as the door opened CNA C had her forearm up with her fist balled up and hit Resident #1 in the stomach area. CNA D said she could see CNA C and Resident #1 quite well. She said all CNA C said was I am tired of her hitting and scratching me. CNA D said LVN E told her she could not do that and to leave the room. CNA D said CNA C walked out of the room. She said Resident #1 was saying to get CNA C out of her room and she appeared upset at the time, but later she was back to her old self. CNA D said it appeared Resident #1 had forgotten the incident. She said she was in shock because had worked with CNA C a long time and had not expected that type of behavior from her. During a telephone interview on 11/26/24 at 2:24 p.m. LVN E said she was sitting at the nursing station and heard a resident saying stop. She said she kept hearing words, grunting, and wanted to know where the noise was coming from. She said she and CNA D opened Resident # 1's and saw CNA C appeared to have just changed Resident #1. LVN E said Resident #1 was holding tight to the covers. She said CNA C was standing facing the door, over Resident #1 and the bed. She said CNA C was yakking on the covers, bulled up her fist, and punched Resident #1 in her side area. LVN E said she told the aide she could not do that, and to leave the room. She said CNA C left the room. LVN E said she assessed Resident #1 after the incident. She said she had two or three blankets on her, and there was no redness or busies. She said Resident #1 said she did not want CNA C in her room and for CNA C to leave her alone. She said she had gone back later, and Resident #1 was asleep. She said she and CNA D had gone in later to provide care to Resident #1 on the last round of the night and she appeared fine. The LVN said she knew to protect Resident #1 and get the aide away from the Resident #1. LVN E said she and CNA D were both in disbelief at the actions of CNA C. LVN E said CNA C disappeared for about 30 minutes. She finished working that night, but she was not allowed to go back into Resident #1's room. The LVN said she had never had anything like that happen before and her concern was protecting Resident #1. LVN E said she did not report the incident until the end of her shift. She said she was written up and in serviced on abuse and reporting. She said the next time she would notify they Administrator and everybody. Record review of the facility policy on Abuse/Reportable Events (not dated) indicated all residents have the right to be fee from abuse. Resident should not be subjected to abuse by anyone. The facility will provide and ensure the promotion and protection of resident's rights. Abuse is the willful infliction of injury. Willful individual must have intended to inflict injury or harm. Physical abuse includes hitting, slapping, pinching, and kicking. The facility took the following actions to correct the noncompliance on 4/19/24. Record review of Resident #1's care plan indicated a problem with a start date of 4/19/24 of psychosocial wellbeing, the resident was a victim of abuse related to an inappropriate interaction by staff. Some of the approaches were the resident received a full head to toe skin assessment. She would have emotional distress monitoring every shift for 72 hours. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of Resident #1's skin assessment dated [DATE] indicated no new areas. Review of Safe Surveys indicated a questionnaire was completed on Resident #1 each shift from 4/19/24 through 4/22/24 with no concerns noted. Record review of one-hour checks indicated they were completed on Resident #1 every hour with her vital signs from 4/19/24 through 4/22/24. Record review of Abuse pre and posttest and Abuse/Reporting in service was completed on 4/19/24 by more than 70 staff to include all departments and agency staff. The in service included the Resident Rights Policy, Abuse/Reporting Events policy the Abuse Coordinator information and to report immediately. Record review of CNA C's Employee Timecard indicated her last date of employment was 4/19/24 and she clocked out on 4/19/24 at 6:06 a.m. Record review of CNA C's employee training indicated she received abuse training on 5/2/23 prior to the incident on 4/19/24. Record review of CNA C's employee file indicated she received a disciplinary action of discharge form employment and to be banned from the property dated 4/19/24. The employee was discharged due to resident abuse or neglect or directly related to the safety and wellbeing of a resident. Record review of LVN E's employee training indicated LVN E received abuse training on 5/5/23 prior to the incident on 4/19/24. Record review of LVN E's employee file indicated LVN E received a disciplinary action with unpaid suspension on 4/19/24. Due to failure to promptly report to the immediate supervisor on the job injury or accident involving an employee. The employee did not report witnessed resident abuse immediately instead reported 3 hours after the incident. Record review of CNA D's employee training indicated she received abuse training on 4/17/23 prior to the incident on 4/19/24. Record review of CNA D's employee file indicated CNA D received a disciplinary action with unpaid suspension on 4/19/24. Due to failure to promptly report to the immediate supervisor on the job injury or accident involving an employee. The employee did not report witnessed resident abuse immediately instead reported 3 hours after the incident. During an interview on 11/26/24 at 8:49 a.m. CNA F said she had worked at the facility for [AGE] years. She said she had heard CNA C had hit Resident #1, but she had not seen the incident. CNA F said she was shocked because she and CNA F had worked at the facility together for about the same amount of time. CNA F said Resident #1 would holler out occasionally, but she was not resistive to care. CNA F said she was in serviced on abuse regularly. She said she had not seen or heard any abuse and if she did, she would report to the administrator immediately. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 11/26/24 at 9:08 a.m. CNA G said she had worked at the facility for a little over a year. She said Resident #1 was a sweet and confused. She said she did not holler out. CNA G said Resident #1 would sometimes be resistive to getting up in the morning but if you give her a little while she was fine. She said she was aware of the multiple types of abuse. She said if she saw or heard abuse, she would report it immediately to the administrator. During an interview on 11/26/24 at 9:30 a.m. CNA I said she did aid Resident #1. She said Resident #1 did not holler out. She said Resident #1 could be stubborn especially in the morning when she did not want to get up. She said she was familiar with what abuse was and if she saw or head abuse, she would report it to the administrator immediately. During an interview on 11/26/24 at 9:41 a.m. CNA J said she was aware of what abuse was and if she saw or heard any abuse she would report to the Administrator immediately. She said Resident #1 did not holler out and was not resistive to care. During an interview on 11/26/24 at 9:50 a.m. LVN K said Resident #1 did not holler out and she was not resistive to care. LVN K said she had never known Resident #1 to hit. LVN K said the only way Resident #1 would strike was if they were forcing her to do something she did not want to do. During an interview on 11/26/24 at 1:20 p.m. LVN L said she worked at the facility for two weeks. She said she received training on abuse and neglect. She said if she saw or heard abouts she would report immediately to the administrator. The noncompliance was identified as PNC (past non-compliance). The IJ (Immediate Jeopardy) began on 4/19/24 and ended 4/19/24. The facility had corrected the noncompliance before the survey began.

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F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 19401 Based on observation, interview, 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 was made, if the events that caused the alleagtion involve abuse or result in serious bodily injury, to the Administrator of the facility and to other officials in accordance with State law for 1 of 7 residents reviewed for abuse (Resident #1.) LVN E and CNA D did not immediately report abuse to the Administrator after they witnessed CNA C abusing Resident #1. CNA C hit Resident #1 and was allowed to remain in the facility for over three hours with access to Resident #1 and other Residents. The noncompliance was identified as PNC (past non-compliance). The IJ (Immediate Jeopardy) began on 4/19/24 and ended 4/19/24. The facility had corrected the noncompliance before the survey began. This failure could have caused continued abuse to Resident #1 and possibly other residents. Findings included: Record review of Resident #1's face sheet indicated she was an [AGE] year-old female admitted to the facility on [DATE]. She had a diagnosis of Alzheimer's disease (progressive disease that destroys memory), and unsteadiness on feet. Record review of Resident #1's Quarterly MDS dated [DATE] indicated she was severely cognitively impaired with a BIMS score of 5. The MDS did not indicate any mood or behavior issues. The resident required substantial to maximum assist with all ADLS except eating, and oral hygiene. Record review of Resident #1's care plan indicated a problem start date of 1/7/22 of frequent incontinence of bowel and bladder. An approach was to provide peri care after each incontinent episode. The plan indicated a problem of ADL Self Care Performance Deficit. Some of the approaches were the resident required maximum assist for bathing, supervised assist for bed mobility, and one person assist for toileting. The plan indicated a problem of Cognitive loss due to dementia. One of the approaches was to provide the resident with necessary cues, stop, and return if the resident was agitated. (continued on next page)

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F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review a Provider Investigation Report indicated an incident occurred on 4/19/24 at 3:30 a.m. The report indicated LVN E and CNA D witnessed CNA C hit Resident #1 in the stomach area. The nurse heard Resident #1 screaming and yelling in her room. The nurse went to assess the resident in her room. When the nurse opened the door, CNA C was changing Resident #1. The resident was grabbing the blankets and yelling to get CNA C away from her and for CNA C to leave her alone. CNA C was seen balling up her fist on her right hand and hit Resident #1 on her right side in the rib area. The nurse immediately yelled what are you doing? You cannot do that. CNA C stated, I'm tired of her pinching The investigation indicated Resident #1 was assessed by LVN E on 4/19/24 at 3:45 a.m. with no visible injuries noted and no complaints of pain. CNA C was suspended pending investigation 4/19/24 at 6:30 a.m. The allegation of abuse was reported to HHSC on 4/19/24 at 8:33 a.m. The resident received another head-to-toe assessment on 4/19/24 at 10:00 a. m. with no injuries noted from this morning's incident. The family, the physician and the police department were notified. LVN E and CNA D were given one on one education on 4/19 by the DON regarding the importance of reporting allegations of abuse immediately. LVN E and CNA D were issued a three-day suspension on 4/19/2024 for failing to report allegations of abuse immediately. CNA C was terminated due to abuse allegation on 4/19/24 being confirmed. All interview able residents were interviewed by the administrator and social worker regarding abuse on 4/19/24. All non-resident received head to toe assessment, to assess for any injuries or evidence of abuse, by Nurses on 4/19/24. The direct care staff were interviewed on 4/19/24 by the administrator and DON regarding abuse and reporting requirements. The Abuse/Reportable Event policy was reviewed on 4/19/24 at 11:00 a.m. by the Administrator, Regional Director of Operations, Regional Nurse, and DON no changes made to the policy at this time. The DON provided education to all staff regarding abuse/reportable events policy, including types of abuse, and reporting requirements all staff present in the facility were educated on 4/19/24. Staff that were not present for education would receive the education prior to their next shift. The social services, Director or design would continue to interview and assess Resident #1 for emotional distress. During an interview on 11/26/24 11:40 a.m. the Administrator after the incident with Resident #1 he did interviews with all staff available at that time. The Administrator said he was notified about the incident on 4/19/24 around 6:00 a.m. He said CNA C had already left, and he talked to CNA C on the phone. He said at first, CNA C denied the incident. He said he told her he had two witnesses, she seemed frustrated, and did not say much. He said she just asked if she was terminated. He said LVN E or CNA D did not notify him that night, they informed him the first thing the next morning. He called the incident into the state at that time around 8:30 a.m. He said they had implemented corrective actions such as terminating CNA C immediately, calling the police, the physician and updated Resident #1's care plan. He said they monitored Resident #1 for three days after the incident from 4/19/24 through 4/22/24, and the completed safe surveys with Resident #1 on each shift to make sure she did not have any reoccurring memories of the event. He said CNA C went home that morning and she never came back. The Administrator said he wrote LVN E and CNA D up for not reporting the incident immediately. He said CNA C was allowed to remain in the building for over three hours before the incident was reported. The Administrator said he received statements from LVN E and CNA D, and they did specific in services with LVN E and CNA D. He said they conducted safe surveys with the residents and follow up interviews with any concerns voiced by residents and there no concerns with abuse. The Administrator said they conducted skin assessments on all the residents. He said they also talked to staff about burn out and he conducted regular training on abuse, at least once a month. During an observation and interview on 11/25/24 at 3:10 p.m. Resident #1 was sitting in a wheelchair by the nursing station. She said she was fine; she said she was still breathing. The rest of her conversation was about her childhood. She was unable to answer any questions about the incident. (continued on next page)

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F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Attempts were made to contact CNA C, but phone numbers for her appeared to be disconnected. During a telephone interview on 11/26/24 at 10:38 a.m. CNA D said Resident #1 had never hit or scratched her. She said the incident happened on the 10 to 6 a.m. shift on 4/19/24. CNA D said it could have been the way the aide approached Resident #1 in the middle of the night to make her resistive to care. She said Resident #1 was clutching the covers and saying, Stop leave me alone. She said she did not see Resident #1 trying to strike CNA C. CNA D said she was sitting in the lounge and LVN E was sitting at the nursing station. She said they kept hearing through the door a resident grunting and saying, no and stop CNA said at first, they did not know which room the noise was coming from, there are two rooms right by the nurse's station. She said they thought someone had fallen. She said she had gotten up to follow the nurse. When LVN E Resident #1's door, she opened the door abruptly. CNA D said as the door opened CNA C had her forearm up with her fist balled up and hit Resident #1 in the stomach area. CNA D said she could see CNA C and Resident #1 quite well. She said all CNA C said was I am tired of her hitting and scratching me. CNA D said LVN E told her she could not do that and to leave the room. She said CNA C left the room. CNA D said CNA C left the room. She said Resident #1 was saying to get CNA C out of her room and she appeared upset at the time, but later she was back to her old self. CNA D said it appeared Resident #1 had forgotten the incident. She said she was a shock because had worked with CNA C a long time and had not expected that type of behavior from her. During a telephone interview on 11/26/24 at 2:24 p.m. LVN E said she was sitting at the nursing station and heard a resident saying stop. She said she kept hearing words, grunting, and wanted to know where the noise was coming from. She said she and CNA D opened Resident #1's door and saw CNA C appeared to have just changed Resident #1. LVN E said Resident #1 was holding tight to the covers. She said CNA C was standing facing the door, over Resident #1 and the bed. She said CNA C was yakking on the covers, bulled up her fist, and punched Resident #1 in her side area. LVN E said she told the aide she could not do that, and to leave the room. LVN E said she assessed Resident #1. She said she had two or three blankets on her, and there was no redness or busies. She said Resident #1 said she did not want CNA C in her room and for CNA C to leave her alone. LVN E said CNA C left the room. She said she was gone for about 30 minutes but did finish her shift. LVN E said she had gone back later, and Resident #1 was asleep. She said she and CNA D had gone in on the last round of the night to provide care to Resident #1 and she appeared fine. The LVN said she knew to protect the patient and get the aide away from the Resident #1. LVN E said she and CNA D were both in disbelief at the actions of CNA C. She said she had never had anything like that happen before, and had not sent CNA C home. She was only thinking of keeping Resident #1 safe and not allowing the aide back in her [NAME]. LVN E said she had reported the incident when the dayshift staff came in. She said she was suspended for three days for not reporting the incident immediately. The LVN said if anything like that happened, she would call everybody as soon as possible. LVN E said CNA C had already left by the time she had reported the incident. Record review of the facility policy on Abuse/Reportable Events with no dated indicated all residents have the right to be fee from abuse. Resident should not be subjected to abuse by anyone. The facility will provide and ensure the promotion and protection of resident's rights. Abuse is the willful infliction of injury. Willful individual must have intended to inflict injury or harm. Physical abuse includes hitting, slapping, pinching, and kicking. Facility employees must report all allegations of abuse. If the allegations involve abuse or result in serious bodily injury, the report is to be made within two hours of the allegation. (continued on next page)

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F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The facility took the following actions to correct the noncompliance on 4/19/24. Record review of Resident #1's care plan indicated a problem with a start date of 4/19/24 of psychosocial wellbeing, the resident was a victim of abuse related to an inappropriate interaction by staff. Some of the approaches were the resident received a full head to toe skin assessment. She would have emotional distress monitoring every shift for 72 hours. Record review of Resident #1's skin assessment dated [DATE] indicated no new areas. Review of Safe Surveys indicated a questionnaire was completed on Resident #1 each shift from 4/19/24 through 4/22/24 with no concerns noted. Record review of one-hour checks indicated they were completed on Resident #1 every hour with her vital signs from 4/19/24 through 4/22/24. Record review of Abuse pre and posttest and Abuse/Reporting in service was completed on 4/19/24 by more than 70 staff to include all departments and agency staff. The in service included the Resident Rights Policy, Abuse/Reporting Events policy the Abuse Coordinator information and to report immediately. Record review of CNA C's Employee Timecard indicated her last date of employment was 4/19/24 and she clocked out on 4/19/24 at 6:06 a.m. Record review of CNA C employee training indicated she received abuse training on 5/2/23 prior to the incident on 4/19/24. Record review of CNA C employee file indicated she received a disciplinary action of discharge form employment and to be banned from the property dated 4/19/24. The employee was discharged due to resident abuse or neglect or directly related to the safety and wellbeing of a resident. Record review of LVN E's employee training indicated LVN E received abuse training on 5/5/23 prior to the incident on 4/19/24. Record review of LVN E's employee file indicated LVN E received a disciplinary action with unpaid suspension on 4/19/24. Due to failure to promptly report to the immediate supervisor on the job injury or accident involving an employee. The employee did not report witnessed resident abuse immediately instead reported 3 hours after the incident. Record review of CNA D's employee training indicated she received abuse training on 4/17/23 prior to the incident on 4/19/24. Record review of CNA D's employee file indicated CNA D received a disciplinary action with unpaid suspension on 4/19/24. Due to failure to promptly report to the immediate supervisor on the job injury or accident involving an employee. The employee did not report witnessed resident abuse immediately instead reported 3 hours after the incident. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455834	A. Building B. Wing	11/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
South Place Rehabilitation and Skilled Nursing	150 Gibson Rd Athens, TX 75751

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F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 11/26/24 at 8:49 a.m. CNA F said she had worked at the facility for [AGE] years. She said she had heard CNA C had hit Resident #1, but she had not seen the incident. CNA F said she was shocked because she and CNA F had worked at the facility together for about the same amount of time. CNA F said Resident #1 would holler out occasionally, but she was not resistive to care. CNA F said she was in serviced on abuse regularly. She said she had not seen or heard any abuse and if she did, she would report to the administrator immediately. During an interview on 11/26/24 at 9:08 a.m. CNA G said she had worked at the facility for a little over a year. She said Resident #1 was a sweet and confused. She said she did not holler out. CNA G said Resident #1 would sometimes be resistive to getting up in the morning but if you give her a little while she is fine. She said she was aware of the multiple types of abuse. She said if she saw or heard abuse, she would report it immediately to the administrator. During an interview on 11/26/24 at 9:30 a.m. CNA I said she did aid Resident #1. She said Resident #1 did not holler out. She said Resident #1 could be stubborn especially in the morning when she did not want to get up. She said she was familiar with what abuse was and if she saw or head abuse, she would report it to the administrator immediately. During an interview on 11/26/24 at 9:41 a.m. CNA J said she was aware of what abuse was and if she saw or heard any abuse. She said she would report to the Administrator immediately. She said Resident #1 did not holler out and was not resistive to care. During an interview on 11/26/24 at 9:50 a.m. LVN K said Resident #1 did not holler out and she was not resistive to care. LVN K said she had never known Resident #1 to hit. LVN K said the only way Resident #1 would strike was if they were forcing her to do something she did not want to do. During an interview on 11/26/24 at 10:14 a.m. the DON said LVN E did immediately remove CNA C from Resident #1 and the LVN assessed the resident. The DON said LVN E did not call immediately, the incident occurred about 3:30 a.m. The DON said they were not informed until the end of the shift about 6:00 a. she said the LVN worked for agency and the aide no longer worked for the facility. During an interview on 11/26/24 at 1:20 p.m. LVN L said she worked at the facility for two weeks. She said she received training on abuse and neglect. She said if she saw or heard abouts she would report immediately to the administrator. The noncompliance was identified as PNC (past non-compliance). The IJ (Immediate Jeopardy) began on 4/19/24 and ended 4/19/24. The facility had corrected the noncompliance before the survey began.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 19401 Based on interview and record review the facility failed to ensure a resident received adequate supervision and assistive devices to prevent accidents for 1 of 7 residents reviewed for accidents (Resident #2). CNA A failed to ensure two staff members provided a Hoyer lift transfer. A family member assisted with the transfer, the Hoyer lift sling strap was not attached properly, and Resident #2 fell out of the Hoyer lift. The noncompliance was identified as PNC (past non-compliance). The noncompliance began on 3/3/24 and ended 3/3/24. The facility had corrected the noncompliance before the survey began. This failure could have caused serious injury. Findings included: Record review of Resident #2's face sheet indicated she was a [AGE] year-old female admitted to the facility on [DATE]. Some of her diagnoses were muscle weakness, obesity, and lack of coordination. Record review of Resident #2's admission MDS dated [DATE] indicated the resident had a BIMs score of 13 indicating she was cognitively intact. Her ADLs were listed as partial to moderate assist for transfers with the helper doing less than half the effort. Record review of Resident #2's care plan indicated a problem with a start date of 2/20/24. Resident #2 had limited ability to transfer herself related to morbid obesity and recent hospitalization . The goal was the resident would transfer with the use of a mechanical lift by staff and a transfer belt with therapy with an edited dated of 3/25/24. The resident had a problem with a start date of 2/20/24 with the category of falls, and an edited date of 3/5/24. The resident had the potential for injury related to falls due to a decline in medical condition, attempts to stand unassisted, impulsiveness, and recent hospitalization . Resident had an actual fall since admission. Some of the approaches were Resident #2 was to be transferred with a Hoyer lift by two staff for all transfers. Record review of Resident #2's physician orders dated 3/4/24 indicated an order for Tylenol 325 mg, two tablets every six hours as need or pain. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of a nursing note dated 3/3/24 at 10:58 a.m. indicated LVN B found Resident #2 on the floor in her room beside the bed. CNA A and Resident #2's family member was also in the room. CNA A was attempting to transfer Resident #2 from the bed to the shower chair with the mechanical lift when the resident fell . Resident #2 complained of a sharp pain in her neck and back at a pain scale of 10 out of 10(with 10 being the worst pain possible.) Resident #2 was assessed, and no abnormalities found. She had a small red area over her left eyebrow. Resident #2 did not complain of head pain. Resident #2 was assisted back to bed. Resident #2 wanted Tylenol and Tylenol was administered. Resident #2 did not want to go to the hospital. Resident #2 and the family member were educated on the benefits of going to the hospital for an evaluation and Resident #2 continued to refuse. The nurse practitioner gave orders for an immediate imaging of the head spine and neck. Resident #2 was checked for a pain level 10 minutes later and voiced her pain was a 7 out of 10. Resident #2's vital signs were within normal limits. Resident #2 was checked again for pain at 10:45 a.m. and said her pain was a 3 out of 10. Resident #2 continued to refuse to go to the hospital. Review of a radiology report dated 3/3/24 indicated Resident #2's x-ray of the skull, and three views of the spine were all negative. Record review of the facility Provider Investigation Report indicated on 3/3/24 at 8:50 a.m. CNA A was transferring Resident #2 from the bed to the wheelchair. The resident was transferred with a Hoyer lift, and her family member was in the room along with CNA A. During the transfer Resident #2 slipped out of the Hoyer sling and fell to the floor. Charge nurse LVN B inspected the Hoyer lift and discovered a strap was not completely in place and caused the resident to slip out. At the time of the incident Resident #2 said her neck and back hurts. The initial assessment indicated Resident #2 had range of motion in all 4 extremities within normal limits. LVN B tried to send Resident #2 to the hospital, but Resident #2 adamantly refused. The nurse practitioner was notified, and neuro checks were initiated. Resident #2 was alert and oriented and her own medical power of attorney. X rays were ordered in house, and they were negative for any fractures. The resident was provided as needed Tylenol for pain. All lifts and slings were checked for proper functioning with no issues noted. Education and disciplinary actions were given to CNA A. The investigation findings were confirmed. The facility took the following actions to correct the noncompliance on 3/3/24. Record review dated 3/3/24 indicated in- services were conducted on Hoyer transfers, Abuse /Reportable events, and Resident Rights. Mechanical lift competency check offs were also completed by staff. Record review an Employee Disciplinary Report dated 3/3/24 indicated CNA A received a written counseling and education training on the mechanical lift transfer safety with a skills competency check. A thirty-day probation, a one-day suspension. Record reviews indicated CNA A had a Certificate of [NAME] Completion on Fall Prevention competed 3/5/24 and Certificate of [NAME] Completion on Position and Transfer Techniques dated 3/5/24. Record review of In-Service Training report dated 3/3/24 indicated staff were in serviced on Abuse Reportable Events, Resident Rights and Mechanical Lift Transfer. Record review of Using a Mechanical Lifting Machine competency demonstration indicated they were conducted on 3/4/24. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the facility Mechanical Lift policy with and effective August 2020. The policy stated it is the policy of this home to utilize the Hoyer or similar lift when it is necessary to safely transfer a resident due to body wight or physical condition. Lifting a resident with a mechanical lift is always a two-person procedure. One of the procedures indicated to check chains and hooks to make [NAME] they are properly positioned. Record review of a Discharge Summary indicated Resident #2 was discharged to home on 3/10/24. During an interview on 11/25/24 at 9:15 a.m. the Administrator said CNA A had been educated on not allowing family members to help her with transfers. He said she was educated on always having another staff member with her for Hoyer lift transfers. She was also given a disciplinary action and was required to take some online courses. He said Resident # 2 did not want to go to the hospital and had no injuries. The Administrator said the resident had since discharged home. During an interview on 11/26/24 at 8:57 a.m. CNA A said she worked at the facility for [AGE] years. CNA A said on the morning of 3/3/24 she was transferring Resident #2 from the bed to the shower chair. CNA A said she did not get another staff member to help her with the Hoyer lift transfer because Resident #2's family member was in the room. CNA A said the family member had assisted with transfers in the past. She said they had placed the loops on the transfer pad/sling to the Hoyer lift. CNA A said she had worked the controls on the mechanical/Hoyer lift and the family member had guided the resident towards the chair. She said they had lifted her from the bed and pivoted around toward the chair. CNA A said right before Resident #2 was at the chair one of the loops connected to the pad/sling came off, and Resident #2 slid to the floor. She said the family member likely did not secure the loop on the Hoyer securely. CNA A said she was in serviced on abuse neglect, and Hoyer lift transfers. She said she was also written up and was now aware to always get another staff for Hoyer lift transfers. She said she was told family members were not to assist with transfers.