| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 455879 | A. Building<br>B. Wing | 07/31/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Marshall Manor West | 207 W Merritt St<br>Marshall, TX 75670 |

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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<br><br>Level of Harm - Minimal harm or potential for 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** 44933<br><br>Based on observation, interview and record review, the facility failed to ensure residents were free from abuse for 2 of 8 residents (Resident #1 and Resident #2) reviewed for abuse.<br><br>The facility failed to ensure on 12/14/23, CNA B, did not verbally and physically abuse Resident #1 when she used foul language and hit Resident #1 on the head.<br><br>The facility failed to ensure on 07/12/24, DA C, did not verbally abuse Resident #2 when he used foul language at him.<br><br>These failures could place residents at risk for emotional distress and further abuse.<br><br>Finding included:<br><br>1. Record review of Resident #1's face sheet dated 07/30/24, indicated Resident #1 was a [AGE] year-old, male and admitted on [DATE] with diagnoses including dementia (is the loss of cognitive functioning - thinking, remembering, and reasoning - to such an extent that it interferes with a person's daily life and activities) and cerebral infarction (stroke).<br><br>Record review of Resident #1's quarterly MDS assessment date 10/31/23, indicated Resident #1 was usually understood and usually understood others. Resident #1's BIMS score was 12 which indicated moderately impaired cognition. Resident #1's mobility device was a wheelchair. Resident #1 required supervision for oral hygiene and upper body dressing, partial assistance for toilet hygiene, shower/bathe self, lower body dressing, and personal hygiene.<br><br>Record review of Resident #1's care plan dated 10/25/22, revised on 01/16/23, indicated Resident #1 wanders and exit seeks daily and was at risk for elopement. Intervention included provide distraction and redirection when pacing/wandering and/or exit seeking.<br><br>Record review of Resident #1's PIR, dated 12/19/23, indicated .date reported: 12/19/23 .incident date: 12/14/23 .common room on Unit B .interviewable: No .Alleged Perpetrator: CNA B .Witness: CNA A .Nurse Aid Trainee [CNA A], reported to DON that CNA B had told Resident #1 that she was about to beat his ass then she [CNA B] 'knocked' once on top of his head and wheeled him behind a table in the corner .Resident #1 is not able to recall any incident .no injuries noted .Resident #1 shows no signs of emotional distress . employee remains suspended .<br><br>(continued on next page) |

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|---|---|
| F 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Record review of CNA A's undated witness statement indicated .On Thursday, December 14, approximately between 3 PM-4:30 PM, I [CNA A] witnessed/overheard three incidents .a CNA told a resident, Resident #1, she either 'would' or 'was about to' 'beat his ass' .she then 'knocked' once on top of his head .she then moved him into a corner where he could not maneuver his wheelchair .these occurred due to her being aggravated that he continued to move his wheelchair in front of the doors .CNA A .12/19/23 .<br><br>During an interview and observation on 07/30/24 at 2:15 p.m., Resident #1 was on the secured unit in the common area. Resident #1 was in a wheelchair dressed and well-groomed watching television. Resident #1 was non interviewable.<br><br>On 07/30/24 at 4:22 p.m., called CNA B but was unable to leave message. CNA B's phone kept ringing but did not prompt to leave a message. CNA B did not return call before or after exit.<br><br>During an interview on 07/30/2024 at 4:26 p.m., CNA A said she was in the main room sitting at a table on 12/14/23. She said CNA B was getting aggravated with Resident #1 because he kept going towards the main door to the secured unit. She said CNA B grabbed Resident #1's wheelchair and pulled it back from the door. She said CNA B told Resident #1 she was going to beat his ass then with a closed fist, hit him on top of his head. She said the hit was hard enough she heard it from where she was sitting across the room. She said Resident #1 looked shocked and confused. She said Resident #1 touched his head where CNA B hit him at.<br><br>During an interview on 07/31/24 at 1:40 p.m., the ADON said CNA A came to her office and reported to her CNA B had hit Resident #1 on the head. She said CNA A told her, that CNA B told Resident #1 she was going to beat his ass. She said CNA A came to her about the incident to make sure what she saw was abuse.<br><br>2. Record review of Resident #2's face sheet dated 07/30/24, indicated Resident #2 was a [AGE] year-old, female and admitted on [DATE] and most recently on 02/05/24 with diagnoses including schizoaffective disorder (a mental health condition including schizophrenia (is a serious mental health condition that affects how people think, feel and behave) and mood disorder symptoms), bipolar disorder (is a mental illness that causes unusual shifts in a person's mood, energy, activity levels, and concentration), mood affective disorder (is a mental health condition that primarily affects your emotional state), and nicotine dependence, cigarettes.<br><br>Record review of Resident #2's annual MDS assessment dated [DATE], indicated Resident #2 was understood and understood others. Resident #2's BIMS score was 14 which indicated intact cognition. The MDS did not indicated physical, verbal, or other behavioral symptoms. Resident #2 was independent for eating, toilet hygiene, upper body dressing, supervision for lower body dressing, and partial assistance for shower/bathe self. Resident #2 currently used tobacco.<br><br>Record review of Resident #2's care plan dated 02/05/24, revised on 07/30/24, indicated Resident #2 was often impatient and demanding of staff. Intervention included remain calm, manage tone and body language, avoid arguing, and set boundaries.<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Record review of Resident #2's PIR dated 07/16/24, indicated .date reported: 07/16/24 .incident date: 07/12/24 .Resident #2 .Interviewable: Yes .Alleged Perpetrator: DA C .Witness: NCNA D .Resident #2 came to administrator's office and stated that dietary aide [DA C] had cussed him out in the smoking area last Friday .He [Resident #2] stated there were other staff and residents in the area .Resident #2 denies any emotional distress or fear of staff member .alleged perpetrator was immediately suspended pending outcome of the investigation .one witness did corroborate Resident #2's statement of AP [DA C] cussing at him .AP [DA C] employment was terminated .facility investigation findings: Confirmed .<br><br>Record review of Resident #2's interview dated 07/16/24, indicated .Resident #2 came to administrator's office and complained about an incident that happened last Friday in the smoking area between himself and dietary staff, DA C .he [Resident #2] stated that DA C cussed him out for telling the cook that his food was cold .he [Resident #2] stated that there were other people around but did not know if anyone heard it .he [Resident #2] gave the names of .a new CNA that he didn't know her name .<br><br>Record review of NCNA D's witness statement dated 07/16/24, indicated .she [NCNA D] stated that she was in the smoking area when the incident with Resident #2 and DA C occurred .she said Resident #2 was mad because he stated his food had been cold and he didn't have big enough portion size .DA C explained to him but he was too upset to listen and kept complaining to anyone around .she stated that DA C said 'stop talking shit. I [DA C] already told you what happened and its not our fault' .Resident #2 and DA C continued to argue until DA C said he was not going to argue with him and went inside .<br><br>Record review of the AP's statement dated 07/16/24, indicated .administrator interviewed AP [DA C] by phone .he stated that he was sitting outside smoking in the smoking area .he stated Resident #2 said, 'What the fuck are you looking at?' .DA C said he asked Resident #2 to calm down and stop yelling .he informed him [Resident #2] that if he wanted his food warmed up then all he needed to do was ask .he stated that resident #2 kept yelling at him until he finally went inside .he denied cussing at Resident #2 .<br><br>During an interview on 07/30/24 at 1:08 p.m., Resident #2 said the facility served popcorn shrimp, green beans, macaroni and cheese, and rolls for lunch on 07/12/24. He said he told [NAME] E, the food was cold, and he was not going to eat that stuff. He said he did not eat food, so he walked out to the smoking area. He said DA C followed behind him to the smoke area. He said DA C pulled up a chair and started cussing at him. He said DA C called him out of his name. He said DA C called him a mother fucker and son of bitch. He said during the argument, he told himself to tell the ADM on Monday (07/16/24). He said DA C made him not feel good and upset him during the incident. He said he had rights as a resident, so it was not right for DA C to cuss at him. He said DA C stopped speaking to him the rest of the weekend.<br><br>On 07/30/24 at 4:25 p.m., called NCNA D and left message. NCNA D texted this surveyor Who is this?. Surveyor explained reason for call and asked for return call.<br><br>On 07/30/24 at 6:36 p.m., NCNA D called surveyor but called was missed.<br><br>On 07/31/24 at 9:59 a.m., surveyor sent text message to NCNA for a return phone call. NCNA did not return call after exit.<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 07/31/24 at 12:20 p.m., called DA C and person who answered the phone said he was not there.<br><br>On 07/31/24 at 1:07 p.m., received call back from DA C's phone number but missed call.<br><br>On 07/31/24 at 1:37 p.m., called DA C and no one answered phone. Unable to leave message. DA C did not return call after exit.<br><br>During an interview on 07/31/24 at 1:51 p.m., the DON said CNA A and CNA B were working together on the secured unit. She said CNA A told her Resident #1 was trying to get up and CNA B kept trying to redirect but he was not listening. She said CNA A told her CNA B knocked Resident #1 on the head and told Resident #1 she was going to beat his ass. She said the incident between Resident #1 and CNA B was abuse. She said CNA B was suspended then terminated. She said the ADM handled Resident #2 and DA C's incident. She said from what she recalled, a witness said Resident #2 was yelling and cussing. She said she guessed DA C got fed up with Resident #2 cussing and yelling and cussed back at him. She said staff were expected to back away from volatile situations and not engage with the resident. She said cussing at a resident would be considered verbal abuse. She said Resident #2 had mental illness which contributed to his behavior. She said she tried to tell staff that the resident may seem to be cognitive, but it was still not appropriate to argue with the resident. She said DA C had abuse training when he was hired. She said he was suspended then quit before the investigation was complete.<br><br>During an interview on 07/31/24 at 2:25 p.m., the ADM said DA C denied cussing at Resident #2. He said DA C told him Resident #2 was belligerent about the food being cold and he walked away. The ADM said Resident #2 reported to him DA C cussed him out. He said DA C was escorted out of the building and suspended. He said the facility confirmed the abuse allegation for Resident #2's incident. He said Resident #1's incident was inconclusive because CNA B denied the allegation and Resident #1 was not interviewable. He said cussing and/or hitting a resident was considered abuse. He said the facility trained staff on abuse to prevent it and made rounds with the residents to monitor for abuse.<br><br>Record review of an undated facility's Abuse and Neglect Prohibition Policy indicated .each resident has the right to be free from mistreatment, neglect, abuse .verbal abuse .is defined as the use of oral, written or gestured language that willfully includes disparaging and derogatory terms to resident or their families, or within their hearing distance regardless of their age, ability to comprehend, or disability .physical abuse . includes hitting, slapping, pinching, and kicking . |

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| F 0607<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Develop and implement policies and procedures to prevent abuse, neglect, and theft.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44933<br><br>Based on interview and record review, the facility failed to implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents, for 2 of 8 residents (Resident #1 and Resident #2) and 2 of 5 staff members (CNA A and NCNA D) reviewed for abuse.<br><br>The facility failed to ensure CNA A, per the facility's policy, immediately reported witnessed physical and verbal abuse towards Resident #1 by CNA B on 12/14/23 to the ADM, DON, or ADON.<br><br>The facility failed to ensure NCNA D, per the facility's policy, immediately reported witnessed verbal abuse towards Resident #2 by DA C on 07/12/24 to the ADM, DON, or ADON.<br><br>Theses failures could place residents at risk for unsafe environment and further abuse.<br><br>Findings included:<br><br>Record review of an undated facility's Abuse and Neglect Prohibition Policy indicated .each resident has the right to be free from mistreatment, neglect, abuse .verbal abuse .is defined as the use of oral, written or gestured language that willfully includes disparaging and derogatory terms to resident or their families, or within their hearing distance regardless of their age, ability to comprehend, or disability .physical abuse . includes hitting, slapping, pinching, and kicking .all types of abuse/neglect/suspicion of either must be immediately reported to: Administrator, Director of Nursing, and Assistant Director of Nursing .<br><br>1. Record review of Resident #1's face sheet dated 07/30/24, indicated Resident #1 was a [AGE] year-old, male and admitted on [DATE] with diagnoses including dementia (is the loss of cognitive functioning - thinking, remembering, and reasoning - to such an extent that it interferes with a person's daily life and activities) and cerebral infarction (stroke).<br><br>Record review of Resident #1's quarterly MDS assessment date 10/31/23, indicated Resident #1 was usually understood and usually understood others. Resident #1's BIMS score was 12 which indicated moderately impaired cognition. Resident #1's mobility device was a wheelchair. Resident #1 required supervision for oral hygiene and upper body dressing, partial assistance for toilet hygiene, shower/bathe self, lower body dressing, and personal hygiene.<br><br>Record review of Resident #1's care plan dated 10/25/22, revised on 01/16/23, indicated Resident #1 wanders and exit seeks daily and was at risk for elopement. Intervention included provide distraction and redirection when pacing/wandering and/or exit seeking.<br><br>Record review of Resident #1's PIR, dated 12/19/23, indicated .date reported: 12/19/23 .incident date: 12/14/23 .common room on Unit B .interviewable: No .Alleged Perpetrator: CNA B .Witness: CNA A .Nurse Aid Trainee [CNA A], reported to DON that CNA B had told Resident #1 that she was about to beat his ass then she [CNA B] 'knocked' once on top of his head and wheeled him behind a table in the corner .Resident #1 is not able to recall any incident .no injuries noted .Resident #1 shows no signs of emotional distress . employee remains suspended .<br><br>(continued on next page) |

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| F 0607<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Record review of CNA A's undated witness statement indicated .On Thursday, December 14, approximately between 3 PM-4:30 PM, I [CNA A] witnessed/overheard three incidents .a CNA told a resident, Resident #1, she either 'would' or 'was about to' 'beat his ass' .she then 'knocked' once on top pf his head .she then moved him into a corner where he could not maneuver his wheelchair .these occurred due to her being aggravated that he continued to move his wheelchair in front of the doors .CNA A .12/19/23 .<br><br>During an interview and observation on 07/30/24 at 2:15 p.m., Resident #1 was on the secured unit in the common area. Resident #1 was in a wheelchair dressed and well-groomed watching television. Resident #1 was non interviewable.<br><br>On 07/30/24 at 4:22 p.m., called CNA B but was unable to leave message. CNA B's phone kept ringing but did not prompt to leave a message. CNA B did not return call before or after exit.<br><br>During an interview on 07/30/2024 at 4:26 p.m., CNA A said she was in the main room sitting at a table on 12/14/23. She said CNA B was getting aggravated with Resident #1 because he kept going towards the main door to the secured unit. She said CNA B grabbed Resident #1's wheelchair and pulled it back from the door. She said CNA B told Resident #1 she was going to beat his ass then with a closed fist, hit him on top of his head. She said the hit was hard enough she heard it from where she was sitting across the room. She said Resident #1 looked shocked and confused. She said Resident #1 touched his head where CNA B hit him at. She said she waited until the next time she worked on 12/19/23, to report it to the ADON. She said she feared CNA B so that was why she waited to report the incident with Resident #1. She said when she reported it to the ADON, she immediately reported it to the ADM. She said it was important to report abuse immediately to protect the resident and it was the facility responsibility to give the resident high quality of care. She said before the incident with CNA B and Resident #1, she did not know who the abuse coordinator was or that she had to report abuse immediately. She said after the incident, the facility has had several in-services and trainings on who the abuse coordinator was, Abuse and Neglect, and reporting. She said the abuse coordinator phone number was posted everywhere in the facility.<br><br>During an interview on 07/31/24 at 1:40 p.m., the ADON said CNA A came to her office, on 12/19/23, and reported to her CNA B had hit Resident #1 on the head. She said CNA A told her, that CNA B told Resident #1 she was going to beat his ass. She said CNA A came to her about the incident to make sure what she saw was abuse. She said CNA A told her she did not want to get anyone in trouble and was afraid. She said she told CNA A, she had to report abuse immediately to someone no matter the situation.<br><br>2. Record review of Resident #2's face sheet dated 07/30/24, indicated Resident #2 was a [AGE] year-old, female and admitted on [DATE] and most recently on 02/05/24 with diagnoses including schizoaffective disorder (a mental health condition including schizophrenia (is a serious mental health condition that affects how people think, feel and behave) and mood disorder symptoms), bipolar disorder (is a mental illness that causes unusual shifts in a person's mood, energy, activity levels, and concentration), mood affective disorder (is a mental health condition that primarily affects your emotional state), and nicotine dependence, cigarettes.<br><br>(continued on next page) |

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| F 0607<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Record review of Resident #2's annual MDS assessment dated [DATE], indicated Resident #2 was understood and understood others. Resident #2's BIMS score was 14 which indicated intact cognition. The MDS did not indicated physical, verbal, or other behavioral symptoms. Resident #2 was independent for eating, toilet hygiene, upper body dressing, supervision for lower body dressing, and partial assistance for shower/bathe self. Resident #2 currently used tobacco.<br><br>Record review of Resident #2's care plan dated 02/05/24, revised on 07/30/24, indicated Resident #2 was often impatient and demanding of staff. Intervention included remain calm, manage tone and body language, avoid arguing, and set boundaries.<br><br>Record review of Resident #2's PIR dated 07/16/24, indicated .date reported: 07/16/24 .incident date: 07/12/24 .Resident #2 .Interviewable: Yes .Alleged Perpetrator: DA C .Witness: NCNA D .Resident #2 came to administrator's office and stated that dietary aide [DA C] had cussed him out in the smoking area last Friday .He [Resident #2] stated there were other staff and residents in the area .Resident #2 denies any emotional distress or fear of staff member .alleged perpetrator was immediately suspended pending outcome of the investigation .one witness did corroborate Resident #2's statement of AP [DA C] cussing at him .AP [DA C] employment was terminated .facility investigation findings: Confirmed .<br><br>Record review of Resident #2's interview dated 07/16/24, indicated .Resident #2 came to administrator's office and complained about an incident that happened last Friday [07/12/24] in the smoking area between himself and dietary staff, DA C .he [Resident #2] stated that DA C cussed him out for telling the cook that his food was cold .he [Resident #2] stated that there were other people around but did not know if anyone heard it .he [Resident #2] gave the names of .a new CNA that he didn't know her name .<br><br>Record review of NCNA D's witness statement dated 07/16/24, indicated .she [NCNA D] stated that she was in the smoking area when the incident with Resident #2 and DA C occurred .she said Resident #2 was mad because he stated his food had been cold and he didn't have big enough portion size .DA C explained to him but he was too upset to listen and kept complaining to anyone around .she stated that DA C said 'stop talking shit. I [DA C] already told you what happened and its not our fault' .Resident #2 and DA C continued to argue until DA C said he was not going to argue with him and went inside .retraining completed this day .ADM .<br><br>Record review of the AP's statement dated 07/16/24, indicated .administrator interviewed AP [DA C] by phone .he stated that he was sitting outside smoking in the smoking area .he stated Resident #2 said, 'What the fuck are you looking at?' .DA C said he asked Resident #2 to calm down and stop yelling .he informed him [Resident #2] that if he wanted his food warmed up then all he needed to do was ask .he stated that resident #2 kept yelling at him until he finally went inside .he denied cussing at Resident #2 .<br><br>(continued on next page) |

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| F 0607<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on 07/30/24 at 1:08 p.m., Resident #2 said the facility served popcorn shrimp, green beans, macaroni and cheese, and rolls for lunch on 07/12/24. He said he told [NAME] E, the food was cold, and he was not going to eat that stuff. He said he did not eat food, so he walked out to the smoking area. He said DA C followed behind him to the smoke area. He said DA C pulled up a chair and started cussing at him. He said DA C called him out of his name. He said DA C called him a mother fucker and son of bitch. He said during the argument, he told himself to tell the ADM on Monday. He said DA C made him not feel good and upset him during the incident. He said he had rights as a resident, so it was not right for DA C to cuss at him. He said DA C stopped speaking to him the rest of the weekend.<br><br>On 07/30/24 at 4:25 p.m., called NCNA D and left message. NCNA D texted this surveyor Who is this?. Surveyor explained reason for call and asked for return call.<br><br>On 07/30/24 at 6:36 p.m., NCNA D called surveyor, but the call was missed.<br><br>On 07/31/24 at 9:59 a.m., surveyor sent text message to NCNA for a return phone call. NCNA did not return call after exit.<br><br>On 07/31/24 at 12:20 p.m., called DA C and person who answered the phone said he was not there.<br><br>On 07/31/24 at 1:07 p.m., received call back from DA C's phone number but missed call.<br><br>On 07/31/24 at 1:37 p.m., called DA C and no one answered phone. Unable to leave message. DA C did not return call after exit.<br><br>During an interview on 07/31/24 at 1:51 p.m., the DON said CNA A and CNA B were working together on the secured unit. She said CNA A told her Resident #1 was trying to get up and CNA B kept trying to redirect but he was not listening. She said CNA A told her CNA B knocked Resident #1 on the head and told Resident #1 she was going to beat his ass. She said the incident between Resident #1 and CNA B was abuse. She said CNA B was suspended then terminated. She said she thought CNA A was scared of CNA B. She said CNA A had training on abuse and reporting of abuse. She said staff were expected to report abuse immediately. She said the abuse coordinator was the ADM. She said she instructed the staff it was not their responsibility to determine if something was abuse, they needed to report everything. She said it was important to report abuse immediately to the abuse coordinator so the AP could be removed from the facility and the offense was not repeated. She said the facility was responsible to protect the residents from abuse and mistreatment. She said not reporting abuse risked repeated occurrence of abuse and the resident being traumatized. She said the ADM handled Resident #2 and DA C's incident. She said from what she recalled, a witness said Resident #2 was yelling and cussing. She said she guessed DA C got fed up with Resident #2 cussing and yelling and cussed back at him. She said staff were expected to back away from volatile situations and not engage with the resident. She said cussing at a resident would be considered verbal abuse. She said Resident #2 had mental illness which contributed to his behavior. She said she tried to tell staff that the resident may seem to be cognitive, but it was still not appropriate to argue with the resident. She said DA C had abuse training when he was hired. She said he was suspended then quit before the investigation was complete.<br><br>(continued on next page) |

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| | 455879 | A. Building<br>B. Wing | 07/31/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Marshall Manor West | 207 W Merritt St<br>Marshall, TX 75670 |

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| F 0607<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on 07/31/24 at 2:25 p.m., the ADM said DA C denied cussing at Resident #2. He said DA C told him Resident #2 was belligerent about the food being cold and he walked away. The ADM said Resident #2 reported to him DA C cussed him out. He said DA C was escorted out of the building and suspended. He said the facility confirmed the abuse allegation for Resident #2's incident. He said NCNA D did not report the incident because she did not think it was abuse. He said NCNA D thought because Resident #2 started the incident and was also cussing and yelling, it was not abuse. He said Resident #1's incident was inconclusive because CNA B denied the allegation and Resident #1 was not interviewable. He said cussing and/or hitting a resident was considered abuse. He said the facility trained staff on abuse to prevent it and made rounds with the residents to monitor for abuse. He said he was the abuse coordinator. He said staff was supposed to report abuse allegations immediately. He said the phone number was posted all around the building to ensure it was easy to contact him for reports of abuse and neglect. He said when abuse was not reported immediately, residents had the potential to be abused again.<br><br>Record review of CNA A's employee file on 07/30/24 at 12:19 p.m., indicated .it is the responsibility of the employees of .to promptly report any incident or suspected incidents of neglect, resident abuse .to administration .the signature below signifies that I fully understand that abuse may be physical, verbal .I have received information and understand the abuse policies of this facility .CNA A .11/15/23 .<br><br>Record review of NCNA D's employee file on 07/30/24 at 12:20 p.m., indicated .it is the responsibility of the employees of .to promptly report any incident or suspected incidents of neglect, resident abuse .to administration .the signature below signifies that I fully understand that abuse may be physical, verbal .I have received information and understand the abuse policies of this facility .NCNA D .06/24/24 .<br><br>Record review of NCNA D's employee file on 07/30/24 at 12:21 p.m., indicated .07/16/24 .administrator completed retraining with trainee NCNA D this date on immediately reporting abuse incidents to the administrator .NCNA D stated she did not recognize it as verbal abuse because the resident had been yelling and cussing at the other employee until he yelled back .she [NCNA D] verbalized understanding .ADM . |

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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** 44933<br><br>Based on observation, interview and record review, the facility failed to ensure all alleged violations involving mistreatment, neglect, abuse, or misappropriation of resident property were reported immediately, but not later than 2 hours after the allegation is made, if the event that caused the allegation involved abuse to the administrator of the facility and to other officials (including to the State Agency) for 2 of 8 residents (Resident #1 and Resident #2) and 2 of 5 staff members (CNA A and NCNA D) reviewed for reporting of abuse and mistreatment.<br><br>The facility failed to ensure CNA A immediately reported witnessed physical and verbal abuse towards Resident #1 by CNA B on 12/14/23 to the ADM.<br><br>The facility failed to ensure NCNA D immediately reported witnessed verbal abuse towards Resident #2 by DA C on 07/12/24 to the ADM.<br><br>These failures could place residents at risk for continued abuse.<br><br>Findings included:<br><br>1. Record review of Resident #1's face sheet dated 07/30/24, indicated Resident #1 was a [AGE] year-old, male and admitted on [DATE] with diagnoses including dementia (is the loss of cognitive functioning - thinking, remembering, and reasoning - to such an extent that it interferes with a person's daily life and activities) and cerebral infarction (stroke).<br><br>Record review of Resident #1's quarterly MDS assessment date 10/31/23, indicated Resident #1 was usually understood and usually understood others. Resident #1's BIMS score was 12 which indicated moderately impaired cognition. Resident #1's mobility device was a wheelchair. Resident #1 required supervision for oral hygiene and upper body dressing, partial assistance for toilet hygiene, shower/bathe self, lower body dressing, and personal hygiene.<br><br>Record review of Resident #1's care plan dated 10/25/22, revised on 01/16/23, indicated Resident #1 wanders and exit seeks daily and was at risk for elopement. Intervention included provide distraction and redirection when pacing/wandering and/or exit seeking.<br><br>Record review of Resident #1's PIR, dated 12/19/23, indicated .date reported: 12/19/23 .incident date: 12/14/23 .common room on Unit B .interviewable: No .Alleged Perpetrator: CNA B .Witness: CNA A .Nurse Aid Trainee [CNA A], reported to DON that CNA B had told Resident #1 that she was about to beat his ass then she [CNA B] 'knocked' once on top of his head and wheeled him behind a table in the corner .Resident #1 is not able to recall any incident .no injuries noted .Resident #1 shows no signs of emotional distress . employee remains suspended .<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 CNA A's undated witness statement indicated .On Thursday, December 14, approximately between 3 PM-4:30 PM, I [CNA A] witnessed/overheard three incidents .a CNA told a resident, Resident #1, she either 'would' or 'was about to' 'beat his ass' .she then 'knocked' once on top pf his head .she then moved him into a corner where he could not maneuver his wheelchair .these occurred due to her being aggravated that he continued to move his wheelchair in front of the doors .CNA A .12/19/23 .<br><br>During an interview and observation on 07/30/24 at 2:15 p.m., Resident #1 was on the secured unit in the common area. Resident #1 was in a wheelchair dressed and well-groomed watching television. Resident #1 was non interviewable.<br><br>On 07/30/24 at 4:22 p.m., called CNA B but was unable to leave message. CNA B's phone kept ringing but did not prompt to leave a message. CNA B did not return call before or after exit.<br><br>During an interview on 07/30/2024 at 4:26 p.m., CNA A said she was in the main room sitting at a table on 12/14/23. She said CNA B was getting aggravated with Resident #1 because he kept going towards the main door to the secured unit. She said CNA B grabbed Resident #1's wheelchair and pulled it back from the door. She said CNA B told Resident #1 she was going to beat his ass then with a closed fist, hit him on top of his head. She said the hit was hard enough she heard it from where she was sitting across the room. She said Resident #1 looked shocked and confused. She said Resident #1 touched his head where CNA B hit him at. She said she waited until the next time she worked on 12/19/23, to report it to the ADON. She said she feared CNA B so that was why she waited to report the incident with Resident #1. She said when she reported it to the ADON, she immediately reported it to the ADM. She said it was important to report abuse immediately to protect the resident and it was the facility responsibility to give the resident high quality of care. She said before the incident with CNA B and Resident #1, she did not know who the abuse coordinator was or that she had to report abuse immediately. She said after the incident, the facility has had several in-services and trainings on who the abuse coordinator was, Abuse and Neglect, and reporting. She said the abuse coordinator phone number was posted everywhere in the facility.<br><br>During an interview on 07/31/24 at 1:40 p.m., the ADON said CNA A came to her office, on 12/19/23, and reported to her CNA B had hit Resident #1 on the head. She said CNA A told her, that CNA B told Resident #1 she was going to beat his ass. She said CNA A came to her about the incident to make sure what she saw was abuse. She said CNA A told her she did not want to get anyone in trouble and was afraid. She said she told CNA A, she had to report abuse immediately to someone no matter the situation.<br><br>2. Record review of Resident #2's face sheet dated 07/30/24, indicated Resident #2 was a [AGE] year-old, female and admitted on [DATE] and most recently on 02/05/24 with diagnoses including schizoaffective disorder (a mental health condition including schizophrenia (is a serious mental health condition that affects how people think, feel and behave) and mood disorder symptoms), bipolar disorder (is a mental illness that causes unusual shifts in a person's mood, energy, activity levels, and concentration), mood affective disorder (is a mental health condition that primarily affects your emotional state), and nicotine dependence, cigarettes.<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 annual MDS assessment dated [DATE], indicated Resident #2 was understood and understood others. Resident #2's BIMS score was 14 which indicated intact cognition. The MDS did not indicated physical, verbal, or other behavioral symptoms. Resident #2 was independent for eating, toilet hygiene, upper body dressing, supervision for lower body dressing, and partial assistance for shower/bathe self. Resident #2 currently used tobacco.<br><br>Record review of Resident #2's care plan dated 02/05/24, revised on 07/30/24, indicated Resident #2 was often impatient and demanding of staff. Intervention included remain calm, manage tone and body language, avoid arguing, and set boundaries.<br><br>Record review of Resident #2's PIR dated 07/16/24, indicated .date reported: 07/16/24 .incident date: 07/12/24 .Resident #2 .Interviewable: Yes .Alleged Perpetrator: DA C .Witness: NCNA D .Resident #2 came to administrator's office and stated that dietary aide [DA C] had cussed him out in the smoking area last Friday .He [Resident #2] stated there were other staff and residents in the area .Resident #2 denies any emotional distress or fear of staff member .alleged perpetrator was immediately suspended pending outcome of the investigation .one witness did corroborate Resident #2's statement of AP [DA C] cussing at him .AP [DA C] employment was terminated .facility investigation findings: Confirmed .<br><br>Record review of Resident #2's interview dated 07/16/24, indicated .Resident #2 came to administrator's office and complained about an incident that happened last Friday [07/12/24] in the smoking area between himself and dietary staff, DA C .he [Resident #2] stated that DA C cussed him out for telling the cook that his food was cold .he [Resident #2] stated that there were other people around but did not know if anyone heard it .he [Resident #2] gave the names of .a new CNA that he didn't know her name .<br><br>Record review of NCNA D's witness statement dated 07/16/24, indicated .she [NCNA D] stated that she was in the smoking area when the incident with Resident #2 and DA C occurred .she said Resident #2 was mad because he stated his food had been cold and he didn't have big enough portion size .DA C explained to him but he was too upset to listen and kept complaining to anyone around .she stated that DA C said 'stop talking shit. I [DA C] already told you what happened and its not our fault' .Resident #2 and DA C continued to argue until DA C said he was not going to argue with him and went inside .retraining completed this day .ADM .<br><br>Record review of the AP's statement dated 07/16/24, indicated .administrator interviewed AP [DA C] by phone .he stated that he was sitting outside smoking in the smoking area .he stated Resident #2 said, 'What the fuck are you looking at?' .DA C said he asked Resident #2 to calm down and stop yelling .he informed him [Resident #2] that if he wanted his food warmed up then all he needed to do was ask .he stated that resident #2 kept yelling at him until he finally went inside .he denied cussing at Resident #2 .<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 | During an interview on 07/30/24 at 1:08 p.m., Resident #2 said the facility served popcorn shrimp, green beans, macaroni and cheese, and rolls for lunch on 07/12/24. He said he told [NAME] E, the food was cold, and he was not going to eat that stuff. He said he did not eat food, so he walked out to the smoking area. He said DA C followed behind him to the smoke area. He said DA C pulled up a chair and started cussing at him. He said DA C called him out of his name. He said DA C called him a mother fucker and son of bitch. He said during the argument, he told himself to tell the ADM on Monday. He said DA C made him not feel good and upset him during the incident. He said he had rights as a resident, so it was not right for DA C to cuss at him. He said DA C stopped speaking to him the rest of the weekend.<br><br>On 07/30/24 at 4:25 p.m., called NCNA D and left message. NCNA D texted this surveyor Who is this?. Surveyor explained reason for call and asked for return call.<br><br>On 07/30/24 at 6:36 p.m., NCNA D called surveyor, but the call was missed.<br><br>On 07/31/24 at 9:59 a.m., surveyor sent text message to NCNA for a return phone call. NCNA did not return call after exit.<br><br>On 07/31/24 at 12:20 p.m., called DA C and person who answered the phone said he was not there.<br><br>On 07/31/24 at 1:07 p.m., received call back from DA C's phone number but missed call.<br><br>On 07/31/24 at 1:37 p.m., called DA C and no one answered phone. Unable to leave message. DA C did not return call after exit.<br><br>During an interview on 07/31/24 at 1:51 p.m., the DON said CNA A and CNA B were working together on the secured unit. She said CNA A told her Resident #1 was trying to get up and CNA B kept trying to redirect but he was not listening. She said CNA A told her CNA B knocked Resident #1 on the head and told Resident #1 she was going to beat his ass. She said the incident between Resident #1 and CNA B was abuse. She said CNA B was suspended then terminated. She said she thought CNA A was scared of CNA B. She said CNA A had training on abuse and reporting of abuse. She said staff were expected to report abuse immediately. She said the abuse coordinator was the ADM. She said she instructed the staff it was not their responsibility to determine if something was abuse, they needed to report everything. She said it was important to report abuse immediately to the abuse coordinator so the AP could be removed from the facility and the offense was not repeated. She said the facility was responsible to protect the residents from abuse and mistreatment. She said not reporting abuse risked repeated occurrence of abuse and the resident being traumatized. She said the ADM handled Resident #2 and DA C's incident. She said from what she recalled, a witness said Resident #2 was yelling and cussing. She said she guessed DA C got fed up with Resident #2 cussing and yelling and cussed back at him. She said staff were expected to back away from volatile situations and not engage with the resident. She said cussing at a resident would be considered verbal abuse. She said Resident #2 had mental illness which contributed to his behavior. She said she tried to tell staff that the resident may seem to be cognitive, but it was still not appropriate to argue with the resident. She said DA C had abuse training when he was hired. She said he was suspended then quit before the investigation was complete.<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 | During an interview on 07/31/24 at 2:25 p.m., the ADM said DA C denied cussing at Resident #2. He said DA C told him Resident #2 was belligerent about the food being cold and he walked away. The ADM said Resident #2 reported to him DA C cussed him out. He said DA C was escorted out of the building and suspended. He said the facility confirmed the abuse allegation for Resident #2's incident. He said NCNA D did not report the incident because she did not think it was abuse. He said NCNA D thought because Resident #2 started the incident and was also cussing and yelling, it was not abuse. He said Resident #1's incident was inconclusive because CNA B denied the allegation and Resident #1 was not interviewable. He said cussing and/or hitting a resident was considered abuse. He said the facility trained staff on abuse to prevent it and made rounds with the residents to monitor for abuse. He said he was the abuse coordinator. He said staff was supposed to report abuse allegations immediately. He said the phone number was posted all around the building to ensure it was easy to contact him for reports of abuse and neglect. He said when abuse was not reported immediately, residents had the potential to be abused again.<br><br>Record review of CNA A's employee file on 07/30/24 at 12:19 p.m., indicated .it is the responsibility of the employees of .to promptly report any incident or suspected incidents of neglect, resident abuse .to administration .the signature below signifies that I fully understand that abuse may be physical, verbal .I have received information and understand the abuse policies of this facility .CNA A .11/15/23 .<br><br>Record review of NCNA D's employee file on 07/30/24 at 12:20 p.m., indicated .it is the responsibility of the employees of .to promptly report any incident or suspected incidents of neglect, resident abuse .to administration .the signature below signifies that I fully understand that abuse may be physical, verbal .I have received information and understand the abuse policies of this facility .NCNA D .06/24/24 .<br><br>Record review of NCNA D's employee file on 07/30/24 at 12:21 p.m., indicated .07/16/24 .administrator completed retraining with trainee NCNA D this date on immediately reporting abuse incidents to the administrator .NCNA D stated she did not recognize it as verbal abuse because the resident had been yelling and cussing at the other employee until he yelled back .she [NCNA D] verbalized understanding .ADM .<br><br>Record review of an undated facility's Abuse and Neglect Prohibition Policy indicated .each resident has the right to be free from mistreatment, neglect, abuse .verbal abuse .is defined as the use of oral, written or gestured language that willfully includes disparaging and derogatory terms to resident or their families, or within their hearing distance regardless of their age, ability to comprehend, or disability .physical abuse . includes hitting, slapping, pinching, and kicking .all types of abuse/neglect/suspicion of either must be immediately reported to: Administrator, Director of Nursing, and Assistant Director of Nursing . |