STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455963	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Carthage Healthcare Center	701 S Market St Carthage, TX 75633

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** 44933 Based on interview and record review, the facility failed to ensure residents were free from abuse for 2 of 10 residents (Resident #1 and Resident #2) reviewed for abuse. The facility failed to prevent LVN A, on 12/10/23, from verbally and physically abusing Resident #1 when she used foul language and threw ice at Resident #1. The facility failed to prevent LVN A, on or about 12/10/23, from verbally and physically abusing Resident #2 when she used foul language and threw an object at Resident #2. The noncompliance was identified as PNC. The IJ began on 12/10/2023 and ended on 12/15/2023. The facility had corrected the noncompliance before the survey began. These failures could place resident at risk for emotional distress, fear, decreased quality of life and further abuse. Findings included: 1.Record review of Resident #1's face sheet, dated 07/08/24, indicated Resident #1 was a [AGE] year-old, male admitted to the facility on [DATE] and discharged on [DATE] with diagnoses including dementia (loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life), mood affective disorder (is any of a group of conditions of mental and behavioral disorder where a disturbance in the person's mood is the main underlying feature), and mild cognitive impairment (is the stage between the expected decline in memory and thinking that happens with age and the more serious decline of dementia). Record review of Resident #1's quarterly MDS assessment dated [DATE] indicated Resident #1 was sometimes understood and sometimes had the ability to understand others. Resident #1 had minimal difficult hearing, clear speech, and adequate vision. Resident #1 had a BIMS score of 03 which indicated severe cognitive impairment. Resident #1 required supervision for ADL assistance except for shower/bathe self which required maximal assistance. Record review of Resident #1's care plan dated 04/19/23 indicated Resident #1 was at risk for altered psychosocial well-being related to dementia. Intervention included listen carefully and be non-judgmental. (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: 455963	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Carthage Healthcare Center	701 S Market St Carthage, TX 75633

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	Record review of a PIR for Resident #1, dated 12/11/23, indicated .on 12/10/23 at 3:00 p.m .LVN A used foul language and threw ice at a resident .LVN A denied .Cook B and Dietary Aide C reported to me [ADM], that they were standing at the nurses station and witnessed resident [Resident #1] come up to the nurses station and LVN A told him to 'stop fucking looking at me and go on' and threw a piece of ice at him .MA D stated that she heard LVN A say 'stop fucking looking at me and go on' but she did not see her throw ice at him [Resident #1] .LVN A was questioned about it, she denied saying anything to him but stated she and Resident #1 were playing and throwing ice at each other .the administrator visited Resident #1 who did not remember any incident .staff interviews indicated that many staff have witnessed LVN A speak rudely or harshly to the residents and often curse or speaks inappropriately to the staff .Resident safe surveys did not indicate any concerns with LVN A .physician and RP for Resident #1 notified of the incident .investigation findings: unconfirmed .Provider action taken post-investigation: staff reeducated on Abuse and Neglect Prevention and reporting, Professionalism, and Resident Rights .5 random staff interviews and resident safe surveys will be conducted monthly and results will be reviewed by QAPI committee monthly for 3 months . 2. Record review of Resident #2's face sheet, dated 07/08/24, indicated Resident #2 was a [AGE] year-old, male admitted on [DATE] and discharge 06/19/24 with diagnoses including anxiety disorder (persistent and excessive worry that interferes with daily activities), Type 2 diabetes (s a chronic condition that happens when you have persistently high blood sugar levels), nicotine dependence, schizoaffective disorder, bipolar type (is a chronic mental health condition characterized primarily by symptoms of schizophrenia (is a serious mental health condition that affects how people think, feel and behave), such as hallucinations or delusions, and symptoms of a mood disorder, such as mania and depression), and restlessness and agitation. Record review of Resident #2's annual MDS assessment dated [DATE], indicated Resident #2 was usually understood and usually understood others. Resident #2 had moderate difficulty hearing, clear speech, and impaired vision with use of corrective lenses. Resident #2 had a BIMS of 09, which indicated moderate cognitive impairment. Resident #2 required set up assistance for eating, dressing, and personal hygiene, supervision assistance for oral and toilet hygiene and partial assistance for shower/bathe self. Record review of Resident #2's care plan dated 06/12/23, indicated: *Resident #2 was at risk for altered psychosocial well-being related to schizoaffective disorder. Intervention included listen carefully and be non-judgmental. *Resident #2 was at risk for altered mood state related to schizoaffective disorder. Resident #2 pace the halls frequently, visit multiple staff members, frequently in/out of office. Resident #2 am easily agitated, yell loudly, make threatening statements to staff and/or residents. Intervention included be reassuring and listen to concerns. During an interview on 07/09/24 at 9:29 a.m., CNA E said she had worked at the facility for [AGE] years. She said she had witnessed LVN A being loud and heard LVN A used inappropriate language at residents. She said LVN A would escalate situations with Resident #2. She said she heard LVN A had cussed at Resident #1 and Resident #2. She said she did not work the day of LVN A and Resident #1 incident. She said cussing and throwing things at resident was abuse. She said LVN A talked ugly, and, in a way, she would not want her family members spoken to. She said after LVN A and Resident #2 would get into, Resident #2 would talk aloud to himself and stated he did not like LVN A. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455963	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Carthage Healthcare Center	701 S Market St Carthage, TX 75633

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	During an interview on 07/09/24 at 10:52 a.m., MA D said she worked for the facility for 2 years. She said she worked the day LVN A cussed at Resident #1. She said Resident #1 said or did something at the nursing station where LVN A was sitting. She said LVN A threw ice at Resident #1 and used the F word towards him. She said Resident #1 liked to touch people and grab drinks so maybe he did something to set her off. She said Resident #1 was walking away from LVN A and she threw ice at him. She said LVN behavior was abusive and inappropriate. She said Resident #2 was at the nursing station and was asking LVN A to take him out to smoke. She said LVN A and Resident #2 exchanged words because she did not take him out. She said LVN A had made a sign on a posted note that said, get the fuck away or go away, leave me alone and would put it up when Resident #2 came to the nurses' station. She said about the second time Resident #2 came to the nurses' station, LVN A cussed at him and threw the posted note at him. She said Resident #2 walked away and was upset. She said another staff member took him out to smoke. She said this incident happened around the same time of Resident #1's incident. She said LVN A escalate situation especially with Resident #2. She said using foul language at resident was abusive. During an interview on 07/09/24 at 11:15 a.m., the ADM said the incident with LVN A and Resident #1 happened on a Sunday. She said on Monday, [NAME] B and DA C told her Resident #1 walked up to the nurses' station and LVN A cussed at him and threw something at him. She said LVN A may have also called him a wierdo. She said [NAME] B and DA C said the situation bothered them, so they reported it, the next day. She said LVN A denied the event happened. She said she believed the incident with LVN A and Resident #2 happened the same day as Resident #1's incident with LVN A. She said she recalled being told LVN A held up a sign at Resident #2 but did not remember anything else about foul language being used between them. On 07/09/24 at 1:10 p.m., called LVN A and left message. LVN A did not return call before or after exit. During an interview on 07/09/24 at 1:45 p.m., [NAME] B said Resident #1 was at the nurses' station and LVN A told Resident #1 go the fuck away and threw ice at him. She said Resident #1 did say anything because he was not very verbal, but he was visibly upset by his facial expression. She said Resident #1 walked away from the nurses' station away from LVN A. She said she considered what LVN A did to Resident #1 was verbal abuse. During an interview on 07/09/24 at 4:15 p.m., DA C said LVN A threw ice and said get the fuck away from me to Resident #1. She said Resident #1 looked upset like anyone else would if they got ice thrown at them. During an interview on 07/10/24 at 11:50 a.m., the ADM said she recalled MA D telling her LVN A was on a roll that day and LVN A had a sign telling Resident #2 to go away. She said LVN A egged Resident #2 on all the time. She said if LVN A threw something at Resident #2, she was surprised Resident #2 did not attack LVN A. She said maybe she misinterpreted the situation when MA D told her about LVN A and Resident #2. She said maybe she thought MA D was talking about LVN A and Resident #1's incident. She said she was the abuse coordinator, and it was her responsibility to investigate and report allegations of abuse to the State. Record review of LVN A's annual training dated 06/01/23 indicated training on subjects of resident rights and abuse and neglect. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455963	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/10/2024
NAME OF PROVIDER OR SUPPLIER Carthage Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 701 S Market St Carthage, TX 75633	

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	Record review of a facility conducted in-service, Abuse Prevention Program dated 12/11/23 reflected all employees were provided education of the topic. Record review of a facility conducted in-service, Reporting Allegations of Abuse, Neglect, and Exploitation dated 12/11/23 reflected all employees were provided education of the topic. Record review of a facility conducted in-service, Resident Rights dated 12/11/23 reflected all employees were provided education of the topic. Record review of 13 resident safe surveys dated 12/12/23-12/14/23 indicated no resident had a staff member curse at them or another resident, knew their rights and who to report abuse to, felt comfortable reporting abuse, and felt safe in the facility. Record review of 29 staff interviews dated 12/12/23-12/14/23 indicated some staff members witnessed LVN A said or did something inappropriate to a resident, they did know what the resident rights were, knew who was considered a mandated reporter, knew who to report abuse to, and was comfortable reporting abuse. Record review of LVN A's Employee Corrective Action Form dated 12/15/23, indicated .type of action: termination .Category I Offense, inappropriate conduct towards a resident .Code of Conduct, Attitude, and Behavior- Policy Violation .Employees are expected and required to be kind, and considerate of residents, visitors, and other facility personnel. Any behavior that is deemed offensive or unsafe. Using profanity, abusive, or suggestive language, or gestures .date of violation 12/10/23 .incident: on, December 11, 2023, it was reported that LVN A used abusive language towards a resident, in which, led to the throwing of a solid object towards the resident .after speaking with all parties involved, we have confirmed these actions .LVN A has received several in-services regarding abuse and neglect among residents, in which, LVN A understands the appropriate conduct when managing residents .consequences: due to category I offense, LVN A will be subjective to immediate termination of employment .employee's comments: the ADM and DON attempted to call LVN A multiple times on 12/15/23 and left message to return call. LVN A texted and stated, 'if I'm fired just let me know so I can find another job'. This ADM responded with 'after we concluded the investigation and spoke to HR, we've decided to terminate your employment.' LVN A did not respond .DON 12/15/23 .ADM 12/15/23 . Record review of LVN A's Notice of Termination dated 12/18/23, indicated .LVN A .termination date 12/18/23 .reason of termination: abusive language toward resident .is employee eligible for rehire: No . Record review of LVN A's personnel file indicated hire date of 10/18/22. The facility had performed background check and employee misconduct search. No concerns were identified. Record review of a facility's Abuse Prevention policy revised 01/09/23 indicated .our residents have the right to be free from abuse, neglect .this includes but is not limited to .verbal, mental, sexual, or physical abuse . The administrator was notified of PNC IJ on 07/09/2024 at 4:40 p.m. due to the above failures. The administrator was provided with the IJ template on 07/09/2024 at 4:45 p.m. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455963	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/10/2024
NAME OF PROVIDER OR SUPPLIER: Carthage Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 701 S Market St Carthage, TX 75633	

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	The surveyor confirmed PNC had been implemented sufficiently to remove the Immediate Jeopardy on (12/15/23) by: - Reviewed completed facility self-reported incident to HHSC for Resident #1 which indicated the following: * dated 12/11/23, indicated .on 12/10/23 at 3:00 p.m .LVN A used foul language and threw ice at a resident . LVN A denied .Cook B and Dietary Aide C reported to me [ADM], that they were standing at the nurses station and witnessed resident [Resident #1] come up to the nurses station and LVN A told him to 'stop fucking looking at me and go on' and threw a piece of ice at him .MA D stated that she heard LVN A say 'stop fucking looking at me and go on' but she did not see her throw ice at him [Resident #1] .LVN A was questioned about it, she denied saying anything to him but stated she and Resident #1 were playing and throwing ice at each other .the administrator visited Resident #1 who did not remember any incident .staff interviews indicated that many staff have witnessed LVN A speak rudely or harshly to the residents and often curse or speaks inappropriately to the staff . - Reviewed paperwork indicating LVN A was suspended until completion of investigation which indicated the following: * dated 12/15/23, indicated .type of action: termination .Category I Offense, inappropriate conduct towards a resident .Code of Conduct, Attitude, and Behavior- Policy Violation .Employees are expected and required to be kind, and considerate of residents, visitors, and other facility personnel. Any behavior that is deemed offensive or unsafe. Using profanity, abusive, or suggestive language, or gestures .date of violation 12/10/23 . incident: on, December 11, 2023, it was reported that LVN A used abusive language towards a resident, in which, led to the throwing of a solid object towards the resident .after speaking with all parties involved, we have confirmed these actions .LVN A has received several in-services regarding abuse and neglect among residents, in which, LVN A understands the appropriate conduct when managing residents .consequences: due to category I offense, LVN A will be subjective to immediate termination of employment .employee's comments: the ADM and DON attempted to call LVN A multiple times on 12/15/23 and left message to return call. LVN A texted and stated, 'if I'm fired just let me know so I can find another job'. This ADM responded with 'after we concluded the investigation and spoke to HR, we've decided to terminate your employment.' LVN A did not respond .DON 12/15/23 .ADM 12/15/23 . - Reviewed termination paperwork for LVN A which indicated the following: *dated 12/18/23, indicated .LVN A .termination date 12/18/23 .reason of termination: abusive language toward resident .is employee eligible for rehire: No . - Reviewed LVN A's time sheet to verify last day worked which indicated the following: * dated 12/01/23-12/31/23, indicated LVN A last day worked was 12/10/23 - Reviewed employee corrective action form for [NAME] B, DA C and MA D which indicated the following: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455963	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/10/2024
NAME OF PROVIDER OR SUPPLIER Carthage Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 701 S Market St Carthage, TX 75633	

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	*dated 12/11/23, indicated .Employee Corrective Action Form for [NAME] B C .verbal coaching .facility policy-Abuse and Neglect Reporting .date of violation: 12/11/23 .employee witnessed situation that could be considered Abuse to a resident and did not report to Administrator until the next day .employee was educated 1:1 on reporting of abuse to administrator immediately so the proper investigation process could occur .further disciplinary action could occur .Cook B .ADM . * dated 12/11/23, indicated .Employee Corrective Action Form for DA C .verbal coaching .facility policy-Abuse and Neglect Reporting .date of violation: 12/11/23 .employee witnessed situation that could be considered Abuse to a resident and did not report to Administrator until the next day .employee was educated 1:1 on reporting of abuse to administrator immediately so the proper investigation process could occur .further disciplinary action could occur .DA C .ADM . * dated 12/11/23, indicated .Employee Corrective Action Form for MA D .verbal coaching .facility policy-Abuse and Neglect Reporting .date of violation: 12/11/23 .employee witnessed situation that could be considered Abuse to a resident and did not report to Administrator until the next day .employee was educated 1:1 on reporting of abuse to administrator immediately so the proper investigation process could occur .further disciplinary action could occur . - Reviewed in-service and sign in sheet on Abuse Prevention for all staff which indicated the following: * dated 12/11/23 reflected all employees were provided education of the topic. - Reviewed in-service and sign in sheet on Reporting Abuse Allegation for all staff which indicated the following: *dated 12/11/23 reflected all employees were provided education of the topic. - Reviewed in-service and sign in sheet on Resident Rights for all staff which indicated the following: * dated 12/11/23 reflected all employees were provided education of the topic. - Reviewed completion of notification of RP which indicated the following: *dated 12/15/23, the PIR, reflected responsible party for Resident #1 was notified of incident - Reviewed completion of notifying physician of incident which indicated the following: * dated 12/11/23, the PIR, reflected the physician was notified of the incident involving Resident #1. - Reviewed staff surveys results concerning LVN A which indicated the following: * dated 12/12/23-12/14/23 indicated some staff members witnessed LVN A said or did something inappropriate to a resident, they did know what the resident rights were, knew who was considered a mandated reporter, knew who to report abuse to, and was comfortable reporting abuse. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455963	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Carthage Healthcare Center	701 S Market St Carthage, TX 75633

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	- Reviewed resident safe surveys conducted after incident which indicated the following: * dated 12/12/23-12/14/23 indicated no resident had a staff member curse at them or another resident, knew their rights and who to report abuse to, felt comfortable reporting abuse, and felt safe in the facility. - Reviewed 5 random staff and resident safe surveys conducted monthly x 3 months for QAPI which indicted the following: dated 01/23/24, indicated no staff members had witnessed a staff member mistreat a resident, knew the resident's rights, and knew who to report abuse to. One resident revealed LVN A had cursed at him or another resident. All other resident indicated no staff member cursed at them or another resident, knew their rights and who to report abuse to, felt comfortable reporting abuse, and felt safe in the facility. * dated 02/22/24, indicated no staff members had witnessed a staff member mistreat a resident, knew the resident's rights, and knew who to report abuse to. All five resident indicated no staff member cursed at them or another resident, knew their rights and who to report abuse to, felt comfortable reporting abuse, and felt safe in the facility. * dated 03/25/24, indicated no staff members had witnessed a staff member mistreat a resident, knew the resident's rights, and knew who to report abuse to. All five resident indicated no staff member cursed at them or another resident, knew their rights and who to report abuse to, felt comfortable reporting abuse, and felt safe in the facility. The noncompliance was identified as PNC. The IJ began on 12/10/2023 and ended on 12/15/2023. The facility had corrected the noncompliance before the survey began.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455963	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Carthage Healthcare Center	701 S Market St Carthage, TX 75633

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 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44933 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 10 residents (Resident #1 and Resident #2) reviewed for abuse. 1. The facility failed to ensure [NAME] B, DA C, and MA D immediately reported witnessed abuse towards Resident #1 to the abuse coordinator. 2. The facility failed to ensure Resident #1, and Resident #2 was free from abuse per the policy. 3. The facility failed to ensure the abuse coordinator obtained in writing or electronic format witness statements from [NAME] B, DA C, and MA D. 4. The facility failed to ensure, per their policy, to report alleged allegation of abuse towards Resident #2 to HHSC. The noncompliance was identified as PNC. The IJ began on 12/10/2023 and ended on 12/15/2023. The facility had corrected the noncompliance before the survey began. These failures could place residents at risk for physical harm, psychosocial harm, unsafe environment, and further abuse. Findings included: Record review of a facility's Abuse Prevention Program policy, revised 01/09/23, indicated .the administrator is responsible for the overall coordination and implementation of our Center's abuse prevention program policies and procedures .our residents have the right to be free from abuse, neglect .our center will not condone any form of resident abuse or neglect .to aide in abuse prevention, all personnel are to report any signs and symptoms of abuse/neglect to their supervisor and to the Abuse Prevention Coordinator immediately .all reports of resident abuse .shall be promptly reported to local, state and federal agencies (as defined by current allegations) and thoroughly investigated by Center management .as part of the resident abuse prevention program, the administration will .develop and implement policies and procedures to aid our Center in preventing abuse, neglect, or mistreatment of our residents .identify and assess all possible incidents of abuse .implement measures to address factors that may lead to abusive situations .investigate and report any abuse within timeframes as required by federal requirements .the administrator will ensure that any further potential abuse, neglect, exploitation or mistreatment is prevented .witness reports will be obtained in writing or in electronic format .the investigator will obtain a statement . (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455963	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/10/2024
NAME OF PROVIDER OR SUPPLIER Carthage Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 701 S Market St Carthage, TX 75633	

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 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of a facility's Reporting Allegations of Abuse, neglect, and Exploitation policy revised 10/2023 indicated .it is the policy of the facility to report to the Administrator of the facility and to other appropriate agencies in accordance with current state and federal regulations within all prescribed timeframes all allegations of abuse/neglect/exploitation or mistreatment .the facility will develop and operationalize policies and procedures for screening and training of employees on the topics of protection of residents and for the prevention, identification, investigation, and reporting of abuse, neglect, mistreatment .prevention .the facility will identify, correct, and intervene in situations in which abuse, neglect .the facility will identify events, occurrences, patterns, and trends that may constitute .abuse: the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish, which can included staff to resident abuse .instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain, or mental anguish .it includes verbal abuse, sexual abuse, physical abuse, and mental abuse .verbal abuse means the use of oral, written, or gestured language that willfully includes disparaging and derogatory terms to residents or their families, or within their hearing distance regardless of their age, ability to comprehend, or disability .mistreatment: inappropriate treatment or exploitation of a resident .alleged violation: a situation or occurrence that is observed or reported by staff, resident, relative, visitor or others but has not yet been investigated and, if verified , could be noncompliance with the Federal requirements related to mistreatment, exploitation, neglect, or abuse .investigation .the facility will investigate all allegation and type of incidents .reporting/response: the facility will report all alleged violations and all substantiated incidents to the state agency .any owner, operator, manager, agent, or contracture of the facility can report an allegation of abuse/neglect .when suspicion of abuse/neglect/exploitation or reports of abuse/neglect/exploitation occur, the following procedure will be initiated .the licensed nurse will .remove the accused employee from resident care areas .notify the Administrator or designee .the Administrator or designee will .notify the appropriate agencies immediately: as soon as possible, but no later than 24 hours after discovery of the incident .obtain statements from direct care staff . 1. Record review of Resident #1's face sheet, dated 07/08/24, indicated Resident #1 was a [AGE] year-old, male admitted to the facility on [DATE] and discharged on [DATE] with diagnoses including dementia (loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life), mood affective disorder (is any of a group of conditions of mental and behavioral disorder where a disturbance in the person's mood is the main underlying feature), and mild cognitive impairment (is the stage between the expected decline in memory and thinking that happens with age and the more serious decline of dementia). Record review of Resident #1's quarterly MDS assessment dated [DATE] indicated Resident #1 was sometimes understood and sometimes had the ability to understand others. Resident #1 had minimal difficult hearing, clear speech, and adequate vision. Resident #1 had a BIMS score of 03 which indicated severe cognitive impairment. Resident #1 required supervision for ADL assistance except for shower/bathe self which required maximal assistance. Record review of Resident #1's care plan dated 04/19/23 indicated Resident #1 was at risk for altered psychosocial well-being related to dementia. Intervention included listen carefully and be non-judgmental. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455963	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Carthage Healthcare Center	701 S Market St Carthage, TX 75633

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 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of a PIR for Resident #1, dated 12/11/23, indicated .on 12/10/23 at 3:00 p.m.LVN A used foul language and threw ice at a resident .LVN A denied .Cook B and Dietary Aide C reported to me [ADM], that they were standing at the nurses station and witnessed resident [Resident #1] come up to the nurses station and LVN A told him to 'stop fucking looking at me and go on' and threw a piece of ice at him .MA D stated that she heard LVN A say 'stop fucking looking at me and go on' but she did not see her throw ice at him [Resident #1] .LVN A was questioned about it, she denied saying anything to him but stated she and Resident #1 were playing and throwing ice at each other .the administrator visited Resident #1 who did not remember any incident .staff interviews indicated that many staff have witnessed LVN A speak rudely or harshly to the residents and often curse or speaks inappropriately to the staff .Resident safe surveys did not indicate any concerns with LVN A .physician and RP for Resident #1 notified of the incident .investigation findings: unconfirmed .Provider action taken post-investigation: staff reeducated on Abuse and Neglect Prevention and reporting, Professionalism, and Resident Rights .5 random staff interviews and resident safe surveys will be conducted monthly and results will be reviewed by QAPI committee monthly for 3 months . The PIR did not indicate an incident between LVN A and Resident #2. 2. Record review of Resident #2's face sheet, dated 07/08/24, indicated Resident #2 was a [AGE] year-old, male admitted on [DATE] and discharge 06/19/24 with diagnoses including anxiety disorder (persistent and excessive worry that interferes with daily activities), Type 2 diabetes (s a chronic condition that happens when you have persistently high blood sugar levels), nicotine dependence, schizoaffective disorder, bipolar type (is a chronic mental health condition characterized primarily by symptoms of schizophrenia (is a serious mental health condition that affects how people think, feel and behave), such as hallucinations or delusions, and symptoms of a mood disorder, such as mania and depression), and restlessness and agitation. Record review of Resident #2's annual MDS assessment dated [DATE], indicated Resident #2 was usually understood and usually understood others. Resident #2 had moderate difficulty hearing, clear speech, and impaired vision with use of corrective lenses. Resident #2 had a BIMS of 09, which indicated moderate cognitive impairment. Resident #2 required set up assistance for eating, dressing, and personal hygiene, supervision assistance for oral and toilet hygiene and partial assistance for shower/bathe self. Record review of Resident #2's care plan dated 06/12/23, indicated: *Resident #2 was at risk for altered psychosocial well-being related to schizoaffective disorder. Intervention included listen carefully and be non-judgmental. *Resident #2 was at risk for altered mood state related to schizoaffective disorder. Resident #2 pace the halls frequently, visit multiple staff members, frequently in/out of office. Resident #2 am easily agitated, yell loudly, make threatening statements to staff and/or residents. Intervention included be reassuring and listen to concerns. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455963	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/10/2024
NAME OF PROVIDER OR SUPPLIER: Carthage Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 701 S Market St Carthage, TX 75633	

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 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 07/09/24 at 9:29 a.m., CNA E said she had worked at the facility for [AGE] years. She said she had witnessed LVN A being loud to resident but had only heard about LVN A using inappropriate language at residents. She said LVN A would escalate situations with Resident #2. She said she heard LVN A had cussed at Resident #1 and Resident #2. She said cussing and throwing things at resident was abuse. She said LVN A talked ugly, and, in a way, she would not want her family members spoken to. She said after LVN A and Resident #2 would get into, Resident #2 would talk aloud to himself and stated he did not like LVN A. She said she thought LVN A had been coached about her conduct with staff and resident before Resident #1's incident. She said if she witnessed or heard abuse toward a resident, she would report it to the ADM immediately. She said she received quarterly abuse prevention training. She said it was important to report abuse to the abuse coordinator immediately so the issue could be taken care of. She said reporting also stopped the abuse from happening. She said not reporting abuse allegations placed resident at risk to getting hurt or harmed. During an interview on 07/09/24 at 10:52 a.m., MA D said she worked for the facility for 2 years. She said she worked the day LVN A cussed at Resident #1. She said Resident #1 said or did something at the nursing station where LVN A was sitting. She said LVN A threw ice at Resident #1 and used the F word towards him. She said Resident #1 liked to touch people and grab drinks so maybe he did something to set her off. She said Resident #1 was walking away from LVN A and she threw ice at him. She said LVN behavior was abusive and inappropriate. She said she did not report the incident between Resident #1 and LVN A. She said she did not have the ADM phone number in her phone, but her number was posted in the sign in book. She said the next day after the incident, the ADM questioned her. She said it was important to report abuse immediately to the ADM so she could report it the state. She said if abuse was not reported immediately, resident could get hurt and situations could escalate. She said Resident #2 was at the nursing station and was asking LVN A to take him out to smoke. She said LVN A and Resident #2 exchanged words because she did not take him out. She said LVN A had made a sign on a posted note that said, get the fuck away or go away, leave me alone and would put it up when Resident #2 came to the nurses' station. She said about the second time Resident #2 came to the nurses' station, LVN A cussed at him and threw the posted note at him. She said Resident #2 walked away and was upset. She said another staff member took him out to smoke. She said this incident happened around the same time of Resident #1's incident. She said LVN A escalate situation especially with Resident #2. She said using foul language at a resident was abusive. She said she immediately reported the incident with Resident #2 and LVN A. She said the situation was getting out of control between LVN A and Resident #2. She said she called the ADM on her phone and told her what was going on. She said the ADM eventually showed up at the facility to handle the situation. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455963	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Carthage Healthcare Center	701 S Market St Carthage, TX 75633

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 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 07/09/24 at 11:15 a.m., the ADM said LVN A and Resident #1 incident happened on a Sunday. She said on Monday, [NAME] B and DA C told her Resident #1 walked up to the nurses' station and LVN A cussed at him and threw something at him. She said LVN A may have also called him a wierdo. She said [NAME] B and DA C said the situation bothered them, so they reported it. She said LVN A denied the event happened. She said LVN A was suspended pending investigation. She said she interviewed staff and resident about LVN A. She said the staff interviews revealed some concerns about LVN A. She said LVN A was terminated 3-4 days later after completion of the investigation. She said she believed the incident with LVN A and Resident #2 happened the same day as Resident #1's incident with LVN A. She said she recalled being told LVN A held up a sign at Resident #2 but did not remember anything else about foul language being used between them. She said in December 2023, she did not believe it was stated in the facility's policy to obtain witness statements. She said in March 2024, the corporation provided reeducation on self-reports and recommended obtaining witness statements. She said it was important to obtain witness statements to get accurate information. She said witness statements were part of the investigation and made it more thorough. She said witness statements were not obtained stories could change. She said not obtaining witness statements could make the investigation not thorough. She said the incident between LVN A and Resident #1 was the first incident involving LVN A and a resident. She said LVN A had a history bullying staff members but not residents. She said general in-services on professionalism and conduct was provided to LVN A. She said LVN A did have one on one counseling for complaint from staff on her attitude and bullying. She said she expected her staff to report allegation of abuse immediately. She said her information to contact her was posted in the posting cabinet, in the hallway, and at the nurses' station. She said the facility had provided in-person training on abuse prevention and reporting to staff. She said not reporting abuse risked the abuse continuing. During an interview on 07/09/24 at 1:45 p.m., [NAME] B said Resident #1 was at the nurses' station and LVN A told Resident #1 go the fuck away and threw ice at him. She said Resident #1 did say anything because he was not very verbal, but he was visibly upset by his facial expression. She said Resident #1 walked away from the nurses' station away from LVN A. She said she considered what LVN A did to Resident #1 was verbal abuse. She said she did not report the incident between LVN A and Resident #1 until the next day. She said she got busy the day of the incident because she had to do her job and forgot. She said she should have reported the incident between LVN A and Resident #1 immediately and received a verbal coaching for not reporting. She said it was important to report to the ADM immediately, so she could deal with it right then. She said if abuse was not reported, it could keep happening. During an interview on 07/09/24 at 4:15 p.m., DA C said LVN threw ice and said get the fuck away from me to Resident #1. She said Resident #1 looked upset like anyone else would if they got ice thrown at them. She said she did not have the ADM phone number the day of the incident which was why she did not report it immediately. She said she did not know the ADM phone number was at the nurses' station in the sign in book. She said she knew the incident should have been reported to the ADM immediately. She said she did get a verbal corrective coaching for not reporting. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455963	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/10/2024
NAME OF PROVIDER OR SUPPLIER Carthage Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 701 S Market St Carthage, TX 75633	

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 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 07/10/24 at 9:02 a.m., the Housekeeping/Laundry Supervisor F said she had witnessed, on one occasion, LVN A being rude to Resident #2 at the nurses' station. She said LVN was just rude but did not use foul language towards him. She said Resident #2 was mad after the incident and went into his room. She said when she heard how she was talking to Resident #2, she told her to stop being rude. She said she did not tell the DON or ADM about the incident. She said she felt the incident was inappropriate but not abuse. She said she knew to report abuse to the ADM as soon as possible. She said it should be reported because the abuse should not be happening. She said she would not want to be treated the LVN A treated Resident #2. She said abuse could keep happening if not immediately reported. She said she had received training on abuse, neglect, and exploitation. During an interview on 07/10/24 at 11:50 a.m., the ADM said she was the abuse coordinator, and it was her responsibility to investigate and report allegations of abuse to the State. She said she had to report abuse allegation within 2 hours. She said reporting and investigating protected the resident. She said not reporting placed resident at risk for abuse. Record review of LVN A's annual training dated 06/01/23 indicated training on subjects of resident rights and abuse and neglect. Record review of a facility conducted in-service, Abuse Prevention Program dated 12/11/23 reflected all employees were provided education of the topic. Record review of a facility conducted in-service, Reporting Allegations of Abuse, Neglect, and Exploitation dated 12/11/23 reflected all employees were provided education of the topic. Record review of a facility conducted in-service, Resident Rights dated 12/11/23 reflected all employees were provided education of the topic. Record review of 13 resident safe surveys dated 12/12/23-12/14/23 indicated no resident had a staff member curse at them or another resident, knew their rights and who to report abuse to, felt comfortable reporting abuse, and felt safe in the facility. Record review of 29 staff interviews dated 12/12/23-12/14/23 indicated some staff members witnessed LVN A said or did something inappropriate to a resident, they did know what the resident rights were, knew who was considered a mandated reporter, knew who to report abuse to, and was comfortable reporting abuse. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455963	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Carthage Healthcare Center	701 S Market St Carthage, TX 75633

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 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of LVN A's Employee Corrective Action Form dated 12/15/23, indicated .type of action: termination .Category I Offense, inappropriate conduct towards a resident .Code of Conduct, Attitude, and Behavior- Policy Violation .Employees are expected and required to be kind, and considerate of residents, visitors, and other facility personnel. Any behavior that is deemed offensive or unsafe. Using profanity, abusive, or suggestive language, or gestures .date of violation 12/10/23 .incident: on, December 11, 2023, it was reported that LVN A used abusive language towards a resident, in which, led to the throwing of a solid object towards the resident .after speaking with all parties involved, we have confirmed these actions .LVN A has received several in-services regarding abuse and neglect among residents, in which, LVN A understands the appropriate conduct when managing residents .consequences: due to category I offense, LVN A will be subjective to immediate termination of employment .employee's comments: the ADM and DON attempted to call LVN A multiple times on 12/15/23 and left message to return call. LVN A texted and stated, 'if I'm fired just let me know so I can find another job'. This ADM responded with 'after we concluded the investigation and spoke to HR, we've decided to terminate your employment.' LVN A did not respond .DON 12/15/23 .ADM 12/15/23 . Record review of LVN A's Notice of Termination dated 12/18/23, indicated .LVN A .termination date 12/18/23 .reason of termination: abusive language toward resident .is employee eligible for rehire: No . Record review of LVN A's personnel file on 07/09/24 indicated hire date of 10/18/22. The facility had performed background check and employee misconduct search. No concerns were identified. Record review of a facility's Abuse Prevention policy revised 01/09/23 indicated .our residents have the right to be free from abuse, neglect .this includes but is not limited to .verbal, mental, sexual, or physical abuse . Record review of 5 Random Interviews of Staff and Residents, dated 01/23/24, indicated no staff members had witnessed a staff member mistreat a resident, knew the resident's rights, and knew who to report abuse to. One resident revealed LVN A had cursed at him or another resident. All other resident indicated no staff member cursed at them or another resident, knew their rights and who to report abuse to, felt comfortable reporting abuse, and felt safe in the facility. Record review of 5 Random Interviews of Staff and Residents, dated 02/22/24, indicated no staff members had witnessed a staff member mistreat a resident, knew the resident's rights, and knew who to report abuse to. All five resident indicated no staff member cursed at them or another resident, knew their rights and who to report abuse to, felt comfortable reporting abuse, and felt safe in the facility. Record review of 5 Random Interviews of Staff and Residents, dated 03/25/24, indicated no staff members had witnessed a staff member mistreat a resident, knew the resident's rights, and knew who to report abuse to. All five resident indicated no staff member cursed at them or another resident, knew their rights and who to report abuse to, felt comfortable reporting abuse, and felt safe in the facility. The administrator was notified of IJ PNC on 07/09/2024 at 4:40 p.m. due to the above failures. The administrator was provided with the IJ template on 07/09/2024 at 4:45 p.m. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455963	A. Building B. Wing	07/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Carthage Healthcare Center	701 S Market St Carthage, TX 75633

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 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The surveyor confirmed PNC had been implemented sufficiently to remove the Immediate Jeopardy on 12/15/23 by: - Reviewed completed facility self-reported incident to HHSC for Resident #1 which indicated the following: * dated 12/11/23, indicated .on 12/10/23 at 3:00 p.m .LVN A used foul language and threw ice at a resident . LVN A denied .Cook B and Dietary Aide C reported to me [ADM], that they were standing at the nurses station and witnessed resident [Resident #1] come up to the nurses station and LVN A told him to 'stop fucking looking at me and go on' and threw a piece of ice at him .MA D stated that she heard LVN A say 'stop fucking looking at me and go on' but she did not see her throw ice at him [Resident #1] .LVN A was questioned about it, she denied saying anything to him but stated she and Resident #1 were playing and throwing ice at each other .the administrator visited Resident #1 who did not remember any incident .staff interviews indicated that many staff have witnessed LVN A speak rudely or harshly to the residents and often curse or speaks inappropriately to the staff . - Reviewed paperwork indicating LVN A was suspended until completion of investigation which indicated the following: * dated 12/15/23, indicated .type of action: termination .Category I Offense, inappropriate conduct towards a resident .Code of Conduct, Attitude, and Behavior- Policy Violation .Employees are expected and required to be kind, and considerate of residents, visitors, and other facility personnel. Any behavior that is deemed offensive or unsafe. Using profanity, abusive, or suggestive language, or gestures .date of violation 12/10/23 . incident: on, December 11, 2023, it was reported that LVN A used abusive language towards a resident, in which, led to the throwing of a solid object towards the resident .after speaking with all parties involved, we have confirmed these actions .LVN A has received several in-services regarding abuse and neglect among residents, in which, LVN A understands the appropriate conduct when managing residents .consequences: due to category I offense, LVN A will be subjective to immediate termination of employment .employee's comments: the ADM and DON attempted to call LVN A multiple times on 12/15/23 and left message to return call. LVN A texted and stated, 'if I'm fired just let me know so I can find another job'. This ADM responded with 'after we concluded the investigation and spoke to HR, we've decided to terminate your employment.' LVN A did not respond .DON 12/15/23 .ADM 12/15/23 . - Reviewed termination paperwork for LVN A which indicated the following: *dated 12/18/23, indicated .LVN A .termination date 12/18/23 .reason of termination: abusive language toward resident .is employee eligible for rehire: No . - Reviewed LVN A's time sheet to verify last day worked which indicated the following: * dated 12/01/23-12/31/23, indicated LVN A last day worked was 12/10/23 - Reviewed employee corrective action form for [NAME] B, DA C and MA D which indicated the following: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455963	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/10/2024
NAME OF PROVIDER OR SUPPLIER Carthage Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 701 S Market St Carthage, TX 75633	

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 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	*dated 12/11/23, indicated .Employee Corrective Action Form for [NAME] B C .verbal coaching .facility policy-Abuse and Neglect Reporting .date of violation: 12/11/23 .employee witnessed situation that could be considered Abuse to a resident and did not report to Administrator until the next day .employee was educated 1:1 on reporting of abuse to administrator immediately so the proper investigation process could occur .further disciplinary action could occur .Cook B .ADM . * dated 12/11/23, indicated .Employee Corrective Action Form for DA C .verbal coaching .facility policy-Abuse and Neglect Reporting .date of violation: 12/11/23 .employee witnessed situation that could be considered Abuse to a resident and did not report to Administrator until the next day .employee was educated 1:1 on reporting of abuse to administrator immediately so the proper investigation process could occur .further disciplinary action could occur .DA C .ADM . * dated 12/11/23, indicated .Employee Corrective Action Form for MA D .verbal coaching .facility policy-Abuse and Neglect Reporting .date of violation: 12/11/23 .employee witnessed situation that could be considered Abuse to a resident and did not report to Administrator until the next day .employee was educated 1:1 on reporting of abuse to administrator immediately so the proper investigation process could occur .further disciplinary action could occur . - Reviewed in-service and sign in sheet on Abuse Prevention for all staff which indicated the following: * dated 12/11/23 reflected all employees were provided education of the topic. - Reviewed in-service and sign in sheet on Reporting Abuse Allegation for all staff which indicated the following: *dated 12/11/23 reflected all employees were provided education of the topic. - Reviewed in-service and sign in sheet on Resident Rights for all staff which indicated the following: * dated 12/11/23 reflected all employees were provided education of the topic. - Reviewed completion of notification of RP which indicated the following: *dated 12/15/23, the PIR, reflected responsible party for Resident #1 was notified of incident - Reviewed completion of notifying physician of incident which indicated the following: * dated 12/11/23, the PIR, reflected the physician was notified of the incident involving Resident #1. - Reviewed staff surveys results concerning LVN A which indicated the following: * dated 12/12/23-12/14/23 indicated some staff members witnessed LVN A said or did something inappropriate to a resident, they did know what the resident rights were, knew who was considered a mandated reporter, knew who to report abuse to, and was comfortable reporting abuse. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455963	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/10/2024
NAME OF PROVIDER OR SUPPLIER Carthage Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 701 S Market St Carthage, TX 75633	

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 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	- Reviewed resident safe surveys conducted after incident which indicated the following: * dated 12/12/23-12/14/23 indicated no resident had a staff member curse at them or another resident, knew their rights and who to report abuse to, felt comfortable reporting abuse, and felt safe in the facility. - Reviewed 5 random staff and resident safe surveys conducted monthly x 3 months for QAPI which indicted the following: dated 01/23/24, indicated no staff members had witnessed a staff member mistreat a resident, knew the resident's rights, and knew who to report abuse to. One resident revealed LVN A had cursed at him or another resident. All other resident indicated no staff member cursed at them or another resident, knew their rights and who to report abuse to, felt comfortable reporting abuse, and felt safe in the facility. * dated 02/22/24, indicated no staff members had witnessed a staff member mistreat a resident, knew the resident's rights, and knew who to report abuse to. All five resident indicated no staff member cursed at them or another resident, knew their rights and who to report abuse to, felt comfortable reporting abuse, and felt safe in the facility. * dated 03/25/24, indicated no staff members had witnessed a staff member mistreat a resident, knew the resident's rights, and knew who to report abuse to. All five resident indicated no staff member cursed at them or another resident, knew their rights and who to report abuse to, felt comfortable reporting abuse, and felt safe in the facility. The noncompliance was identified as PNC. The IJ began on 12/10/2023 and ended on 12/15/2023. The facility had corrected the noncompliance before the survey began.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455963	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/10/2024
NAME OF PROVIDER OR SUPPLIER Carthage Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 701 S Market St Carthage, TX 75633	

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 0609 Level of Harm - Minimal harm or potential for actual harm 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** 44933 Based on interview and record review, the facility failed to ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, were reported immediately, but not later than 2 hours after the allegation was made, if the events that caused the allegation involved abuse or resulted in serious bodily injury, or not later than 24 hours if the events that caused the allegation did not involve abuse and did not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures for 1 of 10 residents (Resident #2) reviewed for abuse and neglect. The facility failed to report Resident #2's abuse allegation within 24 hours to the state agency. This failure could place residents at risk for continued abuse and neglect due to inappropriate interventions and failure to report the allegations of abuse timely. Finding included: Record review of a facility's Reporting Allegations of Abuse, neglect, and Exploitation policy revised 10/2023 indicated .it is the policy of the facility to report to the Administrator of the facility and to other appropriate agencies in accordance with current state and federal regulations within all prescribed timeframes all allegations of abuse/neglect/exploitation or mistreatment . investigation .the facility will investigate all allegation and type of incidents .reporting/response: the facility will report all alleged violations and all substantiated incidents to the state agency .any owner, operator, manager, agent, or contracture of the facility can report an allegation of abuse/neglect .when suspicion of abuse/neglect/exploitation or reports of abuse/neglect/exploitation occur, the following procedure will be initiated .the licensed nurse will .remove the accused employee from resident care areas .notify the Administrator or designee .the Administrator or designee will .notify the appropriate agencies immediately: as soon as possible, but no later than 24 hours after discovery of the incident . Record review of Resident #2's face sheet, dated 07/08/24, indicated Resident #2 was a [AGE] year-old, male admitted on [DATE] and discharge 06/19/24 with diagnoses including anxiety disorder (persistent and excessive worry that interferes with daily activities), Type 2 diabetes (s a chronic condition that happens when you have persistently high blood sugar levels), nicotine dependence, schizoaffective disorder, bipolar type (is a chronic mental health condition characterized primarily by symptoms of schizophrenia (is a serious mental health condition that affects how people think, feel and behave), such as hallucinations or delusions, and symptoms of a mood disorder, such as mania and depression), and restlessness and agitation. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455963	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Carthage Healthcare Center	701 S Market St Carthage, TX 75633

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #2's annual MDS assessment dated [DATE], indicated Resident #2 was usually understood and usually understood others. Resident #2 had moderate difficulty hearing, clear speech, and impaired vision with use of corrective lenses. Resident #2 had a BIMS of 09, which indicated moderate cognitive impairment. Resident #2 required set up assistance for eating, dressing, and personal hygiene, supervision assistance for oral and toilet hygiene and partial assistance for shower/bathe self. Record review of Resident #2's care plan dated 06/12/23, indicated: *Resident #2 was at risk for altered psychosocial well-being related to schizoaffective disorder. Intervention included listen carefully and be non-judgmental. *Resident #2 was at risk for altered mood state related to schizoaffective disorder. Resident #2 pace the halls frequently, visit multiple staff members, frequently in/out of office. Resident #2 am easily agitated, yell loudly, make threatening statements to staff and/or residents. Intervention included be reassuring and listen to concerns. During an interview on 07/09/24 at 10:52 a.m., MA D said she worked for the facility for 2 years. She said Resident #2 was at the nursing station and was asking LVN A to take him out to smoke. She said LVN A and Resident #2 exchanged words because she did not take him out. She said LVN A had made a sign on a posted note that said, get the fuck away or go away, leave me alone and would put it up when Resident #2 came to the nurses' station. She said about the second time Resident #2 came to the nurses' station, LVN A cussed at him and threw the posted note at him. She said Resident #2 walked away and was upset. She said another staff member took him out to smoke. She said this incident happened around the same time of another resident's incident that happened on 12/10/24. She said LVN A escalate situation especially with Resident #2. She said using foul language at a resident was abusive. She said the situation was getting out of control between LVN A and Resident #2. She said she immediately reported the incident with Resident #2 and LVN A. She said she called the ADM on her phone and told her what was going on. She said the ADM eventually showed up at the facility to handle the situation. During an interview on 07/09/24 at 11:15 a.m., the ADM said she believed the incident with LVN A and Resident #2 happened the same day as another resident's incident with LVN A on 12/10/23. She said she recalled being told LVN A held up a sign at Resident #2 but did not remember anything else about foul language being used between them. She said in March 2024, the corporation provided reeducation on self-reports. During an interview on 07/10/24 at 11:35 a.m., the DON said she said the ADM was responsible for investigating and reporting. She said she was normally responsible for in-services. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455963	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/10/2024
NAME OF PROVIDER OR SUPPLIER Carthage Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 701 S Market St Carthage, TX 75633	

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 07/10/24 at 11:50 a.m., the ADM said she recalled MA D telling her LVN A was on a roll that day and LVN A had a sign telling Resident #2 to go away. She said LVN A egged Resident #2 on all the time. She said if LVN A threw something at Resident #2, she was surprised Resident #2 did not attack LVN A. She said maybe she misinterpreted the situation when MA D told her about LVN A and Resident #2. She said maybe she thought MA D was talking about LVN A and another resident's incident. She said she was the abuse coordinator, and it was her responsibility to investigate and report allegations of abuse to the State. She said she had to report abuse allegation within 2 hours. She said reporting and investigating protected the resident. She said not reporting placed resident at risk for abuse.