STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675018	A. Building B. Wing	05/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
River Oaks Health and Rehabilitation Center	2416 NW 18th St Fort Worth, TX 76106

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	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** Based on observation, interview, and record review, the facility failed to ensure residents were free from verbal abuse by Resident #1 for 2 (Residents #2, #3) of 13 reviewed for abuse. The facility failed to protect residents from verbal abuse, threats, and physical abuse by Resident #1. Resident #2 was threatened by Resident #1 on 4/5/2026, 4-25-2026 by Resident #1 saying [Resident #1] was going to have Resident #2 beat up, was not afraid of Resident #2's phone, was going to slap the dog shit out of [Resident #2], and was going to knock the shit out of [Resident #2]. Resident #3 was verbally abused, physically grabbed, and pushed out of the way by Resident #1 on 4-29-2026.Resident #6 was verbally abused and threatened by Resident #1 when he told her I'm going to kick your ass and physically pushed her out of [Resident #1's] way. The Administrator and staff were aware of the abuse and told vulnerable residents with histories of trauma to just avoid the aggressor (Resident #1). On 4-30-2026 at 2:54 PM, an Immediate Jeopardy was identified. While the IJ was removed on 5-1-2026, the facility remained out of compliance at a scope of pattern and a severity level of no actual harm with potential for more than minimal harm that is not Immediate Jeopardy, due to the facility continuing to monitor the implementation and effectiveness of their Plan of Removal.These failures resulted in Resident's #2 and #3 who reported fear and feeling unsafe and placed residents at risk of subsequent abuse, resulting in potential severe physical harm, pain, or mental anguish.Record review of Resident #1's admission record, dated and reviewed on 4-29-2026, revealed a [AGE] year-old male, admitted [DATE] and readmitted [DATE]. Resident #1 had a primary diagnosis of transient cerebral ischemic attach (stroke) and secondary diagnoses of anxiety disorder (mental health condition categorized by excessive worry affecting quality of life), bipolar disorder (mental health condition characterized by significant mood swings), current episode manic severe with psychotic features (a distinct period of abnormally, persistently elevated, or irritable mood and extremely high energy, lasting at least one week like an unrealistic sense of superiority, power, decreased sleep, and racing thoughts with delusions or hallucinations), and intermittent explosive disorder (a mental health condition characterized by recurrent, impulsive, and disproportionate outbursts of rage or aggression). Record review of Resident #1's Quarterly MDS assessment, dated 3-24-2026, reviewed on 04-29-2026, revealed Resident #1 re-entered the facility from a short-term general hospital with a BIMS score of 14 indicating Resident#1 was cognitively intact. The GG, Functional section, revealed Resident#1 could independently move from a sitting position to a standing position and could independently transfer himself from a bed to a chair. The K-Swallowing/Nutritional Status Section, revealed Resident #1 was 6' 4 and weighed 230 pounds. Resident #1 used a wheelchair to ambulate. Record review of Resident #1's most recent care plan with an initial date of 8-25-2021 and a revision date of 9-4-2024, and reviewed on 04-29-2026, indicated Resident #1 had behavior problems of attention-seeking and accusatory behaviors, distorting the truth in attention seeking efforts and/or making false allegations, making negative statements about staff, proposing unrealistic demands, threatening staff with calling the state, inserted himself into staff/other residents' care/affairs causing outbursts, attention seeking (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	behavior, making false allegations, he makes his peers feel uncomfortable or uneasy when around him, and had potential to demonstrate physical behaviors of anger, and poor impulse control. Record review of Resident #1's Event Nurses Note, dated 7-7-2024, reflected Resident #1 had a resident-to-resident incident yelling at his roommate. Record review of Resident #1's Event Nurses Note, dated 9-3-2024, reflected Resident #1 had a resident-to-resident incident verbally threatening another resident yelling for him to get out of his room. Staff explained the resident was his roommate. Record review of Resident #1's Event Nurses Note, dated 12-12-2025, reflected Resident #1 was combative, verbally and physically aggressive by standing up, swinging his hand toward a CNA attempting to hit the CNA. Resident #1 said I will take the shit out of you. Record review of Resident #1's progress notes reflected the following: 3-13-2026 at 8:50 PM - In the last week, the resident experienced verbal behaviors directed toward others 1-3 days . Verbally aggressive with other residents in the hallways. 3-18-2026 at 11:38 PM - In the last week, the resident experienced verbal behaviors directed toward others 1-3 days . 4-5-2026 at 9:58 PM - Resident #1 had a verbal confrontation with another resident witnessed by staff. He was resistant to resolution and intervention. When separated, he claimed the other resident pushed his wheelchair; none of the witnesses saw this happen. During an observation and interview on 4-29-2026 at 12:42 PM, Resident #2 was observed ambulating in a motorized wheelchair in the hallway outside her room. Resident #2 wanted to speak in private and said she did not feel safe around Resident #1. Resident #2 said Resident #1 threatened to have her beat up by his sister on 4-5-2026. Resident #2 then exhibited a video, from her phone, of Resident #1 ambulating in his wheelchair toward Resident #2 saying in a loud voice, I'm not afraid of your phone, I'm going to slap the dog shit out of Resident #2 and I'm going to knock the shit out of Resident #2. Resident #2 said Resident #1 started being aggressive toward her when she observed Resident #1 bullying a non-verbal resident sitting in his wheelchair. Resident #2 said she asked Resident #1 to leave the vulnerable non-verbal resident alone. That was when Resident #1 started to make verbal threats toward Resident #2. Resident #2 said she filed a grievance with the Social Worker on 4-27-2026. The Social Worker told Resident #2 she needed to speak with the Administrator and would get back with her after she spoke with him. Resident #2 said the Social Worker got back with her the same day and said the Administrator said to just avoid Resident #1. Resident #2 said she told the Social Worker she did not feel safe as the facility was not protecting her, she felt lied to by the facility, and wanted the State's phone number and the facility's corporate phone number. Record review of Resident #2's admission sheet, dated and reviewed on 04-29-2026, revealed Resident #2 was a [AGE] year-old female admitted [DATE] and readmitted [DATE]. Resident #2's primary diagnosis was anemia (condition characterized by a deficiency in health red blood cells, leading to insufficient oxygen delivery to the body's tissues) and secondary diagnoses of foot drop, right foot (the inability to lift the front part of the foot, causing it to drag or slap on the floor while walking), heart failure, major depressive disorder (serious mental condition characterized by persistent feelings of sadness, loss of interest in activities, and various emotional and physical problems), and generalized anxiety disorder. Record review of Resident #2's Quarterly MDS assessment, dated 3-10-2026, reflected a BIMS score of 15 indicating cognitively intact. The GG-Functional Abilities revealed Resident #2 used a motorized wheelchair to ambulate. Record review of Resident #2's Care Plan, dated 10-17-2025, revealed she had a history of trauma that may have a negative impact. The trauma is r/t: history of life-threatening illness, physical assault [Family Member], physically threatened and sexually assault. Resident #2 was care planned to have a potential for uncontrolled pain due to Fibromyalgia (chronic condition characterized by widespread pain, fatigue, and other symptoms), chronic right arms pain, left leg pain. back pain and neuropathy (nerve damage outside the brain and spinal cord). Record review of the facility's grievance log, reflected Resident #2 filed a grievance on 4-27-2026 stating she wanted Resident #1 to be discharged because Resident #1 was making her stressed and threatened. Resident #2 said on 4-25-2026 Resident #1 held his fist up to her and threatened to physically harm her. Resident #2 said Resident #1 (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	acted aggressively toward her multiple times. The summary of the pertinent findings by the facility stated Resident #2 did record the interaction. In one of the videos, Resident #1 is clearly heard threatening to slap the shit of Resident #2. The corrective action the facility stated it took was to tell both residents to stay away from each other and educate staff to separate them in case of confrontation. Record review of Resident #2's progress note, dated 4-28-2026 at 12:00 PM, revealed the Social Worker stated she followed up with Resident #2's grievance stating regarding the resolution to her grievance. Resident #2 said it was not satisfactory and that avoiding Resident #1 was not possible. She said he threatened her again last night but would not elaborate further. She stated she feels the facility has lied to her and requested contact information for the State and Corporate. During an interview on 4-29-2026 at 12:50 PM, Resident #5 said she was not comfortable around Resident #1 when he comes to the doorway of her room saying he was going to get the facility shutdown. Resident #5 said she was bedbound. During an interview on 4-29-2026 at 3:57 PM, Resident #3 said she was afraid of Resident #1 because he verbally threatened to hit her and was verbally abusive with his words. Resident #3 said the facility knew about Resident #1's conduct but had not done anything about it. Record review of Resident #3's admission record, dated 4-30-2026, reflected a [AGE] year-old female admitted [DATE] and readmitted [DATE]. Resident #3's primary diagnosis was chronic obstructive pulmonary disease (lung disease causing chronic coughing, wheezing, and severe breathlessness due to damaged airways, primarily caused by smoking, air pollution, or genetic factors) and secondary diagnoses of generalized anxiety disorder, glaucoma (a group of eye diseases that damage the optic nerve, often due to high eye pressure, leading to permanent, irreversible vision loss or blindness), and unsteadiness on her feet. Record review of Resident #3's Quarterly MDS assessment, dated 3-9-2026, revealed she had a BIMS score of 15 indicating being cognitively intact. The GG-Functional Abilities section revealed Resident #3 used a wheelchair to ambulate. The J-Health Conditions of Resident #3 revealed she experienced frequent pain. Record review of Resident #3's care plan, dated 6-6-2023, revealed she was care planned for trauma informed care stating she was in a major natural disaster or technological disaster such as fire, tornado, hurricane, flood, earthquake, or chemical spill. During an observation and interview on 4-30-2026 at 2:00 PM, Resident #3 said last night when she was getting her medication by the nurse's station, Resident #1 came up behind her in his wheelchair, grabbed her arm, and cursed at her demanding she get out of his way. Resident #3 was observed to start crying at this point. Resident #3 said she then slapped Resident #1 to let her go. Record review of Resident #3's progress notes, dated 4-30-2026 at 11:06 AM, revealed Resident #3 told the Dietary Manager that [Resident #1] approached [Resident #3] from behind, yelled and used profanity toward [Resident #3], grabbed [Resident #3's forearm, and pushed [Resident #3] while she was in her wheelchair. During an observation and attempted interview on 4-30-2026 at 10:55 PM, Resident #1 was observed to be sleeping in his bed in a private room. During an interview on 4-30-2026 at 11:00 AM, RN A said Resident #1 got up earlier today, ate breakfast, and went back to sleep. RN A said Resident #1 sleeps all day long. In an interview on 4-30-2026 at 11:10 AM, the SW said Resident #2 did not feel safe around Resident #1. The SW said she spoke with the Administrator regarding Resident #2's grievance and the Administrator said because this was the first grievance Resident #2 filed concerning Resident #1's behavior, he did not want to discharge anyone. The SW said the Administrator said for Resident #2 to just avoid Resident #1. The SW said the facility kept residents safe from Resident #1 by redirecting him. In an interview and record review on 4-30-2026 at 11:30 AM, the Administrator said he was an AIT and had worked at the facility since 11-18-2025. The Administrator said he told Resident #2 to just avoid Resident #1 and staff were informed to keep them apart. The Administrator said verbal abuse was to the best of my understanding would be using defamatory words, racial slurs. The Administrator named different types of abuse as being verbal, emotional, financial, mental, and physical. The Administrator said a self-report was not filed by the facility regarding Resident #2's grievance because he was in and out of the office. The Administrator said, I should have filed a self-report, that was my fault. When asked, (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	if he thought the grievance Resident #2 filed regarding Resident #1's threatening her was abuse, the Administrator said, I don't know. When the video and audio recording of Resident #1 threatening to do bodily harm to Resident #2, dated 4-25-2026, was shown to the Administrator, he said, That was abuse. The Administrator said he saw another video today of Resident #1 verbally abusing Resident #2 where former DON (RN B) was trying to redirect Resident #1. The Administrator said RN B did not report this incident to him. The Administrator said in his absence, the DON became the abuse coordinator, and it was elevated to the Area Director of Operations. The Administrator said the facility had not discharged Resident #1 because, Resident #1 had not crossed the line yet that would fulfill the requirement to justify an immediate discharge as he would have to physically assault someone to justify an immediate discharge, in my opinion. The Administrator said the facility did not follow its own Abuse and Neglect Policy because in this particular situation, the SW did not want to add onto his health issues he had been dealing with. The Administrator said the facility protected other residents from Resident #1 by filing self-reports, and I just don't have a lot of answers right now. The Administrator said Resident #1 had never tried to hit anyone. However, the Administrator was shown an event nurse note from the facility's EMR, revealing on 12-12-2025 at 4:02 PM, Resident #1 attempted to hit a CNA by swinging his hand at the CNA, but missed hitting the CNA. The Administrator said he was shocked to learn that. The event note stated, the DON and Administrator were notified of the incident. During an interview on 4-30-2026 at 3:20 PM, the DON said she had worked at the facility for 3 weeks. The DON said she had never heard from staff that Resident #1 was verbally threatening towards residents. The DON said she knew that Resident #1 talked loudly because he was hard of hearing. The DON said if she had known one resident was being verbally aggressive to another one by saying he wanted to hit another resident, she would have put that resident on a one-to-one supervision, notified the Administrator, doctor, and family. In an interview on 4-30-2026 at 3:30 PM, RN B revealed she worked a 12-hour shift from 6:00PM - 6:00AM. RN B said she had not witnessed Resident #1 being verbally aggressive toward other residents, but when something occurred with Resident #1, Resident #1 told her about it. RN B said if she heard one resident threaten another, she would notify the Administrator. RN B said she was present one night recently when Resident #1 got irritated at Resident #2 in the hallway for no reason. RN B said she did not hear Resident #1 threaten Resident #2. Record review and observation of Resident #2's cell phone audio/video recording taken on 4-25-2026, revealed Resident #1 threatened Resident #2 by saying, I'm going to slap the dog shit out of her and I'm going to knock the shit out of you. During the recording, part of a staff member's body was visible beside Resident #2 when Resident #1 said to the staff member [RN B] do something with her. [RN B] was later revealed to be RN B. A copy of this audio/video recording was obtained. In an interview on 4-30-2026 at 5:26 PM, CNA C said she had worked at the facility for 19 years and was familiar with Resident #1's behaviors. CNA C said Resident #1 liked to bully other residents and would push them out of his way, while they were sitting in their wheelchairs. CNA C said she heard Resident #1 say to Resident #6, who was [AGE] years old in a wheelchair, I'm going to kick your ass and pushed her out of his way. CNA C said she reported this to a nurse but not the Administrator. CNA C said Resident #3 told her Resident #1 bullied Resident #3 and hit the back of her wheelchair and Resident #3 told CNA C to report this to the Administrator. CNA C said she reported it to a nurse but did not remember who the nurse was. CNA C said her last in-service on AN was a month ago and yesterday. CNA C said when the facility in-serviced her, they just handed her a piece of paper, asked her to sign it, and left without going over anything. CNA C said Residents #2 and #3 told her they did not feel safe around Resident #1. CNA C said Resident #1 could stand to his feet independently and showered himself. In an interview on 4-30-2026 at 5:50 PM, CNA D said one day staff from the north hallway, where Resident #1 resided, told staff from the south hallway to come assist them in the north hallway because Resident #1 was going off on Resident #2. CNA D said when she arrived on the north hallway, Resident #1 was saying to Resident #2 fuck you and verbally threatened to hurt Resident #2. CNA D said Resident #1 would go off on anyone. CNA D (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	did not know if this was reported. CNA D said she received an in-service on AN last week, but the facility only had her sign a piece of paper and did not go over anything.Review of the facility's Abuse and Neglect Policy dated 3-29-2018 and titled Abuse/Neglect TG 03-1.0 stated: Abuse/Neglect The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. Residents should not be subjected to abuse by anyone, including, but not limited to, facility staff, other residents, consultants or volunteers, staff of other agencies serving the resident, family members or legal guardians, friends, or other individuals.The facility will provide and ensure the promotion and protection of resident rights. It is each individual's responsibility to recognize, report, and promptly investigate actual or alleged abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property abuse and situations that may constitute abuse or neglect to any resident in the facility.DefinitionsAbuse: Abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. Abuse also includes deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. 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 including abuse facilitated or enabled through the use of technology. Willful, as used in this definition of abuse, means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm.Adverse event. An adverse event is an untoward, undesirable, and usually unanticipated event that causes death or serious injury, or the risk thereof.3. Verbal Abuse: Any use of oral, written or gestured language that willfully includes disparaging and derogatory terms to residents, or within their hearing distance, regardless of their age, ability to comprehend, or disability .Examples of verbal abuse include, but are not limited to: threats of harm; saying things to frighten a resident, such as telling a resident that she will never be able to see her family again, etc. Abuse as defined in 40 TAC 19.101(1) .5. Physical Abuse: Includes, hitting, slapping, pinching and kicking. It also includes controlling behavior through corporal punishment. Abuse as defined in 40 TAC 19.101(1) . E. ReportingAny person having reasonable cause to believe an elderly or incapacitated adult is suffering from abuse, neglect or exploitation must report this to the DON, administrator, state and/or adult protective services. State law mandates that citizens report all suspected cases of abuse, neglect or financial exploitation of the elderly and incapacitated persons.2. When a suspected abused, neglected, exploited, mistreated or potential victim of misappropriation of property comes to the attention of any employee, that employee will make an immediate verbal report to the Abuse Preventionist or designee. If the discovery occurs outside of normal business hours, the Abuse Preventionist and/or designee will be called. 3. Facility employees must report all allegations of: abuse, neglect, exploitation, mistreatment of residents, misappropriation of resident property or injury of unknown source to the facility administrator. The facility administrator or designee will report the allegation to HHSC . This was determined to be an Immediate Jeopardy (IJ) on 04-30-2026 at 2:54 PM. The Interim Administrator was notified. The Interim Administrator was provided with the IJ template on 04-30-2026 at 3:41 PM. The following Plan of Removal (POR) was accepted on 5-1-2026 at 11:59 AM. Date: 4/30/26 Plan of Removal Problem: F600 - Abuse Interventions: Resident #2, #3, #4 was interviewed by the LMSW. No further allegations of abuse were disclosed. Completed 4/30/26. Resident # 1 was placed on 1:1 supervision by the DON. 1:1 will continue until new treatment plan obtained by psych services has been evaluated and deemed effective. Staff performing 1:1 will redirect resident away from any residents if he becomes verbally aggressive. Resident # 1 will be kept physically separated from other resident by room or hall changes and/or alternate dining arrangements as needed. Staff assigned 1:1 will ensure that Resident #1 does not remain in the close proximity of other residents until no signs of verbal threats, intimidation, or aggressive behaviors are (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	5:14 PM, the DON said an IJ was called because the facility did not have interventions in place to protect residents. The DON said staff were in-serviced on abuse, neglect, trauma informed care, resident rights, change of conditions, resident to resident altercations, one-on-one supervision, verbal de-escalation, and how to do it right. The DON said she was in charge for monitoring staff to ensure compliance. The DON said Resident #1 would be on 1:1 supervision until a psychiatrist clears him, the facility no longer feels he is a threat, or he is discharged . The DON said the facility will protect Resident #2 from experiencing trauma from her past by doing assessments if something were to occur, and refer her to psychological and/or social services. The DON said she was going to be the Abuse Coordinator until an Administrator returned to the facility. In an interview on 5-1-2026 at 5:20 PM, the Acting Administrator said the IJ was called because two residents were not getting along in the dining room and arguing. The Acting Administrator said staff were in-serviced on abuse, neglect, exploitation, reporting abuse/neglect timely, and who to report it to. The Acting Administrator said the Administrator (AIT) had been suspended. The Acting Administrator said she and the DON were responsible for ensuring staff were compliant with the POR. The Acting Administrator said Resident #1 would be on 1:1 supervision until the facility found a permanent solution and would ensure Resident #2 would not experience repeat trauma from the past by continuing to do safe surveys to make sure, she feels safe. The Acting Administrator said she would be the Abuse Coordinator until an Administrator returned to the facility and if she was unavailable, the DON would be the Abuse Coordinator. Record review of the facility's EMRs for seven residents (Residents #7, #8, #9, #10, #11, #12, #13) who had aggressive behaviors toward staff were reviewed and no concerns related to abuse of residents were found. Review of the Plan of Removal documentation reflected: 1. Resident #1 was placed on 1:1 supervision until a new treatment plan obtained by psych services can be approved or Resident #1 is discharged .2. Staff who are 1:1 supervision with Resident #1 will redirect Resident #1 away from any residents if he becomes verbally aggressive.3. Staff assigned 1:1 will ensure that Resident #1 does not remain in the close proximity of other residents until no signs of verbal threats, intimidation, or aggressive behaviors are demonstrated.4. Staff were in-serviced on what abuse of any kind is and what to do if they observe any.5. Staff were in-serviced on who to report any type of abuse to and if the Administrator is not available, report it to the DON. On 4-30-2026 at 2:54 PM, an Immediate Jeopardy was identified. While the IJ was removed on 5-1-2026, the facility remained out of compliance at a scope of pattern and a severity level of no actual harm with potential for more than minimal harm that is not Immediate Jeopardy, due to the facility continuing to monitor the implementation and effectiveness of their Plan of Removal.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675018	A. Building B. Wing	05/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
River Oaks Health and Rehabilitation Center	2416 NW 18th St Fort Worth, TX 76106

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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 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** Based on observation, interview, and record review, the facility failed to develop and implement written policies and procedures that prohibit and prevent abuse, investigate allegations of abuse, and protected residents from physical and psychosocial harm during and after the investigation when residents were verbally and physically abused by Resident #1 for 2 (Residents #2, #3) of 13 reviewed for abuse. The facility failed to identify verbal abuse and intervene when Resident #1 threatened Residents #2 and #3, causing Resident #2 to avoid certain areas of the facility and causing Resident #3 to cry. Resident #1 continued to have access to verbally abuse other residents on multiple occasions.Staff witnessed physical pushing and threats but failed to report the abuse to the administrator. The Administrator and staff told vulnerable residents with histories of trauma to just avoid the aggressor, and did not complete an investigation. On 4-30-2026 at 2:54 PM, an Immediate Jeopardy was identified. While the IJ was removed on 5-1-2026, the facility remained out of compliance at a scope of pattern and a severity level of no actual harm with potential for more than minimal harm that is not Immediate Jeopardy, due to the facility continuing to monitor the implementation and effectiveness of their Plan of Removal.These failures resulted in the harm to Resident's #2 and #3 who reported fear and feeling unsafe and placed residents at risk of subsequent abuse, resulting in potential severe physical harm, pain, or mental anguish. Findings included: Record review of Resident #1's admission record, dated and reviewed on 4-29-2026, revealed a [AGE] year-old male, admitted [DATE] and readmitted [DATE]. Resident #1 had a primary diagnosis of transient cerebral ischemic attach (stroke) and secondary diagnoses of anxiety disorder (mental health condition categorized by excessive worry affecting quality of life), bipolar disorder (mental health condition characterized by significant mood swings), current episode manic severe with psychotic features (a distinct period of abnormally, persistently elevated, or irritable mood and extremely high energy, lasting at least one week like an unrealistic sense of superiority, power, decreased sleep, and racing thoughts with delusions or hallucinations), and intermittent explosive disorder (a mental health condition characterized by recurrent, impulsive, and disproportionate outbursts of rage or aggression).Record review of Resident #1's Quarterly MDS assessment, dated 3-24-2026, reviewed on 04-29-2026, revealed Resident #1 re-entered the facility from a short-term general hospital with a BIMS score of 14 indicating Resident#1 was cognitively intact. The GG, Functional section, revealed Resident#1 could independently move from a sitting position to a standing position and could independently transfer himself from a bed to a chair. The K-Swallowing/Nutritional Status Section, revealed Resident #1 was 6' 4 and weighed 230 pounds. Resident #1 used a wheelchair to ambulate.Record review of Resident #1's most recent care plan with an initial date of 8-25-2021 and a revision date of 9-4-2024, and reviewed on 04-29-2026, indicated Resident #1 had behavior problems of attention-seeking and accusatory behaviors, distorting the truth in attention seeking efforts and/or making false allegations, making negative statements about staff, proposing unrealistic demands, threatening staff with calling the state, inserted himself into staff/other residents' care/affairs causing outbursts, attention seeking behavior, making false allegations, he makes his peers feel uncomfortable or uneasy when around him, and had potential to demonstrate physical behaviors of anger, and poor impulse control.Review of Resident #1's Event Nurses Note dated 7-7-2024, reflected Resident #1 had a resident-to-resident incident yelling at his roommate. Review of Resident #1's Event Nurses Note dated 9-3-2024, reflected Resident #1 had a resident-to-resident incident verbally threatening another resident yelling for him to get out of his room. Staff explained the resident was his roommate. Review of Resident #1's Event Nurses Note dated 12-12-2025, reflected Resident #1 was combative, verbally and physically aggressive by standing up, swinging his hand toward a CNA attempting to hit the CNA. Resident #1 said I will take the shit out of you. Record review of Resident #1's progress notes reflected the following: 3-13-2026 at 8:50 PM - In the last week, the resident (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	experienced verbal behaviors directed toward others 1-3 days . Verbally aggressive with other residents in the hallways. 3-18-2026 at 11:38 PM - In the last week, the resident experienced verbal behaviors directed toward others 1-3 days . 4-5-2026 at 9:58 PM - Resident #1 had a verbal confrontation with another resident witnessed by staff. He was resistant to resolution and intervention. When separated, he claimed the other resident pushed his wheelchair; none of the witnesses saw this happen. During an observation and interview on 4-29-2026 at 12:42 PM, Resident #2 was observed ambulating in a motorized wheelchair in the hallway outside her room. Resident #2 wanted to speak in private and said she did not feel safe around Resident #1. Resident #2 said Resident #1 threatened to have her beat up by his sister on 4-5-2026. Resident #2 then exhibited a video, from her phone, of Resident #1 ambulating in his wheelchair toward Resident #2 saying in a loud voice, I'm not afraid of your phone, I'm going to slap the dog shit out of Resident #2 and I'm going to knock the shit out of Resident #2. Resident #2 said Resident #1 started being aggressive toward her when she observed Resident #1 bullying a non-verbal resident sitting in his wheelchair. Resident #2 said she asked Resident #1 to leave the vulnerable non-verbal resident alone. That was when Resident #1 started to make verbal threats toward Resident #2. Resident #2 said she filed a grievance with the Social Worker on 4-27-2026. The Social Worker told Resident #2 she needed to speak with the Administrator and would get back with her after she spoke with him. Resident #2 said the Social Worker got back with her the same day and said the Administrator said to just avoid Resident #1. Resident #2 said she told the Social Worker she did not feel safe as the facility was not protecting her, she felt lied to by the facility, and wanted the State's phone number and the facility's corporate phone number.Record review of Resident #2's admission sheet, dated and reviewed on 04-29-2026, revealed Resident #2 was a [AGE] year-old female admitted [DATE] and readmitted [DATE]. Resident #2's primary diagnosis was anemia (condition characterized by a deficiency in health red blood cells, leading to insufficient oxygen delivery to the body's tissues) and secondary diagnoses of foot drop, right foot (the inability to lift the front part of the foot, causing it to drag or slap on the floor while walking), heart failure, major depressive disorder (serious mental condition characterized by persistent feelings of sadness, loss of interest in activities, and various emotional and physical problems), and generalized anxiety disorder.Review of Resident #2's Quarterly MDS dated [DATE], reflected a BIMS score of 15 being cognitively intact. The GG-Functional Abilities revealed Resident #2 used a motorized wheelchair to ambulate. Record review of Resident #2's Care Plan, dated 10-17-2025, revealed she had a history of trauma that may have a negative impact. The trauma is r/t: history of life-threatening illness, physical assault [Family Member], physically threatened and sexually assault. Resident #2 was care planned to have a potential for uncontrolled pain due to Fibromyalgia (chronic condition characterized by widespread pain, fatigue, and other symptoms), chronic right arms pain, left leg pain. back pain and neuropathy (nerve damage outside the brain and spinal cord).Record review of the facility's grievance log, reflected Resident #2 filed a grievance on 4-27-2026 stating she wanted Resident #1 to be discharged because Resident #1 was making her stressed and threatened. Resident #2 said on 4-25-2026 Resident #1 held his fist up to her and threatened to physically harm her. Resident #2 said Resident #1 has acted aggressively toward he multiple times. The summary of the pertinent findings by the facility stated Resident #2 did record the interaction. In one of the videos, Resident #1 is clearly heard threatening to slap the shit of Resident #2. The corrective action the facility stated it took was to tell both residents to stay away from each other and educate staff to separate them in case of confrontation. Record review of Resident #2's progress note, dated 4-28-2026 at 12:00 PM, revealed the Social Worker stated she followed up with Resident #2's grievance stating regarding the resolution to her grievance. Resident #2 said it was not satisfactory and that avoiding Resident #1 was not possible. She said he threatened her again last night but would not elaborate further. She stated she feels the facility has lied to her and requested contact information for the State and Corporate. In an interview on 4-29-2026 at 12:50 PM, Resident #5 said she was not comfortable around Resident #1 when he comes to the doorway of her room (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	saying he was going to get the facility shutdown. Resident #5 said she was bedbound. In an interview on 4-29-2026 at 3:57 PM, Resident #3 said she was afraid of Resident #1, because he has verbally threatened to hit her and has been verbally abusive with his words. Resident #3 said the facility has known about Resident #1's conduct but has not done anything about it. Review of Resident #3's admission record dated 4-30-2026, reflected a [AGE] year-old female with an original admission date of 11-4-2020 and a re-admission date of 2-27-2023. Resident #3's primary diagnosis was chronic obstructive pulmonary disease(lung disease causing chronic coughing, wheezing, and severe breathlessness due to damaged airways, primarily caused by smoking, air pollution, or genetic factors), and secondary diagnoses of generalized anxiety disorder, glaucoma (a group of eye diseases that damage the optic nerve, often due to high eye pressure, leading to permanent, irreversible vision loss or blindness), and unsteadiness on her feet. Review of Resident #3's Quarterly MDS dated [DATE], revealed she had a BIMS score of 15 indicating being cognitively intact. The GG-Functional Abilities section revealed Resident #3 used a wheelchair to ambulate. The J-Health Conditions of Resident #3 revealed she frequent pain. Review of Resident #3's care plan dated 6-6-2023, revealed she was care planned for trauma informed care stating she had been in a major natural disaster or technological disaster such as fire, tornado, hurricane, flood, earthquake, or chemical spill. In an observation and interview on 4-30-2026 at 2:00 PM, Resident #3 said last night when she was getting her medication by the nurse's station, Resident #1 came up behind her in his wheelchair, grabbed her arm, and cursed at her demanding she get out of his way. Resident #3 was observed to start crying at this point. Resident #3 said she then slapped Resident #1 to let her go. Record review of Resident #3's progress notes, dated 4-30-2026 at 11:06 AM, revealed Resident #3 told the Dietary Manager that [Resident #1] approached [Resident #3] from behind, yelled and used profanity toward [Resident #3], grabbed [Resident #3's forearm, and pushed [Resident #3] while she was in her wheelchair. In an interview on 4-30-2026 at 11:10 AM, the SW said Resident #2 did not feel safe around Resident #1. The SW said she did speak with the Administrator regarding Resident #2's grievance and the Administrator said because this was the first grievance Resident #2 had filed concerning Resident #1's behavior, he did not want to discharge anyone. The SW said the Administrator said for Resident #2 to just avoid Resident #1. The SW said the facility keeps residents safe from Resident #1 by redirecting him. In an interview and record review on 4-30-2026 at 11:30 AM, the Administrator said he was an AIT and had worked at the facility since 11-18-2025. The Administrator said he told Resident #2 to just avoid Resident #1 and staff were informed to keep them apart. The Administrator said verbal abuse was to the best of my understanding would be using defamatory words, racial slurs. The Administrator named different types of abuse as being verbal, emotional, financial, mental, and physical. The Administrator said a self-report was not filed by the facility regarding Resident #2's grievance because he was in and out of the office. The Administrator said, I should have filed a self-report, that was my fault. When asked, if he thought the grievance Resident #2 filed regarding Resident #1's threatening her was abuse, the Administrator said, I don't know. When the video and audio recording of Resident #1 threatening to do bodily harm to Resident #2, dated 4-25-2026, was shown to the Administrator, he said, That was abuse. The Administrator said he saw another video today of Resident #1 verbally abusing Resident #2 where former DON (RN B) was trying to redirect Resident #1. The Administrator said RN B did not report this incident to him. The Administrator said in his absence, the DON became the abuse coordinator, and it was elevated to the Area Director of Operations. The Administrator said the facility had not discharged Resident #1 because, Resident #1 had not crossed the line yet that would fulfill the requirement to justify an immediate discharge as he would have to physically assault someone to justify an immediate discharge, in my opinion. The Administrator said the facility did not follow its own Abuse and Neglect Policy because in this particular situation, the SW did not want to add onto his health issues he had been dealing with. The Administrator said the facility protected other residents from Resident #1 by filing self-reports, and I just don't have a lot of answers right now. The Administrator said Resident #1 had never tried to hit (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	anyone. However, the Administrator was shown an event nurse note from the facility's EMR, revealing on 12-12-2025 at 4:02 PM, Resident #1 attempted to hit a CNA by swinging his hand at the CNA, but missed hitting the CNA. The Administrator said he was shocked to learn that. The event note stated, the DON and Administrator were notified of the incident.On 4-30-2026 at 3:20 PM, the DON said she had worked at the facility for 3 weeks. The DON said she had never heard from staff that Resident #1 had been verbally threatening to residents. The DON said she knew that Resident #1 talked loudly because he was hard of hearing. The DON said if she had known one resident was being verbally aggressive to another one by saying he wanted to hit another resident, she would have put that resident on a one-to-one supervision, notify the Administrator, doctor, and family. Record review and observation of Resident #2's cell phone audio/video recording taken on 4-25-2026, revealed Resident #1 threatened Resident #2 by saying, I'm going to slap the dog shit out of her and I'm going to knock the shit out of you. During the recording, part of a staff member's body was visible beside Resident #2 when Resident #1 said to the staff member [RN B] do something with her. [RN B] was later revealed to be RN B. A copy of this audio/video recording was obtained.In an interview on 4-30-2026 at 5:26 PM, CNA C said she had worked at the facility for 19 years and was familiar with Resident #1's behaviors. CNA C said Resident #1 liked to bully other residents and will push them out of his way, while sitting in their wheelchairs. CNA C said she has heard Resident #1 say to Resident #6, who was [AGE] years old in a wheelchair, I:m going to kick your ass and pushed her out of his way. CNA C said she reported this to a nurse but not the Administrator. CNA C said Resident #3 told her Resident #1 bullied Resident #3 and hit the back of her wheelchair and told her she needed to report this to the Administrator. CNA C said she reported it to a nurse but did not remember who the nurse was. CNA C said her last in-service on AN was a month ago and yesterday. CNA C said when the facility had in-serviced her, they just handed her a piece of paper, asked her to sign it, and left without going over anything. CNA C said Residents #2 and #3 told her they did not feel safe around Resident #1. CNA C said Resident #1 can stand to his feet independently and showered himself. In an interview on 4-30-2026 at 5:50 PM, CNA D said one day staff from the north hallway, where Resident #1 resided, told staff from the south hallway to come assist them in the north hallway because Resident #1 was going off on Resident #2. CNA D said when he arrived on the north hallway, Resident #1 was saying to Resident #2 fuck you and verbally threatened to hurt Resident #2. CNA D said Resident #1 will go off on anyone. CNA D did not know if this was reported. CNA D said she received an in-service on AN last week, but the facility only had her sign a piece of paper and did not go over anything.Review of the facility's Abuse and Neglect Policy dated 3-29-2018 and titled Abuse/Neglect TG 03-1.0 stated: Abuse/Neglect The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. Residents should not be subjected to abuse by anyone, including, but not limited to, facility staff, other residents, consultants or volunteers, staff of other agencies serving the resident, family members or legal guardians, friends, or other individuals.The facility will provide and ensure the promotion and protection of resident rights. It is each individual's responsibility to recognize, report, and promptly investigate actual or alleged abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property abuse and situations that may constitute abuse or neglect to any resident in the facility.DefinitionsAbuse: Abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. Abuse also includes deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. 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 including abuse facilitated or enabled through the use of technology. Willful, as used in this definition of abuse, means the individual must have acted (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	deliberately, not that the individual must have intended to inflict injury or harm.Adverse event. An adverse event is an untoward, undesirable, and usually unanticipated event that causes death or serious injury, or the risk thereof.3. Verbal Abuse: Any use of oral, written or gestured language that willfully includes disparaging and derogatory terms to residents, or within their hearing distance, regardless of their age, ability to comprehend, or disability .Examples of verbal abuse include, but are not limited to: threats of harm; saying things to frighten a resident, such as telling a resident that she will never be able to see her family again, etc. Abuse as defined in 40 TAC 19.101(1) .5. Physical Abuse: Includes, hitting, slapping, pinching and kicking. It also includes controlling behavior through corporal punishment. Abuse as defined in 40 TAC 19.101(1) . E. ReportingAny person having reasonable cause to believe an elderly or incapacitated adult is suffering from abuse, neglect or exploitation must report this to the DON, administrator, state and/or adult protective services. State law mandates that citizens report all suspected cases of abuse, neglect or financial exploitation of the elderly and incapacitated persons.2. When a suspected abused, neglected, exploited, mistreated or potential victim of misappropriation of property comes to the attention of any employee, that employee will make an immediate verbal report to the Abuse Preventionist or designee. If the discovery occurs outside of normal business hours, the Abuse Preventionist and/or designee will be called. 3. Facility employees must report all allegations of: abuse, neglect, exploitation, mistreatment of residents, misappropriation of resident property or injury of unknown source to the facility administrator. The facility administrator or designee will report the allegation to HHSC . This was determined to be an Immediate Jeopardy (IJ) on 04-30-2026 at 2:54 PM. The Interim Administrator was notified. The Interim Administrator was provided with the IJ template on 04-30-2026 at 3:41 PM. The following Plan of Removal (POR) was accepted on 5-1-2026 at 11:59 AM. Facility: [Facility Name] Date: 4/30/26 Plan of Removal Problem: F607 - Development/Implement Abuse/Neglect Polic/Procedures Interventions: Resident #2, #3, #4 was interviewed by the LMSW. No further allegations of abuse were disclosed. Completed 4/30/26. Resident # 1 was placed on 1:1 supervision by the DON. 1:1 will continue until new treatment plan obtained by psych services has been evaluated and deemed effective. Staff performing 1:1 will redirect resident away from any residents if he becomes verbally aggressive. Resident # 1 will be kept physically separated from other resident by room or hall changes and/or alternate dining arrangements as needed. Staff assigned 1:1 will ensure that resident #1 does not remain in the close proximity of other residents until no signs of verbal threats, intimidation, or aggressive behaviors are demonstrated. Resident #1 will remain on 1:1 until evaluated and cleared by the Psychiatric and/or Attending Physician. Completion 4/30/26. Resident #2, #3, #4 had a head-to-toe assessment completed by the charge nurse. No injuries or signs of abuse were noted. Completed 4/30/26. A Trauma informed care assessment was completed by Regional Compliance Nurse on resident #2, #3, #4 and documented in the chart. Telehealth visit or in person visit by psychological services will be completed for resident #2, #3, #4 by 5/1/26. Completed 5/1/26. On 4/30/26, safe surveys were completed for all residents who are able to be interviewed by the DON/ Regional Compliance Nurse. No additional allegations of abuse from staff or residents were disclosed. Completed 4/30/26. On 4/30/26 staff interviews were conducted by the DON/ Regional Compliance Nurse. No additional allegations of abuse towards residents were disclosed. Completed 4/30/26 The medical director was notified of the immediate jeopardy by the DON/Regional Compliance Nurse on 4/30/26. An ADHOC QAPI meeting was completed with the DON, Regional Compliance Nurse, IDT Team and Medical Director to discuss the immediate jeopardy and plan of removal. Completed 4/30/26. The Administrator will be in serviced 1:1 for timely reporting and investigating any allegations on all reportable events. Review of all types of abuse with examples of each type of abuse. New process: the ADO will be notified of all abuse allegations and will report to HHS in a timely manner if Administrator is ill. The DON and ADON were in-serviced 1:1 by the Regional Compliance Nurse on the following policy. Completed 4/30/26. Abuse and Neglect Policy- reporting all allegations of abuse to the Administrator immediately. All alleged perpetrators will be suspended (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	pending investigation. Allegations of abuse must be investigated immediately by the Administrator or designee to ensure the proper measures are implemented to keep residents safe and from abuse. The alleged perpetrator will remain suspended until the investigation has been completed. Administrator and DON provided specific Inservice that they are responsible to answer and immediately begin investigation for any allegation of Abuse. Administrator and DON on types of abuse with examples. In-services: The following in-services were initiated by Regional Compliance Nurse, DON, and ADON for all staff. Any staff member not present or in-serviced as of 4/30/26 will not be allowed to assume their duties until in-serviced. All new hires will be in-serviced during orientation. All PRN, agency staff, or staff on leave will in serviced prior to assuming their next assignment. Competency will be verified via post-test. Completion date 4/30/26. Abuse and Neglect Policy- reporting all allegations of abuse to the Administrator immediately. All alleged perpetrators will be suspended pending investigation. Allegations of abuse must be investigated immediately by the Administrator or designee to ensure the proper measures are implemented to keep residents safe and from abuse. The alleged perpetrator will remain suspended until the investigation has been completed. Staff provided specific In-services on immediately reporting any suspicion, allegation, or witnessed abuse or neglect to the facility administrator, if the administrator does not answer they are to call and report the allegation to the DON. Staff in serviced on types of abuse with examples. Surveyor Monitoring: An interview with the DON on 5-1-2026 at 5:14 PM, revealed the facility did not have other residents like Resident #1 but did have some who had some aggression in the past. Shortly after this interview a list of other residents who sometimes had aggression was provided. On 5-1-2026 between 1:44 PM and 1:55 PM, interviews with three residents who were listed as having aggressive behaviors and observations of all those residents revealed no concerns about these residents having aggressive behaviors toward other residents. Between 12:00 PM and 6:40 PM on 5-1-2026, staff covering all shifts and departments were interviewed about types of abuse, identifying possible abuse (verbal and physical), trauma informed care, resident rights, verbal de-escalation, resident-to-resident altercations, and who to report abuse to. The following staff were interviewed, and all were found to be knowledgeable about the above procedures: RN A, Social Worker, DON, RN B, CNA C, CNA D, laundry staff, LVN E, Activity Director, Dietary Aide F, [NAME] G, [NAME] H, RN I, Rehabilitation Director, LVN J, RN K, CNA L, CNA M, CMA N, Acting Administrator, CNA O, Staffing Coordinator, Dietary Aide P, Director of Food & Nutrition, CNA Q, Rehabilitation Tech R, CNA S, CNA T, CMA U, Interim Administrator. In an interview on 5-1-2026 at 5:14 PM, the DON said an IJ was called because the facility did not have interventions in place to protect residents. The DON said staff were in-serviced on abuse, neglect, trauma informed care, resident rights, change of conditions, resident to resident altercations, one-on-one supervision, verbal de-escalation, and how to do it right. The DON said she was in charge for monitoring staff to ensure compliance. The DON said Resident #1 would be on 1:1 supervision until a psychiatrist clears him, the facility no longer feels he is a threat, or he is discharged . The DON said the facility will protect Resident #2 from experiencing trauma from her past by doing assessments if something were to occur, refer to psychological and/or social services. The DON said she was going to be the Abuse Coordinator until an Administrator returned to the facility. In an interview on 5-1-2026 at 5:20 PM, the Acting Administrator said the IJ was called because two residents were not getting along in the dining room and arguing. The Acting Administrator said staff were in-serviced on abuse, neglect, exploitation, reporting abuse/neglect timely, and who to report it to. The Acting Administrator said the Administrator (AIT) had been suspended. The Acting Administrator said she and the DON were responsible for ensuring staff were compliant with the POR. The Acting Administrator said Resident #1 would be on 1:1 supervision until the facility found a permanent solution and would ensure Resident #2 would not experience repeat trauma from the past by continuing to do safe surveys to make sure, she feels safe. The Acting Administrator said she would be the Abuse Coordinator until an Administrator returned to the facility and if she was unavailable, the DON would be the Abuse Coordinator. Review of the facility's EMRs for seven residents (Residents #7, #8, #9, #10, #11, #12, (continued on next page)

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	675018	A. Building B. Wing	05/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
River Oaks Health and Rehabilitation Center	2416 NW 18th St Fort Worth, TX 76106

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	#13) who had aggressive behaviors toward staff were reviewed and no concerns related to abuse of residents were found. Review of the Plan of Removal documentation reflected: 1. Resident #1 was placed on 1:1 supervision until a new treatment plan obtained by psych services can be approved or Resident #1 is discharged .2. Staff who are 1:1 supervision with Resident #1 will redirect Resident #1 away from any residents if he becomes verbally aggressive.3. Staff assigned 1:1 will ensure that Resident #1 does not remain in the close proximity of other residents until no signs of verbal threats, intimidation, or aggressive behaviors are demonstrated.4. Staff were in-serviced on what abuse of any kind is and what to do if they observe any.5. Staff were in-serviced on who to report any type of abuse to and if the Administrator is not available, report it to the DON. On 4-30-2026 at 2:54 PM, an Immediate Jeopardy was identified. While the IJ was removed on 5-1-2026, the facility remained out of compliance at a scope of pattern and a severity level of no actual harm with potential for more than minimal harm that is not Immediate Jeopardy, due to the facility continuing to monitor the implementation and effectiveness of their Plan of Removal.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** Based on observation, interview, and record review, the facility failed to ensure that all alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of unknown source and misappropriation of resident property, 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, to the administrator of the facility and to other officials, including to the State Survey Agency in accordance with State law through established procedures for 2 (Residents #2, #3) of 13 reviewed for abuse and neglect. The facility failed to report to the Texas Health and Human Services Commission (THHSC) alleged abuse that occurred when Resident #1 verbally threatened to cause physical harm to Resident #2 on 4-05-2026 and 4-25-2026, and verbally and physically abused Resident #3 on 4-29-2026. These failures could place residents at risk of abuse, neglect, pain, psychosocial harm, and a diminished quality of life. Based on observation, interview, and record review, the facility failed to ensure that all alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of unknown source and misappropriation of resident property, 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, to the administrator of the facility and to other officials, including to the State Survey Agency in accordance with State law through established procedures for 2 (Residents #2, #3) of 13 reviewed for abuse and neglect. The facility failed to report to the Texas Health and Human Services Commission (THHSC) alleged abuse that occurred when Resident #1 verbally threatened to cause physical harm to Resident #2 on 4-05-2026 and 4-25-2026, and verbally and physically abused Resident #3 on 4-29-2026. These failures could place residents at risk of abuse, neglect, pain, psychosocial harm, and a diminished quality of life. Findings included: Record review of Resident #1's Face Sheet, dated 4-29-2026, revealed a [AGE] year-old male with an original admission date of 8-4-2021 and most recent admission date of 11-17-2025. Resident #1 had a primary diagnosis transient cerebral ischemic attach (stroke) and secondary diagnoses of anxiety disorder, bipolar disorder, current episode manic severe with psychotic features (a distinct period of abnormally, persistently elevated, or irritable mood and extremely high energy, lasting at least one week like an unrealistic sense of superiority, power, decreased sleep, and racing thoughts with delusions or hallucinations), and intermittent explosive disorder (a mental health condition characterized by recurrent, impulsive, and disproportionate outbursts of rage or aggression). Record review of Resident #1's Quarterly MDS dated [DATE], revealed Resident #1 re-entered the facility from a short-term general hospital with a BIMS score of 14 indicating Resident#1 was cognitively intact. The GG-Functional section revealed Resident#1 could independently move from a sitting position to a standing position and could independently transfer himself from a bed to a chair. The K-Swallowing/Nutritional Status Section revealed Resident #1 was 6' 4 and weighed 230 pounds. Resident #1 used a wheelchair to ambulate. Review of Resident #1's most recent care plan with an initial date of 8-25-2021 and a revision date of 9-4-2024, indicated Resident #1 had behavior problems of attention-seeking and accusatory behaviors, distorting the truth in attention seeking efforts and/or making false allegations, making negative statements about staff, proposing unrealistic demands, threatening staff with calling the state, inserted himself into staff/other residents' care/affairs causing outbursts, attention seeking behavior, making false allegations, he makes his peers feel uncomfortable or uneasy when around him, and had potential to demonstrate physical behaviors of anger, and poor impulse control. Record review of Resident #1's progress note dated 4-5-2026 at 9:58 PM, reflected Resident #1 had a verbal confrontation with another resident witnessed by staff. He was resistant to resolution and intervention. When separated, he claimed the other resident pushed his wheelchair; none of the witnesses saw this happen. In an (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	observation and interview on 4-29-2026 at 12:42 PM, Resident #2 said Resident #1 had threatened to have her beat up by his sister on 4-5-2026. Resident #2 said Resident #1 had threatened to harm her physically on 4-25-2026 then exhibited a video/audio recording, from her cell phone, revealing Resident #1 had threatened her by saying I'm not afraid of your phone, I'm going to slap the dog shit out of Resident #2 and I'm going to knock the shit out of Resident #2. In the video, a staff member was seen next to Resident #2 as threats were being made. Resident #1 referred to this staff member as RN B in the video. In an interview on 4-30-2026 at 3:30 PM, RN B admitted she was recently present one night when Resident #1 got irritated toward Resident #2, in the hallway, but denied she heard Resident #1 threaten Resident #2. In an interview on 5-1-2026 at 5:14 PM, the DON was shown the video/audio recording from Resident #2's cell phone revealing that Resident #1 threatened Resident #2. In the recording, the DON heard Resident #1 speak to the staff member, who was present in the video, and referred to the staff member as Ty. The DON then identified the staff member as RN B. Record review of the facility's grievance log revealed Resident #2 filed a grievance on 4-27-2026, stating Resident #2 wanted Resident #1 discharged as Resident #1 makes Resident #2 feel stressed and threatened. On Saturday, 4-25-2026, Resident #2 said Resident #1 held his fist toward her and threatened to physically harm her and/or his family come to the facility to harm Resident #2. Resident #2 said he had done this multiple times in the past. Resident #2 said on 4-25-2026 when Resident #1 threatened her, RN B was present and witnessed the incident. The grievance stated it was forwarded to the Administrator. Record review of Resident #3's admission record dated 4-30-2026, reflected a [AGE] year-old female with an original admission date of 11-4-2020 and a re-admission date of 2-27-2023. Resident #3's primary diagnosis was chronic obstructive pulmonary disease(lung disease causing chronic coughing, wheezing, and severe breathlessness due to damaged airways, primarily caused by smoking, air pollution, or genetic factors), and secondary diagnoses of generalized anxiety disorder, glaucoma (a group of eye diseases that damage the optic nerve, often due to high eye pressure, leading to permanent, irreversible vision loss or blindness), and unsteadiness on her feet. Record review of Resident #3's Quarterly MDS assessment, dated 3-9-2026, revealed she had a BIMS score of 15 indicating being cognitively intact. The GG-Functional Abilities section revealed Resident #3 used a wheelchair to ambulate. The J-Health Conditions of Resident #3 revealed she had frequent pain. Review of Resident #3's care plan dated 6-6-2023, revealed she was care planned for trauma informed care stating she had been in a major natural disaster or technological disaster such as fire, tornado, hurricane, flood, earthquake, or chemical spill. The care plan stated the facility would meet the needs of Resident #3 to prevent recurrence of trauma through the next review by meeting the emotional needs, providing psych services, and communicate all aspects of care being provided and allow Resident #3 to give feedback. In an interview on 4-29-2026 at 3:57 PM, revealed Resident #3 had been verbally abused and threatened with physical harm by Resident #1. Resident #3 said the facility knew about these incidents but had not done anything about them. Resident #3 could not name specific times or dates. In an interview on 4-30-2026 at 2:00 PM, Resident #3 said last night, when she was getting her medication by the nurse's station, Resident #1 came up behind her in his wheelchair, grabbed her arm, and cursed her demanding she get out of his way. Resident #3 said she then slapped Resident #1 to let her go. Record review of Resident #3's progress notes dated 4-30-2026 at 11:06 AM, revealed Resident #3 told the Dietary Manager that on 4-29-2026, while at a nurse's station, Resident #1 grabbed her arm cussing and screaming, and pushed her wheelchair. The note also stated Resident #2 grabbed Resident #1's arm and pushed his hand away. In an interview 4-30-2026 at 11:30 AM, the AIT said he reviewed the grievance filed by Resident #2 regarding Resident #1 threatening her. The AIT said he told Resident #2 to just avoid Resident #1 but did not report it to the THHSC. The AIT said he was not aware of Resident #3 alleging she was abused by Resident #1. The AIT said he should have filed a self-report with THHSC regarding Resident #2's grievance of abuse. The AIT said he had been in and out of the office with health issues as his blood pressure medication had doubled and got on anxiety medication yesterday. The AIT said in his (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	absence, the DON would take his place, and incidents would be elevated to the Acting Administrator, which was his boss. After this interview, the surveyor was informed that the AIT had left the facility and never returned for the rest of the survey. In an interview on 4-30-2026 at 3:20 PM, the DON said she had worked at the facility for 3 weeks and had not heard complaints from staff members that Resident #1 had verbally threatened anyone. In an interview on 5-1-2026 at 5:14 PM, the DON stated the facility failed in reporting alleged abuse because of a lack of training or a bad judgment call. The DON said the risk to residents if the facility did not report alleged abuse was abuse could continue and next time a resident be hit. The DON expected the facility to report alleged abuse according to the rules. In an interview on 5-1-2026 at 5:20 PM, the Acting Administrator said there was a failure of the facility to report alleged abuse timely either because there was a lack of training or bad judgment. The Acting Administrator said the risk to residents for the facility not reporting alleged abuse was it could lead to any type of abuse or neglect. The Acting Administrator said it was her expectation that alleged abuse be reported timely. Review of the facility's Abuse and Neglect Policy dated 3-29-2018 and titled Abuse/Neglect TG 03-1.0 stated: Abuse/Neglect The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. Residents should not be subjected to abuse by anyone, including, but not limited to, facility staff, other residents, consultants or volunteers, staff of other agencies serving the resident, family members or legal guardians, friends, or other individuals.The facility will provide and ensure the promotion and protection of resident rights. It is each individual's responsibility to recognize, report, and promptly investigate actual or alleged abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property abuse and situations that may constitute abuse or neglect to any resident in the facility.DefinitionsAbuse: Abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. Abuse also includes deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. 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 including abuse facilitated or enabled through the use of technology. Willful, as used in this definition of abuse, means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm.Adverse event. An adverse event is an untoward, undesirable, and usually unanticipated event that causes death or serious injury, or the risk thereof.3. Verbal Abuse: Any use of oral, written or gestured language that willfully includes disparaging and derogatory terms to residents, or within their hearing distance, regardless of their age, ability to comprehend, or disability .Examples of verbal abuse include, but are not limited to: threats of harm; saying things to frighten a resident, such as telling a resident that she will never be able to see her family again, etc. Abuse as defined in 40 TAC 19.101(1) .5. Physical Abuse: Includes, hitting, slapping, pinching and kicking. It also includes controlling behavior through corporal punishment. Abuse as defined in 40 TAC 19.101(1) . E. ReportingAny person having reasonable cause to believe an elderly or incapacitated adult is suffering from abuse, neglect or exploitation must report this to the DON, administrator, state and/or adult protective services. State law mandates that citizens report all suspected cases of abuse, neglect or financial exploitation of the elderly and incapacitated persons.2. When a suspected abused, neglected, exploited, mistreated or potential victim of misappropriation of property comes to the attention of any employee, that employee will make an immediate verbal report to the Abuse Preventionist or designee. If the discovery occurs outside of normal business hours, the Abuse Preventionist and/or designee will be called. 3. Facility employees must report all allegations of: abuse, neglect, exploitation, mistreatment of residents, misappropriation of resident property or injury of unknown source to the facility administrator. The facility administrator or designee will report the allegation to (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	HHSC . Review of (THHSC) Long Term Provider Letter #PL 2024-14 (Replaces PL 2019-17), titled Abuse, Neglect, Exploitation, Misappropriation of Resident Property and Other Incidents that a Nursing Facility (NF) Must Report to the Health and Human Services Commission (HHSC), Provider Type: Nursing Facilities (NF), dated August 29, 2024, stated: A NF must report to CII (Complaint and Incident Intake) the following types of incidents, in accordance with applicable state and federal requirements: Abuse, Neglect . Immediately, but not later than two hours after the incident occurs or is suspected . Review of TULIP (Texas Unified Licensure Information Portal) revealed no reports being filed from the facility for allegations of abuse or neglect concerning Residents#1, #2 or #3 for abuse occurring on 4-5-2026, 4-25-2026, or 4-29-2026, as of 4-30-2026.