STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675053	A. Building B. Wing	06/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Chisolm Trail Nursing and Rehabilitation Center	107 N Medina Lockhart, TX 78644

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the residents had the right to be free from physical abuse and neglect for two (Resident #1 and Resident #3) of five residents reviewed for abuse and neglect. 1. The facility failed to ensure Resident #1 was not physically abused by FM on 05/25/2025 when FM hit Resident #1 after Resident #1 became agitated and hit the FM. 2. The facility failed to protect Resident #3 from physical abuse by Resident #2. Resident #3 wandered into Resident #2's room and was hit by Resident #2 after Resident #2 stated I'm going to hit you. These failures placed residents at risk of abuse, neglect, trauma, and psychosocial harm. Findings include: 1. Review of Resident #1's face sheet dated 05/28/2025 reflected a [AGE] year-old man admitted on [DATE] with diagnoses of unspecified dementia (cognitive functioning severe enough to affect daily life where type cannot be determined), depression (mood disorder characterized by persistent sadness), other specified arthritis (multiple sites) (inflammation in multiple joints), primary generalized osteoarthritis (breakdown of cartilage in multiple joints), Spondylosis (ongoing wear and wear on spinal joints and disks), and essential hypertension (high blood pressure). Review of Resident #1's admission MDS dated [DATE] reflected a BIMS score of 2 which indicated severe cognitive impairment. Further review reflected Resident #1 had inattention and had difficulty focusing and being easily distractible. Review of Resident #1's care plan dated 05/22/2025 reflected Resident #1 had little, or awareness of safety or boundaries related to other's personal space and wandered within his living space interventions included invite Resident #1 to participate in activities. Further review revealed care plan dated 05/27/2025 reflected Resident #1 had behaviors that included physical aggression. (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675053	A. Building B. Wing	06/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Chisolm Trail Nursing and Rehabilitation Center	107 N Medina Lockhart, TX 78644

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of incident report dated 05/25/2025 by LVN B reflected there was an altercation between Resident #1 and FM. When LVN B walked onto the memory care unit, Resident #1 was pacing and assessed for injury. LVN B spoke with FM and stated that Resident #1 was sitting in a chair beside Resident #5. FM told Resident #1 he had to leave and Resident #1 stood up and said Resident #5 was his (Resident #1's) wife. Resident #1 then punched FM twice in the face. FM punched Resident #1 in the cheek in self-defense. NP was notified, DON, ADM and Resident #1's RP. Review of police report dated 05/25/2025 reflected incident was reported at 5:43 PM. Review reflected police spoke with FM and FM indicated that he went to visit Resident #5 and when FM entered Resident #5's room, Resident #1 was there. FM stated Resident #1 became confrontational and believed Resident #5 was his wife. FM claimed Resident #1 punched FM in the face twice and FM punched Resident #1 back and knocked him to the ground in self-defense. FM declined to press charges and a small mark was observed on FM right cheek. Further review reflected Resident #1 wandered the hallway and swelling was observed with band-aid over Resident #1's left cheek. Police officer attempted to speak with Resident #1 and appeared not fully aware or did not recall the incident. Observation on 05/28/2025 at 10:46 AM, revealed Resident #1 was asleep in his room on his bed. Resident #1 was observed with bruising around his left eye that appeared dark purple. Observation on 05/28/2025 at 11:46 AM, revealed Resident #5 no longer resided on the memory care unit and was non-verbal and non-ambulatory. Observation and interview on 05/28/2025 at 4:41 PM, revealed Resident #1 sitting in his room with 1:1 supervision. Resident #1 stated his eye was fine and stated peanut butter stuff caused the bruise. During an interview on 05/28/2025 at 11:39 PM, CNA E stated she was not at work when the incident with Resident #1 occurred. CNA E stated that Resident #1 appeared the same since he admitted to the facility and had not noticed any changes or pain. CNA E stated she never had concerns with FM's behavior during visits to the facility and he always appeared calm. During an interview on 05/28/2025 at 11:42 AM, CNA F stated that she worked yesterday (05/27/2025) and both yesterday and today (05/28/2025) she was to remain 1:1 with Resident #1. CNA F stated that she was required to keep Resident #1 within eyesight at all times. CNA F stated there have been no issues with his behavior and that she redirected him if he went to another resident's room. CNA F stated that she had not noted any changes in Resident #1 and that his appetite has also remained the same. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675053	A. Building B. Wing	06/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Chisolm Trail Nursing and Rehabilitation Center	107 N Medina Lockhart, TX 78644

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 05/28/2025 at 12:02 PM, CNA C stated that she worked on 05/25/2025. CNA C stated that she started to gather residents for dinner and she asked Resident #1 to make his way to the dining room, but he stayed on the hall. CNA C stated this was before 5:00 pm which was dinner time. CNA C stated that Resident #1 sat in a chair next to Resident #5's bed and rubbed her face and Resident #1 recognized Resident #5 as a relative. CNA C stated she asked Resident #1 to leave the room and he became agitated and she attempted to redirect him, but was not successful. CNA C stated that she left to get LVN B and as she went to do so FM arrived to visit Resident #5. CNA C stated that FM asked Resident #1 to leave the room and Resident #1 stated no this is my dad. CNA C stated when she returned Resident #1 was near a medication cart and had blood on his face and FM came from Resident #5's room. CNA C stated when Resident #1 first walked up he stated two guys beat me up and after ice was applied Resident #1 stated he fell off a train. CNA C stated that FM appeared calm and did not yell and did not sound aggressive and apologized when he spoke with LVN B. CNA C stated that Resident #1 did not recall the event after it occurred and ate 100% of his dinner that evening and had no additional incidents the remainder of her shift. CNA C stated Resident #1 remained on 1:1 the remainder of her shift. During an interview on 05/28/2025 at 1:01 PM, the DON stated that he was made aware of the incident with Resident #1 and FM on Sunday (05/25/2025) when MCD called. The DON stated he instructed MCD to place Resident #1 on 1:1. The DON stated NP ordered a facial x-ray and results were pending. The DON stated the police were called and FM visited supervised and outside the memory care unit. The DON stated that no concerns with FM had been observed or concerns regarding his behavior and he was usually very quiet. The DON stated that there had been no behaviors reported by Resident #1 prior to the incident. The DON stated that Resident #1 wandered throughout the memory care unit and had not had any outburst previously. During an interview on 05/28/2025 at 1:14 PM, the MCD stated that she was called by LVN B and informed that an altercation occurred between Resident #1 and FM on 05/25/2025. The MCD stated that she contacted the DON and ADM immediately after speaking with LVN B. The MCD stated she instructed CNA C and LVN B to remain with Resident #1. The MCD stated she interviewed FM and he stated that he found Resident #1 sitting in Resident #5's room. The MCD stated that FM reported that Resident #1 swung at FM so FM swung back at Resident #1 in reaction. The MCD called the police to make a report and stated the DON instructed MCD to ask FM to leave the facility. The MCD stated that prior to the incident FM would visit from out of state and would visit during meals to feed Resident #5. The MCD described FM's demeanor as calm, respectful and stated he often brought staff food. The MCD denied that FM was harsh or aggressive prior to the incident. The MCD stated that FM was instructed he could not enter the facility and visits had to occur with supervision. The MCD stated that Resident #1 was placed on 1:1 and a staff member was asked to stay on the shift later and remain on 1:1 with Resident #1. MCD stated that Resident #1 had not been physically aggressive or have outburst prior to the incident. MCD stated Resident #1 usually wandered. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675053	A. Building B. Wing	06/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Chisolm Trail Nursing and Rehabilitation Center	107 N Medina Lockhart, TX 78644

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 05/28/2025 at 1:27 PM, the ADM stated he was made aware of the incident with Resident #1 on 05/25/2025 after 4:00 PM and before 5:00 PM. The ADM stated that LVN B contacted him and LCD reached out as well. The ADM stated that it was reported there was an altercation between FM and Resident #1. The ADM stated that Resident #1's RP was notified as well as the staff that was working to assess and separate FM and Resident #1. The ADM stated that all other residents in memory care was assessed, and a police report was made. The ADM stated that in order to protect other residents, Resident #1 was placed on 1:1 supervision and FM was asked to leave the building and instructed that he was not allowed inside the building. The ADM stated he had a discussion with FM via telephone on 05/27/2025 that visitation could be held outside and would be supervised. The ADM stated FM was informed he was not allowed back in the building at this time in order to protect all the residents. The ADM stated the FM was confused initially and FM believed his (FM) actions were justified. The ADM stated there was no concerns with FM's actions or behaviors until 05/25/2025. The ADM stated that prior to the incident Resident #1 had no behavioral concerns or physical aggression prior to the incident. The ADM stated Resident #1 would stay on 1:1 supervision for his safety and the safety of other residents. During an interview on 05/28/2025 at 4:36 PM, CNA G stated she did not work during the incident with FM and Resident #1. CNA G stated that physical abuse included hitting, slapping or punching. CNA G stated that any suspicious or witnessed abuse would be reported to the abuse coordinator who was the ADM. CNA G stated that Resident #1 had to be redirected constantly and wandered into other residents' rooms. During an interview on 05/28/2025 at 4:42 PM, CNA H stated she was on 1:1 with Resident #1 and he just woke up. CNA H stated any incidents that involved a family member to resident would be reported to the charge nurse and ADM. CNA H stated physical abuse was hitting someone or being aggressive. During an interview on 058/28/2025 at 4:55 PM, LVN J stated that an example of physical abuse included hitting or scratching of any kind and would be reported immediately to the ADM and DON and potentially police after the resident was separated. A telephone interview was attempted to LVN B on 05/28/2025 at 12:44 PM, and 06/05/2025 at 12:02 PM, there was no answer. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675053	A. Building B. Wing	06/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Chisolm Trail Nursing and Rehabilitation Center	107 N Medina Lockhart, TX 78644

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 06/11/2025 at 10:01 AM, FM stated that he arrived at the facility on 05/25/2025 it was around 4:00 PM. FM stated that he went to visit Resident #5. FM stated CNA C was at the end of the hall near Resident #5's room and heard CNA C tell Resident #1 that is not your room, come on. FM stated that Resident #1 sat next to Resident #5's bed in a chair and Resident #1 patted Resident #5's head. FM stated that he told Resident #1 that was not his room and Resident #1 was going to have to leave. FM stated Resident #1 jumped up and said you stupid ass this is my wife. FM stated he turned to look for CNA C and Resident #1 hit FM and kicked him in the shin and knocked FM on the floor. FM stated that Resident #1 caused FM's glasses to bend. FM stated he subdued Resident #1 and stated he hit Resident #1. FM stated Resident #1 hit FM and did not back down so FM hit Resident #1. FM stated that Resident #1 then left the room. FM stated he was unsure if CNA C witnessed the incident but stated when he looked around he did not see anyone. FM stated he hit Resident #1 once and Resident #1 fell to the ground and he held Resident #1 because Resident #1 still tried to hit FM. FM stated when Resident #1 relaxed, FM let him up and stated he held him down for about 20-30 seconds. FM stated he reported that Resident #1 hit FM twice to staff and the police. FM stated that Resident #5 had been a resident at the facility since 2016 and he was informed he could only visit Resident #5 outside the facility. FM stated he received a statement from ADM about the visitation restrictions and it was to be ongoing with no end date. FM stated he was not allowed to enter the facility at all and that included the common area. FM stated that he did nothing wrong. FM stated that the day prior to the incident Resident #1 had entered Resident #5's room and touched Resident #5's roommate's feet and then left. Review of in-service dated 05/08/2025 with topic of dealing with aggressive behaviors was completed with all staff and included tips for working with residents who had dementia/Alzheimer's. Review of in-service dated 05/28/2025 completed with staff reflected training was reviewed with the topic of current restricted visitation and 1:1 care. FM was not allowed to visit Resident #5 without supervision and needed to visit outside away from other / minimal residents with nursing team to supervise. Resident #1 was currently on 1:1 supervision until IDT concluded it was safe to discontinue. Review of safety surveys completed with 9 residents dated 05/28/2025 reflected there were no concerns noted from additional residents interviewed. Review of total body skin and body assessment conducted with 11 residents in the memory care unit dated 05/27/2025 reflected there were no new wounds observed. Review of 9 staff questionnaire dated 05/28/2025 reflected staff were aware of who to report abuse to, changes such as a bruise or cut on a resident and to report any incident. Review of letter addressed to FM from ADM dated 05/28/2025 reflected that due to the incident on 05/25/2025, FM was not allowed to enter the facility and any visitation with Resident #5 required supervision outside of he facility. The letter reflected that the facility had a responsibility to assure the residents were safe and supervised visitation was to assure no other resident and the potential of any possible harm. Review of in-service dated 05/26/2025 reflected training was reviewed with staff over abuse policy, report guidelines, resident rights. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675053	A. Building B. Wing	06/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Chisolm Trail Nursing and Rehabilitation Center	107 N Medina Lockhart, TX 78644

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 06/05/2025 at 12:06 PM, the ADM stated that a written letter was going to be sent to FM, but the facility's legal team had not approved it yet. Review of in-service dated 05/26/2025 reflected training was reviewed with staff over abuse policy, report guidelines, resident rights. 2. Review of Resident #2 face sheet dated 05/28/2025 reflected a [AGE] year-old man admitted on [DATE] and discharged on 04/13/2025 with diagnoses of idiopathic epilepsy and epileptic syndromes (group of syndromes characterized by seizures without identified brain abnormalities), chronic pain syndrome (pain lasting longer than three to six months), other specified disorders of the brain (wide range of brain conditions), and dysphagia (difficulty swallowing). Review of Resident #2's discharge MDS dated [DATE] reflected no BIMS score was completed due to Resident #2 discharged from the facility. Further review reflected there was no physical symptoms directed towards others in the 7 days prior to the assessment. Review of Resident #2's care plan dated 03/06/2025 reflected he had a physical functioning deficit with transfers and required assistance. Interventions reflected to use a Hoyer with transfers. There were no behaviors noted in Resident #2's care plan. Review of skin assessment dated [DATE] for Resident #2 reflected no bruising or open areas noted, there were no reddened areas, open areas (cuts/tears) found. Review of Resident #3 face sheet dated 05/28/2025 reflected a [AGE] year-old male admitted on [DATE] with diagnoses of unspecified dementia (cognitive functioning severe enough to affect daily life where type cannot be determined), other abnormalities of gait and mobility (clumsy, unsteady movements), other lack of coordination (wide range of conditions where there is a disruption in the body's ability to coordinate movements), and unspecified glaucoma (condition of fluid buildup in the eye that can cause vision loss or blindness). Review of Resident #3's quarterly MDS dated [DATE] reflected Resident #3 had a BIMS score of 7 which indicated severe cognitive impairment. Further review reflected Resident #3 had no physician behavioral symptoms directed toward others 7 days prior to the assessment. Review of Resident #3's care plan dated 04/19/2025 reflected Resident #3 had little or no awareness of safety or no boundaries and went into other resident's rooms. Interventions reflected to re-direct Resident #3 to his room to rummage through items safely, invite him to participate in activities and offer opportunities for social interaction. Review of Resident #3's care plan dated 06/05/2025 reflected he had behaviors which included being aggressive with others. Interventions included help residents avoid situations or people that are upsetting and attempt interventions before behaviors begin. Review of skin assessment dated [DATE] for Resident #3 reflected no bruising or open areas noted, there were no reddened areas, open areas (cuts/tears) found. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675053	A. Building B. Wing	06/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Chisolm Trail Nursing and Rehabilitation Center	107 N Medina Lockhart, TX 78644

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 05/28/2025 at 4:48 PM, Resident #3 stated he did not recall any incident with another resident. Resident #3 stated he felt safe at the facility. Resident was observed laying in bed in his room. Review of surveys completed with 9 residents date 04/07/2025 reflected there were no concerns noted from any resident and they were aware of who the abuse prevention coordinator was. Review of body audit's completed with 28 residents dated 04/08/2025 through 04/10/2025 reflected there were no suspicious alterations in skin found. Review of incident report dated 04/06/2025 with a time of 10:00 AM reflected RN A was outside of Resident #3's room and he kicked open Resident #2's door and entered the doorway of Resident #2's room. Resident #2 asked Resident #3 to leave his room and Resident #2 stated before I kick your [Resident #3's] ass. Resident #3 responded do it and Resident #2 punched Resident #3 in the face. Further review reflected DON, family and NP were notified and RN A separated the residents. Incident report reflected no injuries were noted on either resident. Further review reflected Resident #3 was confused and wandered into other residents' rooms. Review of investigation summary by ADM dated 04/07/2025 reflected nursing reported an incident that occurred on 04/06/2025 between Resident #2 and Resident #3. Further review reflected Resident #3 wandered into Resident #2's room and a dispute was heard by nursing and intervened and separated both residents. Resident #3 and Resident #2 lived on separate halls and were assessed with no signs of bruising or marks. ADM stated he spoke with Resident #2 and he stated there was an argument and Resident #3 did not recall. ADM stated there were no concerns or lasting effects. Review of 10 staff questionnaires dated 04/07/2025 reflected staff were aware of who to report abuse to, changes such as a bruise or cut on a resident and to report any incident. Review of statement dated 04/06/2025 by CNA K reflected she was writing to report an incident that occurred that involved Resident #2 and Resident #3. CNA K wrote that when she was in the hallway after lunch she observed Resident #3 roaming and entered the room of Resident #2. CNA K's statement reflected Resident #3 proceeded to kick the door and directed a verbal threat at Resident #2 that Resident #3 was going to hit Resident #2. CNA K stated she did not witness Resident #3 strike Resident #2 but she did hear Resident #2 said you hit me upon the nurses entry to the room. During an interview on 05/28/2025 at 4:19 PM, RN A stated that Resident #3 tended to wander door to door and kicked the doors open with his foot to other resident rooms. RN A stated she was charting and Resident #3 kicked open Resident #2's door. RN A stated Resident #2 told Resident #3 to quit and get away from the door. RN A stated when she turned she saw Resident #2 was at the door and hit Resident #3. RN A stated that she reported it to the physician, family member and reported it to the DON. RN A stated that she assessed each resident and completed a head-to-toe assessment and there were no injuries. RN A stated that Resident #3 was the only resident who was hit. RN A stated the residents was separated and removed from the area. RN A stated that any resident-to-resident incidents should be reported to the DON and the ADM. RN A stated looking back she saw that resident-to-resident incident could have been abuse and neglect. RN A stated at the time she thought it was just an incident and only did an incident report. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675053	A. Building B. Wing	06/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Chisolm Trail Nursing and Rehabilitation Center	107 N Medina Lockhart, TX 78644

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 05/28/2025 at 4:33 PM, the DON stated the incident occurred prior to his role as DON at the facility. The DON stated that all emergencies were reported to him and the ADM. During an interview on 05/28/2025 at 4:36 PM, CNA G stated if she observed an incident between two residents, would let the nurse know what was going on. CNA G stated that physical abuse included hitting, slapping or punch . CNA G stated that any suspicious or witnessed abuse would be reported to the abuse coordinator who was the ADM. During an interview on 05/28/2025 at 4:49 PM, LVN I stated that for incidents that involved residents she would separate the individuals and ask someone to assist . LVN I stated she would assess for any injuries and notify the ADM, MD, RP, and DON. LVN I stated that physical abuse was pulling, tugging, or being rough with a resident. LVN I stated any abuse or suspicion of abuse would be reported to the DON as soon as it occurred. During an interview on 05/28/2025 at 5:07 PM, the ADM stated that he was made aware of the incident with Resident #3 and Resident #2. ADM stated that he spoke with nursing and it was stated Resident #3 was going down the hallway and Resident #2 stated for Resident #3 to get out of the room. The ADM stated nursing intervened and no injuries were found. The ADM stated he spoke with both residents the next day and they had no concerns. The ADM stated he was not able to confirm Resident #2 struck Resident #3. The ADM stated an investigation was conducted but he was unable to confirm that Resident #2 stuck Resident #3 and he understood from RN A that a commotion was overheard. The ADM stated staff are educated on abuse and neglect at least three or four times a year. During an interview on 06/05/2025 at 11:25 AM, the SSD stated that she was familiar with Resident #3. The SSD stated that normally Resident #3 was calm, but lately he went into other resident's rooms and kicked the doors open. The SSD stated she knew he had an altercation with Resident #2 but was not sure what happened. The SSD stated that Resident #3 started to wonder recently (last few months). The SSD stated Resident #3 is redirected, taken outside on the patio as interventions. During an interview on 06/05/2025 at 11:39 PM, the AD stated Resident #3 was a very sweet person and liked to listen to music, have snacks and play bingo. The AD stated that Resident #3 never exhibited behavior during activities and was easily directed to activities. The AD stated that she had observed Resident #3 on different halls than his own, but he did not go into other resident's room or kicked doors. The AD stated Resident #3 looked out the window. The AD stated she has not observed increased wandering. The AD stated Resident #2 had no aggressive behavior that was observed and stated he preferred to remain in his room most of the time and he was quiet. During an interview on 06/05/2025 at 11:46 AM, the ADON stated that she started at the facility at the end of April 2025. The ADON stated she had observed Resident #3 as pleasant and had not observed him wandering or going into other resident's rooms and that he was just sitting in his wheelchair. The ADON stated that according to other people he can be aggressive, but was unable to recall anything specific. The ADON stated that interventions for Resident #3 included increased rounding, communication in shift report, discussion in morning meeting of any issues. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675053	A. Building B. Wing	06/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Chisolm Trail Nursing and Rehabilitation Center	107 N Medina Lockhart, TX 78644

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 06/05/2025 at 12:06 PM, the ADM stated that prior to the incident on 04/06/2025, Resident #3 wandered. The ADM stated Resident #3 would be up and active in activities and during that time he would have an eye on him. The ADM stated that interventions included redirection, trying to keep his mind stimulated and offered activities. The ADM stated Resident #3 would also visit his ex-spouse who was also a resident at the facility and that he enjoyed eating meals with her. The ADM stated that prior to the incident there was nothing reported that Resident #3 had wandered into other residents' rooms just that he wandered in general. The ADM stated potential harm for increased wandering behaviors was that other residents could be startled. During an interview on 06/05/2025 at 12:21 PM, the DON stated that Resident #3 was usually a calm guy and moved around the halls and looked for his ex-spouse. The DON stated that he knocked on doors until he found the ex-spouse. The DON stated that he did not consider this wandering because Resident #3 had a purpose and goal to find the ex-spouse. The DON stated that once Resident #3 found the ex-spouse he remained in her room. The DON stated that some resident yelled when Resident #3 opened the door. The DON stated that interventions for Resident #3 were to move him to the secured unit and bring him out to the ex-spouse to prevent him going up and down each hall. The DON stated he was also taken out to the back patio. Review of in-service dated 04/06/2025 reflected abuse policy, reporting guidelines and resident rights was reviewed with all staff. During an interview on 06/05/2025 at 12:06 PM, the ADM stated he prevented abuse and neglect in the facility through education of staff and checking in with residents and families. The ADM stated that the phone number for the abuse coordinator was posted in resident rooms. During an interview on 06/05/2025 at 12:21 PM, the DON stated that abuse and neglect was prevented by rounding and residents, reeducating the team and what abuse and neglect was. The DON stated it was important to continue to educate staff on what they are supposed to do and how to conduct themselves. The DON listed example of abuse as hitting or punching. Review of facility policy titled Abuse Policy dated 02/2017 reflected abuse is the willful (individual acted deliberately, not that they must have intent to injury or harm) infliction of injury that resulted in physical harm, pain or mental anguish. The facility shall take corrective action consistent with the investigation findings and to eliminate any ongoing dangers to the resident or other residents that may be affected. Review of facility policy titled Resident's Rights and Quality of Life dated 05/01/2012 reflected a resident has the right to be free from verbal, sexual, physical and mental abuse.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675053	A. Building B. Wing	06/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Chisolm Trail Nursing and Rehabilitation Center	107 N Medina Lockhart, TX 78644

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 - 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 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, are reported immediately, but not later than 2 hours if the alleged violation involved abuse or neglect resulted in bodily injury, to other officials (including the State Agency) for 4 of 6 residents (Resident #1, Resident #2, Resident #3 and Resident #4) reviewed for abuse and neglect. 1. The facility failed to report to the State Agency an incident that involved Resident #1 on 05/25/2025 within the allotted timeframe. 2. The facility failed to report to the State Agency an incident that involved Resident #2 and Resident #3 on 04/06/2025. 3. The facility failed to report to the State Agency after x-ray results revealed Resident #4 sustained a fracture after a fall on 03/31/2025 within the allotted timeframe. This failure could place residents at risk for harm to include physical abuse, a diminished quality of life, and psychosocial harm. Findings include: 1. Review of Resident #1 face sheet dated 05/28/2025 reflected a [AGE] year-old man admitted on [DATE] with diagnoses of unspecified dementia (cognitive functioning severe enough to affect daily life where type cannot be determined), depression (mood disorder characterized by persistent sadness), other specified arthritis (multiple sites) (inflammation in multiple joints), primary generalized osteoarthritis (breakdown of cartilage in multiple joints), Spondylosis (ongoing wear and wear on spinal joints and disks), and essential hypertension (high blood pressure). Review of Resident #1 admission MDS dated [DATE] reflected a BIMS score of 2 which indicated severe cognitive impairment. Further review reflected Resident #1 had inattention and had difficulty focusing and being easily distractible. Review of Resident #1 care plan dated 05/22/2025 reflected Resident #1 had little, or awareness of safety or boundaries related to other's personal space and wandered within his living space. Further review revealed care plan dated 05/27/2025 reflected Resident #1 had behaviors that included physical aggression. Review of incident report dated 05/25/2025 reflected an incident occurred between Resident #1 and a FM in which Resident #1 struck the FM and FM struck Resident #1 that resulted in bruising to Resident #1's face. Further review reflected the incident occurred on 05/25/2025. Review of TULIP intake submission reflected the facility first learned of the incident on 05/25/2025 at 6:00 PM but the report was not submitted until 05/26/2025. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675053	A. Building B. Wing	06/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Chisolm Trail Nursing and Rehabilitation Center	107 N Medina Lockhart, TX 78644

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 - Some	Review of intake email from the ADM reflected submission was sent into the state agency on 05/26/2025 at 3:58 PM, and not within two hours of incident despite Resident #1 suffering from facial bruising. A telephone interview was attempted to LVN B on 05/28/2025 at 12:44 PM, but there was no answer. During an interview on 05/28/2025 at 1:14 PM, the MCD stated that she was called by LVN B that an incident occurred and involved Resident #1. The MCD stated that she contacted the DON and ADM immediately after speaking with LVN B. During an interview on 05/28/2025 at 1:27 PM, the ADM stated he was made aware of the incident with Resident #1 on 05/25/2025 after 4:00 PM and before 5:00 PM. The ADM stated that LVN B contacted him and LCD reached out as well. The ADM stated that it was reported there was an altercation between FM and Resident #1. The ADM stated that Resident #1's RP was notified as well as the staff that were working to assess and separate FM and Resident #1. The ADM stated that all other residents in memory care were assessed, and a police report was made. The ADM stated that in order to protect other residents, Resident #1 was placed on 1:1 supervision and FM was asked to leave the building and instructed that he was not allowed inside the building. The ADM stated he had a discussions with FM via telephone on 05/27/2025 that visitation could be held outside and would be supervised. The ADM stated FM was informed he was not allowed back in the building at this time in order to protect all the residents. The ADM stated FM was confused initially and FM believed his (FM) actions were justified. The ADM stated there were no concerns with FM's actions or behaviors until 05/25/2025. The ADM stated that prior to the incident Resident #1 had no behavioral concerns or physical aggression prior to the incident. The ADM stated Resident #1 would stay on 1:1 supervision for his safety and the safety of other residents. 2. Review of Resident #2's face sheet dated 05/28/2025 reflected a [AGE] year-old man admitted on [DATE] and discharged on 04/13/2025 with diagnoses of diagnoses of idiopathic epilepsy and epileptic syndromes (group of syndromes characterized by seizures without identified brain abnormalities), chronic pain syndrome (pain lasting longer than three to six months), other specified disorders of the brain (wide range of brain conditions), and dysphagia (difficulty swallowing). Review of Resident #2's discharge MDS dated [DATE] reflected no BIMS score was not completed due to Resident #2 discharged from the facility. Further review reflected there was no physical symptoms directed towards others in the 7 days prior to the assessment. Review of Resident #2's care plan dated 03/06/2025 reflected he had a physical functioning deficit with transfers and required assistance. Interventions reflected to use a Hoyer with transfers. There were no behaviors noted in Resident 2's care plan. Review of skin assessment dated [DATE] for Resident #2 reflected no bruising or open areas noted, there were no reddened areas, open areas (cuts/tears) found. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675053	A. Building B. Wing	06/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Chisolm Trail Nursing and Rehabilitation Center	107 N Medina Lockhart, TX 78644

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 - Some	Review of Resident #3 face sheet dated 05/28/2025 reflected a [AGE] year-old male admitted on [DATE] with diagnoses of unspecified dementia (cognitive functioning severe enough to affect daily life where type cannot be determined), other abnormalities of gait and mobility (clumsy, unsteady movements), other lack of coordination (wide range of conditions where there is a disruption in the body's ability to coordinate movements), and unspecified glaucoma (condition of fluid buildup in the eye tat can cause vision loss or blindness). Review of Resident #3 quarterly MDS dated [DATE] reflected Resident #3 had a BIMS score of 7 which indicated severe cognitive impairment. Further review reflected Resident #3 had no physician behavioral symptoms directed toward others 7 days prior to the assessment. Review of Resident #3's care plan dated 04/19/2025 reflected Resident #3 had little or no awareness of safety or no boundaries and went into other resident's rooms. Interventions reflected to re-direct Resident #3 to his room to rummage through items safely, invite him to participate in activities and offer opportunities for social interaction. Review of Resident #3's care plan dated 06/05/2025 reflected he had behaviors which included being aggressive with others. Interventions included help residents avoid situations or people that are upsetting and attempt interventions before behaviors begin. Review of incident report dated 04/06/2025 reflected RN A was outside of Resident #3's room and he kicked open Resident #2's door and entered the doorway of Resident #2's room. Resident #2 asked Resident #3 to leave his room and Resident #2 stated before I kick your [Resident #3's] ass. Resident #3 responded do it and Resident #2 punched Resident #3 in the face. Further review reflected DON, family and NP were notified and RN A separated the residents. Incident report reflected no injuries were noted on either resident. Further review reflected Resident #3 was confused and wandered into other residents' rooms. Review of investigation summary by the ADM dated 04/07/2025 reflected nursing reported an incident that occurred on 04/06/2025 between Resident #2 and Resident #3. Further review reflected Resident #3 wandered into Resident #2's room and a dispute was heard by nursing and intervened and separated both residents. Resident #3 and Resident #2 lived on separate halls and were assessed with no signs of bruising or marks. The ADM stated he spoke with Resident #2 and he stated there was an argument and Resident #3 did not recall. The ADM stated there were no concerns or lasting effects. During an interview on 05/28/2025 at 4:19 PM, RN A stated that Resident #3 tended to wander door to door and kicked the doors open with his foot to other resident rooms. RN A stated she was charting and Resident #3 kicked open Resident #2's door. RN A stated Resident #2 told Resident #3 to quit and get away from the door. RN A stated when she turned she saw Resident #2 was at the door and hit Resident #3. RN A stated that she reported it to the physician, family member and reported it to the DON. RN A stated that she assessed each resident and completed a head-to-toe assessment and there were no injuries. RN A stated that Resident #3 was the only resident who was hit. RN A stated the residents were separated and removed from the area. RN A stated that any resident-to-resident incidents should be reported to the DON and the ADM. RN A stated looking back she saw that resident-to-resident incident could have been abuse and neglect. RN A stated at the time she thought it was just an incident and only did an incident report. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675053	A. Building B. Wing	06/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Chisolm Trail Nursing and Rehabilitation Center	107 N Medina Lockhart, TX 78644

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 - Some	Review of TULIP on 05/28/2025 reflected no intakes were submitted by the facility related to incident between Resident #2 and Resident #3. During an interview on 05/28/2025 at 4:33 PM, DON stated the incident occurred prior to his role as DON at the facility. DON stated that all emergencies were reported to him and the ADM. During an interview on 05/28/2025 at 5:07 PM, the ADM stated that he was made aware of the incident with Resident #3 and Resident #2 but could not recall when exactly. The ADM stated that he spoke with nursing and it was stated Resident #3 was going down the hallway and Resident #2 stated Resident #3 to get out of the room. The ADM stated nursing intervened and no injuries were found. The ADM stated he spoke with both residents the next day and they had no concerns. The ADM stated he was not able to confirm Resident #2 struck Resident #3. The ADM stated an investigation was conducted but he was unable to confirm that Resident #2 stuck Resident #3 and he understood from RN A that a commotion was overheard. The ADM stated staff are educated on abuse and neglect at least three or four times a year. During an interview on 06/05/2025 at 12:06 PM, the ADM stated that prior to the incident on 04/06/2025 Resident #3 wandered. The ADM stated Resident #3 would be up and active in activities and during that time he would have an eye on him. The ADM stated that interventions included redirection, trying to keep his mind stimulated and offered activities. The ADM stated Resident #3 would also visit his ex-spouse who was also a resident at the facility and that he enjoyed eating meals with her. The ADM stated that prior to the incident there was nothing reported that Resident #3 had wandered into other residents' rooms just that he wandered in general. The ADM stated potential harm for increased wandering behaviors was that other residents could be startled. 3. Review of Resident #4's face sheet dated 05/28/2025 reflected Resident #4 was admitted on [DATE] and discharged on 04/02/2025 as a hospice respite resident with diagnoses of senile degermation of brain (various neurological disorders that cause ongoing decline in cognitive functioning, memory and reason), essential hypertension (high blood pressure) and pain unspecified (discomfort that does not have a clear cause or a particular area of the body). Review of Resident #4's discharge MDS dated [DATE] reflected Resident #4 was unable to complete the BIMS assessment. Further review reflected Resident #4 had a fall since admission and a major injury from 1 fall. Review of Resident #4's progress note by RN A dated 03/30/2025 reflected Resident #4 was found on floor in his room and had complaints of pain to right hip and an order was received for an x-ray. Review of incident report by RN A dated 03/30/2025 with a time of 7:30 PM reflected Resident #4 was found in his room on the floor. Resident #4 was confused and unable to express how he got onto the floor. Vitals were taken and on-call NP was notified. There were no injuries observed at the time of the incident. Resident #4 had complaints of right hip pain. Pre-disposing factors included non-compliance with care. Review of provider investigation reported dated 04/07/2025 reflected incident was reported to HHSC on 04/02/2025 despite x-ray results being returned to the facility on [DATE]. Review of investigation summary reflected it was unable to determine how the fall occurred and hospice opted to treat in-house. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675053	A. Building B. Wing	06/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Chisolm Trail Nursing and Rehabilitation Center	107 N Medina Lockhart, TX 78644

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 - Some	Review of Resident #4's orders reflected he had an order to monitor for pain every shift dated 03/31/2025. Review of Resident #4's March and April 2025 MARS reflected there was no pain indicated during any shift between 03/31/2025 and 04/02/2025. Review of Resident #4's physician orders dated 03/28/2025 reflected he had an order for morphine sulfate . 25 ml to give every hour as needed for mild pain and 1 mg to give every hour as needed for severe pain. Resident #4 was administered .25 m1 of morphine one time on 03/30/2025. Review of Resident #4's radiology results report reflected report date was 03/31/2025 at 1:06 AM, with examination date on 03/30/2025 at 10:33 PM. Findings reflected right sub capital impaction fracture with minimal callus and mild displacement. Findings reflected mild degenerative changes were seen. During an interview on 05/28/2025 at 4:19 PM, RN A did not recall Resident #4 or his fall. RN A stated fall interventions included to have the bed in a low position. RN A stated if an x-ray returned with a fracture, family, physician and DON were made aware of any findings. During an interview on 05/28/2025 at 4:36 PM, CNA G stated that if she found a resident had a fall she would let the nurse know and make sure the resident was safe. CNA G stated that residents were not to be moved after a fall until they were assessed. CNA G stated that she prevented falls with residents by clearing clutter, providing resident with a walker if needed and ensure they had proper footwear. During an interview on 05/28/2025 at 4:42 PM, CNA H stated that fall prevention interventions included ensuring a resident had a low bed, a fall mat if the nurse let them know they needed one. During an interview on 05/28/2025 at 4:49 PM, LVN I stated fall interventions included signs to call for help and educating a resident to use the call light for assistance. LVN I stated any x-ray that reveled a fracture would be reported to the doctor or on-call NP, ADM, DON and RP right away. During an interview with 05/28/2025 at 4:55 PM, LVN J stated that after a fall a resident was assessed for injuries and then assisted to the bed or chair. LVN J stated that interventions for falls included keeps residents within eyesight, frequent rounding and to have bed in a low position. LVN J stated that an x-ray that revealed a fracture would be reported to the doctor and DON right away. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675053	A. Building B. Wing	06/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Chisolm Trail Nursing and Rehabilitation Center	107 N Medina Lockhart, TX 78644

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 - Some	During an interview on 05/28/2025 at 5:07 PM, the ADM stated after he was made aware of an allegation of abuse or neglect he had 24 hours to report it to the state agency. The ADM stated he expected staff to report any resident-to-resident altercation. The ADM stated that he was made aware of the incident with Resident #2 and Resident #3 and that he spoke with RN A and that she reported Resident #2 stated for Resident #3 to get out of Resident #2's room but nursing intervened and confirmed there were no injuries. The ADM stated he spoke with both Resident #2 and Resident #3 the following day (04/07/2025) and he was unable to confirm that Resident #2 struck Resident #3 and neither resident was able to recall the incident. The ADM stated that the DON at the time did speak with RN B and that RN B stated she overheard the two residents but was out in the hallway. The ADM stated that he did review the incident report for Resident #2 and Resident #3, but ADM was unable to confirm the altercation had occurred and that it was just a commotion. The ADM stated that an investigation was initiated, and he spoke with both residents. The ADM stated only incidents that involved immediate danger were reported within a two hour time frame. The ADM stated he was made aware of the results of Resident #4's x-ray midmorning on 03/31/2025 and that the results were returned late 03/31/2025. The ADM stated that there was no specific facility policy on reporting and that information was included in the facility abuse policy. Review of facility in-service dated 03/31/2025 reflected topic was reviewed over preventing falls with all staff. Review of facility in-service dated 03/31/2025 reflected program content of Elder Justice Act/ Resident Rights/ Reporting guidelines was covered with all staff. In-service included facility policy titled Elder Justice Act Reporting dated 03/13/2020 which reflected employee reporting requirements included employes to report reasonable suspicion of a crime to the state agency within a designated time frame. Further review reflected if the reportable event results in serious bodily injury, the staff member shall report the suspicion immediately, but not later than two (2) hours after forming the suspicion. If t he reportable event does not result in serious bodily injury, the staff member shall report the suspicion not later than 24 hours after forming the suspicion. Review of facility policy titled Abuse, Neglect, Misappropriation, Exploitation Policy dated 01/219 reflected the purpose of the policy was to prevent abuse, neglect and exploitation and to ensure reporting and investigation of alleged violations (which included injuries of unknown source) in accordance with state laws. The policy defined injury of unknown source as source of the injury was not observed or could not be explained by the resident and the injury was suspicious because of the extent of the injury. Reporting and response section of the policy reflected all violations will be reported to the administrator immediately and immediately report all alleged violations to the administrator, state agency and/or law enforcement within specified timeframes. Specified time frames as indicated in policy reflected allegations with serious bodily injury should be reported immediately but not later than 2 hours after forming the suspicion. Allegations with no serious bodily injury should be reported no later than 24 hours.