STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675065	A. Building B. Wing	08/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cass Valley Healthcare Center	103 Teakwood St Centerville, TX 75833

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49851 Based on observation, interview, and record review, the facility failed to ensure residents were free from abuse for 1 (Resident #22) of 4 residents reviewed for abuse. The facility failed to prevent physical abuse against Resident #22 by CNA H as seen on video surveillance. The noncompliance was identified as PNC IJ. The IJ began on 07/04/2024 and ended on 07/05/2024. The facility had corrected the noncompliance before the survey began. This failure placed the resident at risk of physical and psychological harm. Findings include: Observation of Resident #22's video surveillance revealed CNA H assaulting the resident on three occasions during the 6:00 PM to 6:00 AM shift on 07/04/2024. The video captured CNA H striking Resident #22 with an open hand and the strikes were clearly heard on the audio. Due to the angle of the camera, it was difficult to identify where exactly on his body Resident #22 was slapped, but it appeared to be on the right arm and the backside. No observable reaction was noted by Resident #22 in the videos. Review of Resident #22's face sheet reflected a [AGE] year old male admitted to the facility on [DATE] and again on 12/22/2023 with diagnoses of Peripheral Vascular Disease (A circulatory condition in which narrowed blood vessels reduce blood flow to the limbs), Alzheimer's disease (a progressive disease that destroys memory and other important mental functions), Cognitive Communication Deficit (may have trouble reasoning and making decision while communicating, have trouble responding in an appropriate manner), and Amnesia (memory loss). Review of Resident #22's comprehensive MDS, dated [DATE], reflected resident was rarely or never able to understand verbal communication, cognitive skills for daily decision making were severely impaired and the resident was always incontinent of bowel and bladder. (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	Review of Resident #22's Care Plan, revised 06/12/2024, reflected resident had an electronic monitoring device in his room with consent signed, resident was moved to memory care wing, resident required staff assistance for meeting emotional, intellectual, physical and social needs related to dementia. Care Plan also reflected resident had potential to be physically aggressive with staff and would hit staff during incontinence brief change. Interventions included in-service staff on Abuse Prohibition Policy, analyze times of day, places, circumstances, triggers and what de-escalates behavior and document, and provide physical and verbal cues to alleviate anxiety. In an interview on 08/20/204 at 2:20 PM, the ADON stated the for Resident #22 came to the facility and showed the DON the video of CNA H abusing Resident #22. She stated CNA H was employed by the Staffing agency. She stated the facility agreed it was abuse and law enforcement put out a warrant for CNA H's arrest. In an interview on 08/21/2024 at 10:45 AM, Resident #22's RP (FM 1) stated that himself or FM 2 monitored the video surveillance camera in Resident #22's room daily. FM 1 stated the evening of the incident 07/04/2024 FM 2 reviewed the video and observed CNA H being rough and slapping the resident. FM 2 went to the facility and showed the DON the video. FM1 stated the DON at the time called in the incident to the state and FM 2 met with the sheriff's office and filed a report. FM 1 stated he believed the suspect had been arrested. He stated there was a lot of turnover with the administrator and DON but he felt the facility handled the investigation well. FM 1 stated he did not notice a change in Resident #22's behavior follwing the incident. Observations and interviews with Resident #4, Resident #6, and Resident #21 revealed none had concerns with abuse and all felt safe at the facility. Interviews with direct care staff revealed all were knowledgeable of abuse prohibition policy. In an interview 08/22/2024 at 3:51 PM, CNA C stated she received abuse training several times a year. She stated if she witnessed abuse she would report it to the administrator. In an interview on 08/22/2024 at 4:10 PM, LVN A stated she was trained on abuse in July. She stated if she witnessed abuse she would report it to the administrator immediately. In an interview on 08/22/2024 at 5:30 PM, the interim DON stated the staff are trained on Abuse Prohibition Policy annually and as needed. She stated that staff are screened for history of abuse before hire. In an interview on 08/22/2024 at 5:50 PM, the Administrator stated staff are trained on Abuse Prohibition Policy annually and after every reportable event. She stated they run abuse/neglect registry checks before hire for all new staff. Attempted interview with CNA H with no return communication. The Administrator and DON at the time of the incident are no longer employed at the facility. Review of reports received from the Staffing Agency reflected a background check was completed for CNA H on 03/13/2024, with clear status. Records also reflected CNA H was deactivated from the Staffing Agency platform as of 07/06/2024 and her account had been permanently disabled. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the facility investigation, dated 07/12/2024, reflected the Administrator at the time took the appropriate actions to ensure the safety of the residents after the incident and provided education for the staff. Behavior monitoring was conducted for all residents on the memory care unit for 72 hours, weekly random check-offs were implemented for staff members providing direct care, and Abuse/Neglect in-service and drills were conducted. The report further reflected CNA H was immediately, on 07/05/2024, reported to the Staffing Agency and taken off the facility schedule. A skin assessment was completed on Resident #22 and all other residents that received care from CNA H with no issues/injuries noted. Per facility report, Resident #22 continued same meal intake, sleep pattern and no increased behaviors following the incident. CNA H only worked that one shift at the facility and has been banned from working at any company facility. Facility investigation report reflected 5 direct care staff completed an abuse questionnaire on 07/11/2024, abuse drill evaluations were completed as well as an in-service on abuse policy. Review of the questionnaire reflected staff were aware of how and when to report abuse to the Abuse Prohibition Coordinator (Administrator). The abuse policy in-service, dated 07/05/2024, was signed by 49 employees. Review of the police report, dated 07/08/2024, reflected CNA H intentionally and knowingly caused physical contact with Resident #22, by striking the resident several times with an open hand and should have believed that the resident would regard the contact as offensive or provocative. Review of facility Abuse Prohibition Policy, dated 05/17/2024, reflected physical abuse defined as . slapping . and controlling behavior through corporal punishment. The policy reflected the facility would investigate alleged abuse and provide notification of information to the proper authorities according to state and federal regulations. It also reflected employees will receive training and reinforcement on all aspects of abuse program at the time of initial orientation, annually and through ongoing in -services. The noncompliance was identified as PNC IJ. The IJ began on 07/04/2024 and ended on 07/05/2024. The facility had corrected the noncompliance before the survey began.