STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675105	A. Building B. Wing	04/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Country View Nursing and Rehabilitation	1900 N Frances St Terrell, TX 75160

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 - Some	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** 46929 Based on observation, interview and record review, the facility failed to ensure residents the right to be free from abuse and/or neglect for 1 (Resident #1) of 7 residents reviewed for abuse and/or neglect. The facility failed to ensure Resident #1 was free from physical abuse. CNA A grabbed Resident #1's arm and twisted it and then CNA A put her hands on Resident #1's neck and choked her. The incident occurred on 03/03/25. An IJ was identified on 4/22/25. The IJ began on 03/03/25 and removed on 03/03/25. The facility took action to remove the IJ before the survey began. While the IJ was removed on 03/03/25, 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 because all staff had not been trained on behavior management procedures, abuse, and trauma informed care plans. These failures could place residents at risk of physical or emotional harm. Findings included: Record review of Resident #1's face sheet, dated 04/21/25, indicated she was a [AGE] year-old female, initially admitted to the facility on [DATE] and readmitted on [DATE]. Her diagnoses included hemiplegia (complete paralysis on one side of the body) and hemiparesis (refers to a weakness on one side of the body) following cerebral infarction (condition where a brain tissue area dies due to a lack of blood supply and oxygen) affecting right dominant side, vascular dementia (a type of dementia caused by brain damage due to impaired blood flow), bipolar disorder (a mental illness characterized by significant mood swings, ranging from extreme highs to extreme lows), and anxiety disorder (a group of mental health conditions characterized by excessive worry, fear, and anxiety that significantly impair daily functioning). (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 - Some	Record review of Resident #1's Quarterly MDS assessment, dated 02/21/25, indicated she had a BIMS score of 11, which indicated moderate cognitive impairment. She was usually able to make herself understood and she was able to understand others. She did not exhibit behaviors of rejection of care or wandering. She had impairment on one side of both her upper and lower extremities. She used a cane/crutch and a wheelchair for mobility. She was able to independently complete activities of eating, oral hygiene, toileting hygiene, lower body dressing, putting on/taking off footwear, personal hygiene, sit-to-standing, and chair/bed-to-chair transfers, and toilet transfers. She required supervision or touching assistance with showering/bathing and tub/shower transfers. She required moderate assistance with upper body dressing. She was able to independently walk 150 feet. Record review of Resident #1's care plan, last revised on 03/03/25, indicated a focus of Resident #1 has a history of trauma that may have a negative impact. The trauma is related to domestic abuse, Resident #1 prefers not to talk about incident. Resident #1 has a history of trauma related to physical assault, she indicates she is ok and does not wish to continue talking about it. The goal was staff will assist in avoiding triggers through next review. Interventions included: *Consult with family regarding resident's condition as appropriate *If the resident has escalated, if at all possible do not touch the resident unless absolutely necessary for resident's or others safety *Monitor for escalating anxiety, depression or suicidal thought and report immediately to the nurse *Psych consult ordered *Social worker or designee to follow up for 3 days. The care plan addressed another focus of Resident #1 has a communication problem related to expressive aphasia. The goal was the resident will be able to make basic needs known on a daily basis through the review date. Interventions included: * Anticipate and meet needs * Ensure/provide a safe environment: Call light in reach, Adequate low glare light, Bed in lowest position and wheels locked, Avoid isolation. * Monitor/document frustration level. Wait 30 seconds before providing resident with word. * Use communication techniques which enhance interaction: Allow adequate time to respond, repeat as necessary, do not rush, Request feedback, clarification from the resident, to ensure understanding, Face when speaking and make eye contact, Turn off TV/radio as needed to reduce environmental noise, ask yes/no questions if appropriate, use simple, brief, consistent words/cues, Use alternative communication tools as needed, such as communication book/board, writing pad, gestures, signs, and pictures. Record review of Resident #1's progress notes, dated 03/03/25 - 03/06/25 indicated the following: (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	*03/03/25 at 5:30PM, by the ADON, indicated, .NP notified of altercation between resident and staff member. NP notified of scratches to residents left arm, bruising to both sides of neck, abrasion to left arm, and bruising to left arm. NP also notified of resident's refusal to go to ER for further evaluation. New orders received to clean scratches to left arm with [normal saline], apply TAO, cover with dry dressing if resident allows, if not leave open to air and monitor for changes. Notify MD/NP of changes. Monitor bruising to left arm and both sides of neck . *03/04/25 at 07:45AM, by the SW, indicated, LMSW spoke with resident concerning incident that occurred on 3/3/2025. Resident advised she was assaulted by CNA. Resident is unable to speak but showed LMSW that CNA had pulled her left arm behind her person while squeezing/placing pressure of left forearm. Resident then advised CNA grabbed her by the neck and squeezed, causing pain. LMSW observed what appeared to injuries sustained by nail markings and blue/green bruising to resident's left forearm and nail marking to both the right and left side of resident's neck. LMSW contacted/made referral .Psych services to follow up with resident, ensuring care of mental health. LMSW also asked if she feels safe at facility with remainder of staff or if there was anything needed to help with safety concerns. Resident advised she currently feels safe and advised she did not have further concerns at this point. Physical Therapy .also met with resident, resident advised [Rehab Director] that she is doing well and will participate in physical therapy on today's date (03/04/2025) LMSW will continue to follow-up with resident, ensuring she continues to feel safe and addressing if any other concerns present. *03/06/25 at 10:28AM, by the MDS Coordinator, indicated This nurse and administrator followed up with resident regarding incident with staff member .she is pleased that staff member is no longer employed here at facility, indicates that she feels safe, and that she is appreciative of the actions taken by management in this incident. No other concerns voiced/indicated. Record review of Resident #1's Initial Skin Assessment, dated 02/28/25, indicated she had normal skin color, with no bruising, skin tears, abrasions, lacerations, incisions, rashes, or ulcers. Record review of Resident #1's Weekly Skin Assessment, dated 03/03/25 at 05:08PM, and completed by the ADON, indicated she had right inner forearm- circular, dime-sized beginning of purplish bruising. She also had an abrasion to the right inner forearm - 0.5cm x 0.5cm. Further, she had other skin findings: scattered scratches to the right inner forearm: 1). 0.5cm x 0.5cm 2). 0.3cm x 0.5cm 3). 0.8cm x 0.3cm 4). 1.3cm x 0. 3cm 5). 0.5cm x 0.2cm 3 red areas to right side of neck: 1). 1.2cm x 0.2cm 2). 0.5cm x 0.2cm 3). 2cm x 1cm 1.5cm x 0.5cm red area to left side of neck. Record review of a Physician's progress note, dated 03/06/25, indicated: .On 3/3 resident [and] staff had physical altercation in hallway. [patient] [care of] multiple scratches . scratches [and] bruising to [left] neck. States [left] arm sore but better. Tearful and quiet / states safe now . The note further indicated the resident had a skin tear, and a bruise to the left forearm and neck. Resident #1 was also anxious. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview and observation on 04/21/25 at 10:28AM, Resident #1 was lying in bed in her room. She was unable to verbalize most words, but she was able to point and act out her story with motions. She mostly spoke with no and nodded or shook her head to indicate yes or no. This surveyor asked her yes or no questions to gather the story. When asked if CNA A grabbed her arm she said yes. She made a motion to indicate that CNA A grabbed her arm and twisted it behind her back. When asked if it was the left arm she said no and pointed to her right arm. When asked if CNA A touched her neck she said yes, and then put her hands on her neck in a choking motion. When asked if CNA A choked her, she said yes. When asked if she could not breathe when CNA A choked her, she said yes. When asked if CNA A left marks and bruising on her, she said yes, and pointed to her right arm and neck. When asked if it was painful, she said yes. When asked if she had seen CNA A since the incident, she said no. When asked if she was upset and tearful by the incident she said yes. When asked if she felt safe at the facility now, she said yes. When asked who witnessed this event this surveyor gave several names of staff members and residents. She said yes that CNA B and Resident #2 had witnessed the incident. When asked if the police came to the facility she said yes. When asked if she pressed charges against CNA A she said yes. When asked if any other staff have tried to abuse her, she said no. Record review of Resident #2's face sheet, dated 04/21/25, indicated she was a [AGE] year-old female, admitted to the facility on [DATE]. Her diagnoses included hemiplegia (complete paralysis on one side of the body) and hemiparesis (refers to a weakness on one side of the body) following cerebral infarction (condition where a brain tissue area dies due to a lack of blood supply and oxygen) affecting unspecified side, dementia (a general term for the loss of memory and other thinking abilities that are severe enough to interfere with daily life), and major depressive disorder (a mental illness characterized by persistent low mood, loss of interest or pleasure in activities, and other symptoms that significantly impair daily functioning). Record review of Resident #2's quarterly MDS Assessment, dated 01/17/25, indicated she was sometimes understood, and sometimes able to understand others. Her vision was marked as adequate, indicated she was able to see fine detail, such as regular print in newspapers/books. She had a BIMS score of 12, which indicated moderate cognitive impairment. During an interview and observation on 04/21/25 at 11:58AM, Resident #2 was lying in bed in her room. She was unable to form some words. She was able to use hand motions to tell her story. This surveyor also asked yes or no questions. When asked if she remembered the incident with Resident #1 and CNA A she said yes. When asked if CNA A grabbed Resident #1, she said yes. When asked what happened, Resident #2 made a motion with her right arm and moved it behind her back. When asked if CNA A grabbed Resident #1's arm and twisted it she said yes. When asked if Resident #1 was swinging and trying to hit staff she said yes. This surveyor asked her to point at the arm that CNA A grabbed on Resident #1 she pointed to her right arm. When asked if she saw bruises and scratches, she said yes and pointed to her right arm. When asked what else CNA A did to Resident #1, she put her hand up towards her neck and made a choking sign. This surveyor asked her if CNA A used her hands, or her arms and the Resident pointed to her hand. When asked if Resident #1 hit CNA A and then CNA A choked Resident #1 she said yes. When asked if she had seen CNA A since the incident, she said no. When asked if she had observed any other abuse in the facility, she said no. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of an undated witness statement by the MDS coordinator indicated on [03/03/25] at approximately 3:15[PM], this nurse heard yelling, I went to the nurses station to investigate and noted [Resident #1] in front of the 500 hall with several staff members standing around her. When I asked her what was going on, she showed me her left forearm, at that time I noted several dark, half moon shaped indentions, a dark blue circular mark, and a scratch with a small amount of red blood. Resident was upset, had tears in her eyes and indicating towards hall 600. I looked up and saw [CNA A] coming from the 600 hall, who went to the time clock and I witnessed her walk out the front door. On seeing her, resident became even more upset, yelling and pointing at her. At that point, I assisted resident to the administrator's office. While talking with her with the administrator, she indicated that her arm was pulled backwards and that her neck was grabbed. When looking at her neck, I noted a bright red mark going from under her chin in the middle of her neck, to just below the corner [of] her jawbone noted a small abrasion with no bleeding, resident also had a small circular abrasion to her chin. This nurse stayed with resident in administrator's office talking with her and reassuring her until she calmed down and was no longer crying. She indicated that she wanted to leave the office, and headed to her room, she had her phone and indicated that she wanted to make a phone call. Record review of a witness statement by CNA B, dated 03/03/25, indicated [CNA B, CNA A, and CNA C] were in the linen room. [Resident #1] approached us and said 'no no' and was rubbing her body to let her aide know she wanted a shower. [CNA A] [continued] grabbing her linen. I walked away to answer one of my lights. When I came out [of] my resident room [CNA A] was at the end of the hall with her linen cart. [Resident #1] was blocking [CNA A] from passing by. [CNA A] asked her to move [and] she would not. [Resident #1] was hitting [CNA A]. [CNA A] was allowing it. After a while [CNA A] grabbed [Resident #1's] arm and told her to stop [and] she would not. [Resident #1] put her wheelchair in lock [and] stood up to hit [CNA A]. [CNA A] .put her hands on [Resident #1's] neck to calm her down. I grabbed [CNA A] and told her to walk away. Record review of a witness statement by CNA A, dated 03/03/25, indicated I was loading my linen cart when [Resident #1] stopped and asked for a shower. (after checking my computer chart I had my shower sheets available.) I informed [Resident #1] I had to prioritize those residents first before I take on the other responsibilities. After closing the linen closet, I asked her if she needed anything else - bed linen changes, a snack? She refused. Trying to get back to my hallway, I begin to push my cart. I thought I bumped her, so I stopped and apologized. Only to realize she was actively pushing my cart as she was rolling down the hall. She stopped near the nursing station and blocks my path. (another resident is no the other sides, so I wasn't able to fit with my linen cart). I pushed [Resident #1's] wheelchair slightly to the right after asking for space repeatedly. When I feel I have enough space I pull my linen cart between the residents. [Resident #1] locks her wheelchair and begins swinging at me. I grabbed her wrist to keep from getting hit. I informed her that she was about to hit another resident after releasing her wrist. She's still trying to attack me and elbows me and hits me in the face. I give her a hug and told her I love my job! When releasing from my embrace I grab my linen closet and take it back to my hall. During an interview on 04/21/25 at 1:09PM, the MDS Coordinator said she did not witness the incident between CNA A and Resident #1. She said she did hear yelling and went down to where the resident was. The incident was already over when she made it to the area. She said she did not see CNA A. She checked on Resident #1 and saw marks and scratches on her arm. She said she did not see blood. She said she also saw red marks on Resident #1's neck. She said Resident #1 was visibly upset and crying. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 04/21/25 at 1:12PM, the Treatment Nurse said she heard the screaming at the time of the incident. She said she came out and saw marks on Resident #1's arm. She said she saw dug in fingernail marks that were beginning to bruise. She said she saw 4-5 marks. She said she asked CNA A what had happened, and CNA A said she did not remember. During an interview on 04/21/25 at 1:21PM, CNA D said she heard the commotion of the incident. She said when she walked outside of the facility, she saw CNA A leaving the facility. She said did not see the Resident. She said it seemed out of character for the CNA. She said she had worked with the CNA in the past. She said the CNA seemed like something was wrong that day. During an interview on 04/21/25 at 1:28PM, CNA B said she witnessed the incident between CNA A and Resident #1. She said she was near the linen room with CNA A. She said Resident #1 came by and made a gesture that she wanted a shower. She said CNA A asked Resident #1 to give her a minute. She said at this point she had to walk away and complete a task with another resident. She said she then heard yelling. She said when she came back out to the hall, she saw Resident #1 standing out of her wheelchair and Resident #1 slapped CNA A. She said CNA A was holding Resident #1's arm to keep her from swinging and hitting her. She said CNA A then reached out and put her hands on Resident #1's neck and choked her. She said she intervened and split up the altercation and asked CNA A to walk away. She said she had not really worked with CNA A before, so she was unsure if this was out of character for her. She said it was not okay for a CNA or any health care staff to do this to a resident. She said she did not look at the resident's skin. She said at this point there was a bunch of people around and the nurses were assessing her. She said someone reported it to the Administrator. She said she wrote a statement. During an interview on 04/21/25 at 2:00PM, CNA A said on the day of the incident she was loading one of her hallway linen carts. She said another aide saw Resident #1 saying that she needed something. She said when she addressed Resident #1, she motioned that she needed a shower. She said she checked her shower sheets, and Resident #1 was not on her sheets for that day so she would take care of her after her scheduled showers were completed. She said the resident remained in the hallway. She said after she finished stocking her cart, the resident then asked again for a shower. She said she offered to strip Resident #1's bed so she would have clean linens. She said the resident refused. She said she started moving her linen cart down the hallway and she thought she ran into Resident #1 with the linen cart, so she stopped and apologized. She said she looked over and noticed Resident #1 had her hand up and was pushing the linen cart. She said she stopped walking and let the resident move away from her cart. She said she waited a few minutes and then tried to move again. She said Resident #1 blocked the end of the hallway from her leaving with the cart. She said she asked Resident #1 to move so she could pass. She said Resident #1 had a hard time communicating. She said Resident #1 was ignoring her request to move so she could get through and out of the hall. She said Resident #1 tried to swing at her. She said she was trying to protect herself from the resident hitting her. She said there was also another resident nearby she was trying to keep Resident #1 from hitting. She said Resident #1 elbowed her in the stomach and then hit her in the face. She said she hugged the resident and then clocked out and left. She said she did not hold Resident #1's hand. She said she was making contact with her wrist. She said she held Resident #1's shoulder when she gave her a hug. She said she did not grab Resident #1's arm and twist it. She said she did not put her hands on Resident #1's neck. She said she clocked out because she was afraid the situation would upset her and make her lose her job. She said she felt she had to leave the environment because she was not safe. She said CNA B was not around when she was talking to Resident #1. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 04/23/25 at 10:26AM, the Social Worker said she did a trauma assessment the next day following the incident for Resident #1. She said she spoke with the resident and the injuries lined up with her story. She said she observed bruising and scratches on Resident #1's arm. She said she saw a nail mark on the resident's neck at the time of the trauma assessment. She said the resident appeared to be in an okay state. She said the resident was relatively calm. She said she assured the Resident that she would be safe in the facility. She said the resident has a history of being a victim of domestic violence and sexual assault. She said she was unsure if the CNA abusing her could have been triggering for her considering that the resident had a history of being a victim of domestic violence and sexual abuse. She said she started the resident on psychological services to check on her. She said she was not in the facility at the time of the incident. During an interview on 04/23/25 at 10:35AM, the ADON said she was not in the facility on the day of the incident. She said she felt like CNA A abused Resident #1. She said she expected the CNA to not abuse the resident. She said the resident was calm the next day when she saw her. She said it was possible that due to the resident's history of being a victim of domestic violence and sexual abuse it could have been triggering for her. She said the CNA never showed any indication that she would hurt a resident. She said all the residents liked CNA A and she was shocked when it happened. She said Resident #1 had bruising and scratches on her arm and she had red marks on her neck after the incident. She said Resident #1 also had fingernail indentions on her arm. During an interview on 04/23/25 at 10:48AM, the DON said she was not in the facility when the incident between CNA A and Resident #1 occurred. She said she was sick with the flu and came back later that week. She said she did visit with the resident when she was able to come back. She said she could not remember if she saw anything on her neck when she came back, but she did have bruising and scratches on both arms. She said she felt like CNA A abused Resident #1. She said she expected her staff to not abuse residents. She said the measures to correct the noncompliance were in place on 03/03/25. She said this incident was probably triggering to Resident #1 considering she had a history of being a victim to domestic violence and sexual abuse. She said she checked on the resident on 04/22/25 and the resident was crying because she felt like she was reliving the incident when talking to this surveyor on 04/22/25. During an interview on 04/23/25 at 11:08AM, the Administrator said he was in the facility at the time of the incident between CNA A and Resident #1. He said his door was open and he was in his office. He said there was a bunch of noise in the common area. He said he came out and the other staff were gathered around Resident #1. He said he asked the staff what had happened. He said at this time CNA A had already walked out the front door of the facility. He said he initiated an investigation and checked on the resident's safety. He said CNA A had already removed herself from the facility. He said he took a statement from CNA A and suspended her. He said he called the police and notified them. He said several staff followed up with the resident. He said he ultimately substantiated abuse and terminated CNA A. He said after the incident he noticed the red marks to Resident #1 on both sides of her neck. He said there was a red mark that looked like a hand on her neck. He said he conducted in-services on abuse and neglect and behavior management. He said Resident # 1 felt better after he notified her that the CNA was not going to return. He said he felt like this incident could be triggering for the resident considering her history of being a victim of domestic violence and sexual abuse. He said it was 100% physical abuse of a resident. He said he did not expect the staff to abuse the residents. He said he has a zero tolerance for abuse or neglect. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 04/23/25 at 12:04PM, the MDS Coordinator said she conducted a trauma assessment on Resident #1 shortly after the incident between her and CNA A. She said at first when she checked on Resident #1, she was crying and visibly upset. She said the resident had crescent moon indentions on her arm and bruising. Her neck had a red mark that went from her back of her neck in a line towards the front. She said there were marks on the other side of her neck as well. Record review of the facility's policy, Abuse/Neglect, last revised 03/29/18, indicated: The Resident has the right to be free from abuse .as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion .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 . .1. Abuse: abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish .Instance of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. It included 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 . The administrator was notified of the IJ on 04/22/25 at 11:30AM due to the above failures. The administrator was provided with the IJ template on 04/22/25 at 11:32AM. The surveyor confirmed the following measures had been implemented sufficiently to remove the Immediate Jeopardy on (03/03/25) by: - Reviewed completed facility self-reported incident to HHSC for Resident #1 dated 03/03/25 - This surveyor interviewed Resident #2, Resident #3, Resident #4, Resident #5, and Resident #6 on 04/21/25. Each resident indicated they had not been abused, and they enjoyed the facility staff. - Reviewed paperwork which indicated CNA A was suspended until completion of investigation which indicated the following: *dated 03/03/25 indicated .Type of Disciplinary Action: Investigatory Suspension .[CNA A] will be placed on an investigatory suspension pending an investigation into allegations of abuse .ADM .HR Director . - Reviewed paperwork which indicated CNA A was terminated after the allegation of abuse was investigated, which indicated the following: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675105	A. Building B. Wing	04/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Country View Nursing and Rehabilitation	1900 N Frances St Terrell, TX 75160

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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 - Some	*dated 03/05/25 indicated .Type of Disciplinary Action: Discharge .[CNA A] failed to adhere to the Corporate Code of Conduct. [CNA A] was placed on an investigatory suspension pending an investigation into allegations of abuse; allegations were substantiated. [CNA A] is aware of all policies and procedures via their signature on the employee handbook acknowledgement. [CNA A] meets criteria for immediate termination . DON .ADM .HR Director . - Reviewed paperwork which indicated CNA A had a criminal history check before hire. CNA A had a criminal history check on 02/01/24 and her date of hire was 02/01/24. - Reviewed paperwork which indicated the incident between CNA A and Resident #1 was reported to the local police department. The local police were notified on 03/03/25. - Reviewed documented safe survey resident interviews conducted on 03/03/25 during the course of investigation. They indicated no residents complained of resident abuse/neglect or misappropriation. The sampled residents verified they felt safe in the facility, were treated well by the staff, they did not have any concerns to report, and that any concerns were to be reported to the abuse coordinator. - Record review of a facility conducted in-service, Abuse and neglect dated 03/03/25, indicated 26 of 49 facility staff were provided education on the topic. - Record review of a facility conducted in-service, Behavior Management dated 03/03/25, indicated 26 of 49 facility staff were provided education on the topic. - During interviews on 04/22/25, starting at 8:54AM, the MDS Coordinator, PTA F, the Rehab Director, the Maintenance Director, the Dietary Manager, Dietary [NAME] G, RN H, LVN K, CNA L, LVN M, CNA D, CNA N, the ADON, the Activity Director, the HR Director, the DON, CNA O, LVN P, CNA Q, and LVN R had been in serviced on abuse and neglect. They were able to identify an example of abuse and were able to verbalize to report any abuse to the abuse coordinator, (Administrator). They were also able to verbalize an understanding of behavior management, and proper de-escalation techniques for a resident that was trying to hit another staff or resident. - Record review of Resident #1's Trauma Informed PRN Assessment, dated 03/03/25, indicated a trauma assessment was completed by the MDS Coordinator.altercation with employee in this facility. Was handled by other facility staff, and feels safe now that the offending employee is no longer in the building . - Record review of Resident #1's Psych Visit Note, dated 03/04/25, indicated the resident was added to psych services and saw a provider this day. [Resident #1] is seen in her room. She is calm, pleasant and consents to the interview .The patient is unable to elaborate on what happened but reports feeling safe now that the staff member in question is no longer working at the facility. She reports no issues with any of the remaining staff and says they all treat her well. She denies being fearful . (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675105	A. Building B. Wing	04/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	The noncompliance was identified as Past Immediate Jeopardy. The IJ began on 03/03/25 and was removed on 03/03/25. While the IJ was removed on 03/03/25, 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 because all staff had not been trained on behavior management procedures, abuse, and trauma informed care plans.