STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675128	A. Building B. Wing	06/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Midwestern Healthcare Center	601 Midwestern Pkwy Wichita Falls, TX 76302

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** Based on observation, interview, and record review, the facility failed to keep the residents free from abuse, neglect, misappropriation of resident property, and exploitation for 1 (Resident #1) of 16 residents reviewed. The facility failed to prevent verbal abuse to Resident #1 by LVN B. This failure resulted in the identification of Immediate Jeopardy (IJ) on 6/04/25 at 2:09 pm. While the immediacy was removed on 6/06/25 at 1:02 pm, the facility remained out of compliance at scope of pattern and severity no actual harm due to the facility's need to monitor the implementation of the plan of removal. This failure could place the residents at risk of serious emotional, psychological, and physical anguish. Findings included: Record review of Resident #1's electronic health record revealed a [AGE] year-old female, admission date 4/30/25. Her diagnoses included: Autistic Disorder (neurodevelopmental disorder with difficulties in social interaction and social communication), Fetal Alcohol Syndrome (life-long physical, cognitive, and behavioral issues), long-term drug therapy, epilepsy (seizure disorder), tachycardia (rapid heart rate). Resident was discharged on 05/05/2025. (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
	675128	A. Building B. Wing	06/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Midwestern Healthcare Center	601 Midwestern Pkwy Wichita Falls, TX 76302

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of police report dated 5/4/25 at 6:59pm revealed When [Police officer] arrived, [Police officer] made contact with the reporting party, [LVN A], she stated they received a new patient [Resident #1] approximately 2 days ago. [LVN A] stated [Resident #1] was a psych patient who had been having a hard time adjusting to the facility. [LVN A] requested that [Police officer] speak with [Resident #1] to see if she met criteria to be assessed by [LIDDA] for a psych evaluation. [Police officer] made contact with [Resident #1] at the nurse's station, [Resident #1] was very upset at the time and was refusing to speak with [Police officer]. While [Police officer] was speaking to [Resident #1] in an attempt to build a rapport [LVN B] began walking towards the nurse's station. When [LVN B] approached the area, she began making statements like, Y'all need to take her ass somewhere. and Her [family member] needs to come get her! [LVN B] was very agitated and extremely rude. [Police officer] began asking [LVN B] for more background information on [Resident #1] because she did not speak to me. [LVN B] stated She is trying her crap. after she stated this [Resident #1] yelled at [LVN B] to shut up. [LVN B] stated, You don't scare me none, you might your [family member] but not me. I began explaining to [LVN B] our criteria and that I would not just be able to take her. [LVN B] began talking and said, Well then she needs to go to her room because she is one on one. [Resident #1] then yelled, I don't have to if I don't fucking want to! [LVN B] then turned to [Resident #1] pointed at her and yelled very angrily Go to your room! and then held her middle finger up towards [Resident #1]. That was when [Resident #1] stated I can punch you! and [LVN B] turned to [Resident #1] and waved her fingers as if inviting her over and stated, Come on! [Resident #1] stood aggressively and began walking towards [LVN B]. An aide and I stood between the two to keep things from escalating. [LVN B] stated She needs to go to jail mam! she then stated, Her [family member] dropped her here because she can't take care of her. another nurse stated neither of [Resident #1's] [family members] was answering the phone and [LVN B's] response was They don't want to have anything to do with her. [Resident #1] responded Shut up! and [LVN B] replied, Just telling the truth honey. This upset [Resident #1] to the point where she wanted to hurt [LVN B]. An aide and I continued following [Resident #1] and trying to keep her calm and away from [LVN B]. I was finally able to get [Resident #1] to separate and have a seat in the living area of the facility .[Police officer] contacted crisis line to see if she could be assessed by [LIDDA] .[LIDDA] came to the facility for the assessment and put in a referral to [Behavioral health hospital] and was denied due to [Resident #1's] IQ. LIDDA attempted an emergency detention order to the state hospital, and they refused the order. Officers remained until [Resident #1] was in bed and no longer a threat to the staff. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675128	A. Building B. Wing	06/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Midwestern Healthcare Center	601 Midwestern Pkwy Wichita Falls, TX 76302

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	Observation of body cam footage from police officer dated 5/4/25 from 7:12pm-7:19pm revealed the Police officer entered the building of the facility and went to the nurse's station and asked for the nurse that called and was directed down the hall to LVN A at her med cart. LVN A stated Resident #1 is a psych patient and need to see about an evaluation. LVN A pointed towards the nurse's station and stated the Police Officer could ask and aide where Resident #1 is. The Police officer walked to the nurse's station and CNA E showed Police officer who Resdient #1 was. Resident #1 was sitting in chair against the wall at the nurse's station quiet and looking around shaking her left leg and 1:1 aide (CNA E) was three chairs down from resident. Three residents sitting in chairs next to resident. Police officer attempted to speak to Resident #1, and she would not speak to the police officer. Resident #1 stated shut up to someone behind the police officer not seen on camera. Police officer turned around and LVN B wheeled her cart to the nurse's station and stated to the police officer, She's trying her crap & she needs to go to jail and Resident #1 stated shut up, shut up. LVN B stated, Don't scare me none, might your [family member] but not me. The police officer attempted to explain to LVN B that she can't just take her, and Resident #1 is not speaking to her. LVN B stated, she needs to go to her room, she's 1:1 and looks towards Resident #1. Resident #1 said, I don't have to if I don't fucking want to. LVN B stated, you need to go to your room loudly towards Resident #1 (Resident #1 not in camera view). LVN B flips Resident #1 off and states, I can do it too and Resident #1 stated, I can punch you and LVN B stated, come on and waved her fingers gesturing towards her to come, you punch me you're going to jail as Resident #1 is seen getting up and walking towards LVN B. Police officer says uh-uh and CNA D puts herself between LVN B and Resident #1. LVN B no longer in camera view. Resident #1 stated I don't care and Police officer tells her to go sit down. LVN B stated, she needs to go to jail ma'am, her [family member] left her here because she can't take care of her. They don't want to have anything to do with her. Resident #1 stated shut up and appeared to be tearing up. LVN B said, just telling the truth honey. CNA D stated, let's go for a walk, want to go for a walk with me and Resident #1 states, No, I want to punch that bitch. CNA D and Police officer said no, we are not doing that, and we have to respect our elders. CNA D stated again, want to go for a walk and LVN B (no longer in camera view) stated she's not to be out of her room for one thing. Resident #1 stated, yes I can and LVN B stated, she's on 1:1. CNA D encouraged Resident #1 to practice breathing. Resident #1 looks at her watch and a sound from watch played and Police officer stated, that's you [family member] right there. Resident #1 stated, I don't care. Police officer said, you don't want to talk to your [family member]? Resident #1 pulled a pen out of her left shorts pocket and stated, I wanna stab that bitch and CNA D stated, let's go on a walk, let's remove ourselves from the situation and we don't have to be ugly let's remove and go on a walk and calm down. We don't need to do the extra stuff. Resident #1 started walking towards the entrance of the nurse's station and CNA D walked with her and LVN C is seen at a med cart on the computer. Police and CNA D walk with Resident #1. CNA D put herself in the entry and police asked if she wanted to go walk with CNA D and Resident #1 said No and police said, we are not going over there with her and touched Resident #1's arm. Resident #1 shook police officer off and said move. The police officer said, back up, you're not going over there. Resident #1 tried to walk around CNA D and CNA D said [Resident #1], I'm not letting you in there, we can go for a walk, we can remove ourselves but that is not happening and Resident #1 stopped and stood still. Someone unknown stated, she's not supposed to be out here and Resident #1 stated yes I can. CNA D stated Let's go for a walk. LVN A is heard explaining Resident #1's actions to someone. The police officer asked Resident #1 if she wants to go outside, and she said no. CNA D stated I need you to back up, you are in my bubble and Resident #1 stepped back. CNA D thanked her. Someone from the nurse's station attempted to give Resident #1 the phone and CNA D stated your [family member] wants to talk to you. Resident #1 hung up the phone. The police officer stated How can we help you if you won't talk to anybody. We are here to help you. CNA D asked Resident #1 if she wants to go get a soda and Resident #1 shook her head no. LVN A asked CNA D she hung up? and CNA D said, oh yeah she hung up the phone. Resident #1 starts walking away. End video. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675128	A. Building B. Wing	06/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Midwestern Healthcare Center	601 Midwestern Pkwy Wichita Falls, TX 76302

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	In an interview on 5/18/25 at 10:45 am with the Police Officer, she stated she went out to the facility for a call for a welfare check on Resident #1 by LVN A. Resident #1 was very upset, and the Police officer got her to calm down. The Police officer stated that LVN B told the Police Officer she needed to take her [Resident #1] ass to jail. Resident #1 was right there so she heard LVN B. LVN B stated Resident #1's [family member] needed to come get her and Resident #1 needed to be in her room on 1:1. The Police officer stated Resident #1 stated she did not have to be in her room and LVN B flipped off Resident #1 and Resident #1 flipped off LVN B and then LVN B stated that's why nobody wants you. That's why she (family member) dropped you off to Resident #1. The police officer stated that Resident #1 said she was going to hit LVN B and LVN B said, do it. The Police officer said she got in between them and there were lots of staff around and nobody removed LVN B. The Police Officer stated it was not against the law, there was no immediate threat for Resident #1, and she had another nurse, and the police de-escalate the situation, so it was not enough to take LVN B in. LVN A was the nurse that called 911 to come check on Resident #1. In an interview on 5/18/25 at 1:30pm with DON, the DON stated she had never been told about the incident with LVN B by anyone until right then. Resident #1 was trying to hurt herself while she was at the facility and was there for 5 days, and was never without staff supervision. The DON stated she was never told about LVN B acting that way and would report it now and start an investigation now. She would have reported it at the time had she been made aware. The DON stated the Administrator, at the time, was no longer there. The DON stated he was the abuse coordinator and DON was the backup abuse coordinator at that time. In an interview on 5/18/25 at 5:50pm with LVN A, she stated she spoke with the police and witnessed Resident #1 trying to get at LVN B, but she did not know what initiated it. LVN A stated the aides prevented Resident #1 from getting LVN B so Resident #1 started throwing things down the hall. LVN A stated Resident #1 did calm down, went back to her room with her 1:1 staff, and went to sleep. LVN A stated she called Guardian A, and she was out of town, so LVN A tried to call Guardian B and he did not answer, so she called 911. LVN A stated she called because Resident #1 had grabbed an ink pen and started carving her arm and the police were right there. LVN A stated she told Resident #1 to stop, and she did. LVN A stated there was no injury. LVN A stated she did not see LVN B flip off Resident #1 or curse at her or tell her she was not wanted anywhere. In an interview on 5/18/25 at 6:48pm with CNA D, she stated that on 5/4/25, Resident #1 was frustrated and agitated, was trying to get out of the facility, and was on 1:1. CNA D stated the police had been called and LVN B said to Resident #1, you are here because your [family member] can't deal with you and you need to go to jail. Resident #1 said shut up, bitch and flipped off LVN B. LVN B flipped off Resident #1 and said, I can do it too. Resident #1 called LVN B a bitch and LVN B said, you need to go to jail and need to go to a mental hospital to Resident #1. CNA D stated Resident #1 said, shut up bitch, I'm gonna punch you and LVN B said, come on and punch me and I want you to punch me and CNA D stated she got up and tried to redirect Resident #1 and LVN B kept talking trash to Resident #1. CNA D stated she thought other nurses would have reported. CNA D stated she had been trained on abuse and neglect and she should have reported to the DON immediately because the DON was the Abuse coordinator and failure to report would not happen again. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675128	A. Building B. Wing	06/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Midwestern Healthcare Center	601 Midwestern Pkwy Wichita Falls, TX 76302

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	In an interview on 5/18/25 at 7:05pm with CNA C, she stated LVN B was agitating Resident #1 and told Resident #1 she needed to go to jail, and her [family member] dropped her off because nobody wanted her. CNA C stated Resident #1 got upset and said, shut up bitch and flipped off LVN B and LVN B kept going and flipped her off back. CNA C stated she could not believe this was happening right in front of the cops. CNA C stated Resident #1 went after LVN B and the aides intervened, and the cops didn't do anything. CNA C stated she thought the police would do something and take care of it. CNA C stated she came into work the next day to report it to the DON, but she was not there and then CNA C was off for a couple of days and time just went by. CNA C stated she did not report the incident because she thought others would and she should have reported it herself immediately. CNA C stated she had been trained on abuse and neglect and she should report to the DON, the abuse coordinator. CNA C stated she feels she can report to the DON and has in the past. In an interview on 5/19/25 at 12:24pm with Guardian A, she stated she did not want this writer to speak to Resident #1 as there were no current effects, but Guardian A did not want to upset Resident #1 and cause behaviors. Guardian A stated Resident #1 did tell her after discharge from the facility that a nurse flipped her off and told her they wanted her to go to jail. Resident #1 told Guardian A that the police saw the nurse do it. In an interview on 5/19/25 at 12:56pm with the ADON, she stated that all staff had been trained on abuse and neglect. The ADON stated all staff had been trained on what abuse would look like and who to report to. The ADON stated that they should report to the DON, abuse coordinator. The ADON stated she was not aware and had not heard anything about LVN B being abusive. The ADON stated what she had been told was that Resident #1 was throwing computers and laptops and swinging at nurses. The ADON stated she was told that by LVN A and LVN B. The ADON stated she spoke with the DON about it and the DON told the ADON she had went and checked on Resident #1 the next morning and she was fine and did not report anything. The ADON stated Guardian B requested Resident #1 be sent to the state hospital. The ADON stated LVN B would be terminated, and CNA C and CNA D were placed on final warning for not reporting it. In an interview on 5/19/25 at 4:54pm with LVN B, she stated Resident #1 was trying to get at patients and knocking things off the nurse's station and was psycho and 300 pounds. LVN B stated [Resident #1] was supposed to be on 1:1 in her room for suicide watch and coming to the front agitating other patients. LVN B stated, Resident #1 was [AGE] years old acting like a smart ass and would not mind staff. LVN B stated she was passing medications, parked her cart, and Resident #1 threw her the finger and LVN B did the same thing back. LVN B stated that Resident #1 needed to be in a mental institution and the facility was not appropriate, and staff were just babysitting. LVN B stated she told Resident #1 to go to her room and Resident #1 flipped her off and LVN B could not handle disrespectful children. LVN B stated she did flip off Resident #1 but did not say anything. LVN B stated it was a reaction because Resident #1 was pushing buttons. LVN B then stated she did tell the police they needed to take Resident #1 because she would not calm down. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675128	A. Building B. Wing	06/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Midwestern Healthcare Center	601 Midwestern Pkwy Wichita Falls, TX 76302

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	In a follow up interview on 5/20/25 at 12:48pm with the DON, she stated all staff had been trained on abuse and neglect a bunch of times. The DON stated she had her number posted and was the abuse coordinator. The DON stated at the time of the incident with LVN B, the abuse coordinator was the administrator, and the DON was back up abuse coordinator. The DON stated she had never heard of, and no one reported abuse from LVN B to Resident #1. The DON stated she had started 1:1 training with each staff member to prevent this in the future. The DON stated staff failed to report and she had retrained, counseled, and wrote up the staff that failed to report. The DON stated LVN B was suspended as soon as this writer informed DON about allegation, and LVN B was now terminated. LVN B worked approximately 10 shifts between 05/04/2025 and 05/18/2025. In an interview on 6/3/25 at 3:35pm with LVN C, she stated she was on another hall, and walked up to the nurse's station. LVN C stated she saw Resident #1 yelling at LVN B and LVN B was yelling back at her. LVN C stated she was attending to the other residents and LVN B was talking to Resident #1 about how she hated taking care of residents like her and stuff like that, something to that affect. LVN C stated LVN B did say Resident #1 needed to go to jail. LVN B said Resident #1's [family member] dropped her at the facility because she couldn't handle her. LVN C stated she did not see LVN B flip off Resident #1. LVN C stated, it was verbal abuse. LVN C stated she was going to report to the DON, but LVN A, the night nurse, was on the phone with her at that time, right after the incident, and she said, yes I'm talking to her right now. So, LVN C stated she didn't and thought LVN A reported it. LVN C stated LVN A said she was on the phone with the DON after the incident, but she did not know what she reported. LVN C stated she was covering the shift and was late to her shift because she got called in and never worked the night shift before. LVN C stated she said to LVN A, you got this, you are reporting it and LVN A said yes, she was talking to the DON right then. LVN C stated she went back to passing meds. In a follow up interview on 6/3/25 at 4:11pm with the DON, she stated LVN A did call her that night at 7:24pm and said Resident #1 was having behaviors, throwing things at the nurse's station, and grabbing pens and the cops were there. The DON advised LVN A to call the [family member] because the cops would not take Resident #1 but maybe they would calm her. The DON said LVN A never told her about LVN B, and LVN B was never even mentioned, and she wasn't even the patients nurse, so the DON did not think to ask anything about that. The DON stated she went to see Resident #1 the next morning and checked on her first thing that morning and Resident #1 never told the DON that happened either. In an interview on 6/4/25 at 8:40am with CNA E, she stated she was Resident #1's 1:1 on the evening of the incident and it was her first time working with Resident #1. Resident #1 was throwing everything, books, and pens off the nurse's station. Resident #1 would be yelling, and she called CNA E a bitch for following her and she said she didn't need a 1:1. CNA E stated other residents did see, maybe 2 or 3 residents at the nurse's station. They were staring at Resident #1, and one lady said we (staff) needed to call the cops. CNA E stated she did not see Resident #1 try to hurt herself. CNA E stated Resident #1 went outside because she did not want to be there at the facility. CNA E stated there were CNAs, residents, and nurses around during the incident. CNA E stated Resident #1 was calling LVN B a bitch and flipped her off. She stated LVN B flipped her off back, Resident #1 tried to hit LVN B, and another aide got in between them. CNA E stated she had moved back so she did not see everything. She stated the cops calmed Resident #1 down. Then CNA D stepped in between them. CNA E stated she heard LVN B say, I can do that too and flipped off Resident #1. LVN B told Resident #1 to go to her room. CNA E stated she should have reported, but there was a lot going on and a lot of people involved so she thought they would report because she felt they had a better account of the situation. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675128	A. Building B. Wing	06/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Midwestern Healthcare Center	601 Midwestern Pkwy Wichita Falls, TX 76302

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	In an interview on 6/4/25 at 4:15pm with the DON and the ADM when shown the body cam footage, the ADM stated it was abuse and feels staff thought LVN A reported and that was why they didn't report. The DON stated it was abuse and she feels all staff felt the others would report. The DON stated she did get a report from LVN A, but it was only what she saw and not all of what happened or what LVN B did. In an interview on 6/5/25 at 12:12pm with Resident #11, he stated he had not seen any staff be rude or rough to any resident. Resident #11 stated Resident #1 was very upset. Staff calmed her down. Resident #11 stated he wheeled by the nurse's station, and Resident #1 was cursing and upset. Police were there and they took her back to her room and she calmed down. Resident #11 stated he didn't see the nurse flip her off. Resident #11 stated he had never seen staff do or say anything like that. He stated he had no concerns about his care at the facility. In an interview on 6/5/25 at 12:22pm with Resident #12, he shook his head no when asked if he had ever seen staff be rude or rough with a resident. Resident #12 shook his yes when asked if he remembers the incident. Resident shook his head no, when asked if he saw the nurse be rude or say mean things to the resident. Resident shook his head no, when asked if he saw the nurse flip off the resident. Shook his head yes when asked if he felt safe. Resident #12 shook his head yes when asked if he felt staff acted appropriately. Resident #12 shook his head yes when asked if he felt staff acted quickly to keep everyone safe. Shook his head no, when asked if anyone was hurt. Resident #12 shook his head yes when asked if he was removed from the incident. In an interview on 6/5/25 at 12:33pm with Resident #13, she stated she remembered the incident. Resident #13 stated that staff were trying to get something Resident #1 had taken and Resident #1 got mean. She stated Resident #1 was cursing and throwing things. Resident #13 stated she did not see the nurse say anything rude or flip off Resident #1. Resident #13 stated she felt safe, staff took care of it, and the police came. In an interview on 6/5/25 at 1:30pm with CNA F, she stated she came out of the break room to prepare to do a round and saw Resident #1 trying to get at LVN B. She stated she saw staff got in between Resident #1 and LVN B and cops calmed her down. CNA F stated then the police left, and Resident #1 started throwing things and going after LVN B again. CNA F stated she got in between them. CNA F stated the cops came back in and they stayed for a couple of hours, and they got Resident #1 to calm and then they left. CNA F stated LVN B made comments about how the police needed to take Resident #1 and she would not calm, and she would keep doing this. CNA F stated she did not see her flip off Resident #1. CNA F stated she did here LVN B tell her multiple times she needed to go to her room. CNA F stated she did not hear abuse but did feel LVN B was agitating Resident #1. Resident #1 was very disruptive and agitated and was throwing things and staff, including CNA F removed the other residents from the area the second time the police came in and we removed the residents for their safety. CNA F stated staff didn't remove the other residents the first time when Resident #1 was just saying she would hurt LVN B. CNA F stated she did hear about LVN B flipping off Resident #1 after LVN B had been fired. Record review of LVN B employee file revealed Abuse and Neglect training on 8/7/24. Record review of In-Service Training Report dated 4/3/25 revealed LVN A, LVN B, CNA C, and CNA D had been trained on abuse and neglect. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675128	A. Building B. Wing	06/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Midwestern Healthcare Center	601 Midwestern Pkwy Wichita Falls, TX 76302

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of the facility's Abuse Prohibition Policy dated 5/17/2024, revealed Each resident has the right to be free from abuse, mistreatment, neglect, corporal punishment, involuntary seclusion, and financial abuse.Verbal Abuse is defined as the use of, oral, written, or gestured language that willfully includes disparaging or derogatory terms to residents or their families, or within their hearing distance regardless of their age, ability to comprehend, or disability. Record review of Resident Rights policy dated 4/2017 revealed .Residents shall .b. be treated as individuals in a manner that supports their dignity .g. Be free from mental, emotional, and physical abuse and neglect . On 6/04/25 at 2:09pm, an Immediate Jeopardy (IJ) was identified. The ADM was notified. The ADM was provided with the IJ template, and a Plan of Removal (POR) was requested at that time. The following Plan of Removal was submitted by the facility and accepted on 06/05/25 at 4:35 pm and included: Social worker, or designee made life satisfaction rounds to residents that can be interviewed to ensure free from abuse and neglect. Staff caring for residents who are unable to be interviewed have been interviewed for any noted changes in residents' behavior. Any abuse or neglect identified will be immediately reported to the abuse coordinator and then HHSC by who ever witnessed or heard about the incident. Completed 6/5/2025.No findings of abuse reported. Administrator trained and is initiating the implementation of Neighbor rounds completing assessments on their residents for potential abuse on 6/5/2025. This will be completed daily by the leadership team during the week and Manager on Duty on weekends. Neighbor rounds are reported daily to the IDT team and will be reviewed during monthly QAPI meeting. This systemic change will ensure that all residents, whether they are able to be interviewed or not, are free from abuse. On May 18, 2025, LVN B was suspended pending the outcome of the investigation. Upon completion of the investigation, LVN B was terminated May 21,2025. On May 19, 2025, Corporate Clinical specialist in-serviced DON regarding Abuse and Neglect policies and procedures, with emphasis on definition of verbal abuse and different scenarios. Competency was verified by a quiz. DON in-serviced staff regarding Abuse and Neglect policies and procedures, with emphasis on definition of verbal abuse and scenario example discussed. Competency was verified with a quiz. Staff will not be allowed to work until they have passed the quiz. Verbal abuse quiz and in-service will be added to the new hire abuse training. Staff were trained over Approaches, Activities and Interventions in Response to Behaviors of people with Mental Health or Psychiatric Needs including how to manage different behaviors, deescalating the situation, removing aggressive resident from the area where other residents may be present or removing the other residents from the area of situation, and to immediately report incident to facility Abuse Coordinator. Completed 6/5/2025. Peer interviews over knowledge of facility's Abuse and Neglect Policy and Procedures, will be conducted weekly, with no less than 10 staff members, by Social Worker, and/or designee for 8 weeks. Following 8 weeks follow up, monthly Peer Interviews will be conducted by Social Worker and/or designee. The abuse coordinator, or designee, shall be responsible for monitoring this corrective action. Any negative findings will be reported to the facility's QA committee for review and corrective action. Completed 6/5/25. Monitoring of the Plan of Removal from 6/05/25 - 6/06/25 included 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
	675128	A. Building B. Wing	06/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Midwestern Healthcare Center	601 Midwestern Pkwy Wichita Falls, TX 76302

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of Inservice dated 6/5/25 with leadership team of 12 staff for neighbor rounds revealed staff are to assess residents for changes in behavior/mood; auditing/asking staff about any signs of abuse and whether sexual, physical, or verbal abuse. In an interview on 6/5/25 at 5:56pm with the ADON, she stated the SW interviewed her on abuse and what she should do to check her knowledge. The ADON stated she had been trained on neighbor rounds. She stated staff will be dividing certain hallways, certain rooms, and do morning rounds. The ADON stated staff would talk to those residents and assess for any issue. She stated staff would see if they had any issues or concerns, and address the concerns, and bring to the morning IDT meetings. The ADON stated staff also did a drill on how to clear the room of other residents, keep everyone safe, and how to approach and deescalate a resident that is aggressive or displaying behaviors. The ADON stated the facility Inserviced all staff on abuse & neglect, reiterated differences and examples of each, and who to report to and when. The ADON stated the DON was going to randomly audit staff on their training. In an interview on 6/5/25 at 6:15pm with SW, she stated she had completed resident and staff interviews regarding abuse and specifically verbal abuse and staff interviews going forward and upping the neighbor rounds program. SW stated she was to round on the second half of A hall every morning and check with residents to see how things are going. She stated she was to see if residents are well and check environmentally and if they have concerns write grievances for that, The SW stated staff are to build rapport to find the abuse if it was happening. The SW stated she had completed life satisfaction rounds and found no concerns of abuse. In an interview on 6/6/25 at 10:35 am with the Administrator and the DON, the ADM stated this day was the first day for Neighbor rounds. The ADM stated staff are assigned rooms and report on the rooms daily (no one has more than 6 rooms each), utilizing a check list. The ADM provided the checklist to the investigator. The DON stated this day was the first day. It went well, and no issues of abuse or neglect was identified. The ADM stated the rounds sheets are reviewed in the morning round each morning daily. The ADM stated on the weekend, the Manager on Duty completes the review of the sheets and reports to the Administrator directly if there is a concern. In an observation on 6/6/25 at 10:35am observed the checklist with staff to use for Neighbor rounds. Record review of Neighbor round observations for 6/6/25 at 10:54 am. All rooms and residents were observed in facility. No concerns regarding abuse and neglect identified. In an interview on 6/6/25 at 11:03 am with Resident # 15, she stated this morning a staff told her she was her neighbor and would be checking on her every day. Resident #15 stated she feels safe and had no concerns with care. In an interview on 6/6/25 at 11:08 am with Resident #16, she stated staff told her this morning that she was her neighbor and would be checking on her every day. Resident #16 stated she feels safe and had no concerns with care. In an interview on 6/6/25 at 11:09 am with Resident #17, she stated a staff told her this morning that she was her neighbor and would be checking on her every day. Resident #17 stated she feels safe a[TRUNCATED]

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675128	A. Building B. Wing	06/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Midwestern Healthcare Center	601 Midwestern Pkwy Wichita Falls, TX 76302

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to implement written policies and procedures that prohibit and prevent abuse, for 1 (Resident #1) of 16 residents reviewed. As a result of the failure to implement the facility policy, the resident was not free from abuse, staff did not report the abuse, residents were not protected from further abuse, and the facility administration was unaware of the verbal abuse and police intervention on 05/04/2025 between LVN B and Resident #1 until surveyor intervention on 05/18/2025 This failure resulted in the identification of Immediate Jeopardy (IJ) on 6/04/25 at 2:09 pm. While the immediacy was removed on 6/06/25 at 1:02 pm, the facility remained out of compliance at scope of pattern and severity no actual harm due to the facility's need to monitor the implementation of the plan of removal. This failure could place the residents at risk of not being free of abuse. Findings included: Record review of the facility's Abuse Prohibition Policy dated 5/17/2024, revealed Each resident has the right to be free from abuse, mistreatment, neglect, corporal punishment, involuntary seclusion, and financial abuse.Verbal Abuse is defined as the use of, oral, written, or gestured language that willfully includes disparaging or derogatory terms to residents or their families, or within their hearing distance regardless of their age, ability to comprehend, or disability. Record review of Resident #1's electronic health record revealed a [AGE] year-old female, admission date 4/30/25. Her diagnoses included: Autistic Disorder (neurodevelopmental disorder with difficulties in social interaction and social communication), Fetal Alcohol Syndrome (life-long physical, cognitive, and behavioral issues), long-term drug therapy, epilepsy (seizure disorder), tachycardia (rapid heart rate). Resident discharged from the facility on 05/05/2025. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675128	A. Building B. Wing	06/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Midwestern Healthcare Center	601 Midwestern Pkwy Wichita Falls, TX 76302

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of police report dated 5/4/25 at 6:59pm revealed When [Police officer] arrived, [Police officer] made contact with the reporting party, [LVN A], she stated they received a new patient [Resident #1] approximately 2 days ago. [LVN A] stated [Resident #1] was a psych patient who had been having a hard time adjusting to the facility. [LVN A] requested that [Police officer] speak with [Resident #1] to see if she met criteria to be assessed by [LIDDA] for a psych evaluation. [Police officer] made contact with [Resident #1] at the nurse's station, [Resident #1] was very upset at the time and was refusing to speak with [Police officer]. While [Police officer] was speaking to [Resident #1] in an attempt to build a rapport [LVN B] began walking towards the nurse's station. When [LVN B] approached the area, she began making statements like, Y'all need to take her ass somewhere. and Her [family member] needs to come get her! [LVN B] was very agitated and extremely rude. [Police officer] began asking [LVN B] for more background information on [Resident #1] because she did not speak to me. [LVN B] stated She is trying her crap. after she stated this [Resident #1] yelled at [LVN B] to shut up. [LVN B] stated, You don't scare me none, you might your [family member] but not me. I began explaining to [LVN B] our criteria and that I would not just be able to take her. [LVN B] began talking and said, Well then she needs to go to her room because she is one on one. [Resident #1] then yelled, I don't have to if I don't fucking want to! [LVN B] then turned to [Resident #1] pointed at her and yelled very angrily Go to your room! and then held her middle finger up towards [Resident #1]. That was when [Resident #1] stated I can punch you! and [LVN B] turned to [Resident #1] and waved her fingers as if inviting her over and stated, Come on! [Resident #1] stood aggressively and began walking towards [LVN B]. An aide and I stood between the two to keep things from escalating. [LVN B] stated She needs to go to jail mam! she then stated, Her [family member] dropped her here because she can't take care of her. another nurse stated neither of [Resident #1's] [family members] was answering the phone and [LVN B's] response was They don't want to have anything to do with her. [Resident #1] responded Shut up! and [LVN B] replied, Just telling the truth honey. This upset [Resident #1] to the point where she wanted to hurt [LVN B]. An aide and I continued following [Resident #1] and trying to keep her calm and away from [LVN B]. I was finally able to get [Resident #1] to separate and have a seat in the living area of the facility .[Police officer] contacted crisis line to see if she could be assessed by [LIDDA] .[LIDDA] came to the facility for the assessment and put in a referral to [Behavioral health hospital] and was denied due to [Resident #1's] IQ. LIDDA attempted an emergency detention order to the state hospital, and they refused the order. Officers remained until [Resident #1] was in bed and no longer a threat to the staff. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675128	A. Building B. Wing	06/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Midwestern Healthcare Center	601 Midwestern Pkwy Wichita Falls, TX 76302

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Observation of body cam footage from police officer dated 5/4/25 from 7:12pm-7:19pm revealed the Police officer entered the building of the facility and went to the nurse's station and asked for the nurse that called and was directed down the hall to LVN A at her med cart. LVN A stated Resident #1 is a psych patient and need to see about an evaluation. LVN A pointed towards the nurse's station and stated the Police Officer could ask and aide where Resident #1 is. The Police officer walked to the nurse's station and CNA E showed Police officer who Resdient #1 was. Resident #1 was sitting in chair against the wall at the nurse's station quiet and looking around shaking her left leg and 1:1 aide (CNA E) was three chairs down from resident. Three residents sitting in chairs next to resident. Police officer attempted to speak to Resident #1, and she would not speak to the police officer. Resident #1 stated shut up to someone behind the police officer not seen on camera. Police officer turned around and LVN B wheeled her cart to the nurse's station and stated to the police officer, She's trying her crap & she needs to go to jail and Resident #1 stated shut up, shut up. LVN B stated, Don't scare me none, might your [family member] but not me. The police officer attempted to explain to LVN B that she can't just take her, and Resident #1 is not speaking to her. LVN B stated, she needs to go to her room, she's 1:1 and looks towards Resident #1. Resident #1 said, I don't have to if I don't fucking want to. LVN B stated, you need to go to your room loudly towards Resident #1 (Resident #1 not in camera view). LVN B flips Resident #1 off and states, I can do it too and Resident #1 stated, I can punch you and LVN B stated, come on and waved her fingers gesturing towards her to come, you punch me you're going to jail as Resident #1 is seen getting up and walking towards LVN B. Police officer says uh-uh and CNA D puts herself between LVN B and Resident #1. LVN B no longer in camera view. Resident #1 stated I don't care and Police officer tells her to go sit down. LVN B stated, she needs to go to jail ma'am, her [family member] left her here because she can't take care of her. They don't want to have anything to do with her. Resident #1 stated shut up and appeared to be tearing up. LVN B said, just telling the truth honey. CNA D stated, let's go for a walk, want to go for a walk with me and Resident #1 states, No, I want to punch that bitch. CNA D and Police officer said no, we are not doing that, and we have to respect our elders. CNA D stated again, want to go for a walk and LVN B (no longer in camera view) stated she's not to be out of her room for one thing. Resident #1 stated, yes I can and LVN B stated, she's on 1:1. CNA D encouraged Resident #1 to practice breathing. Resident #1 looks at her watch and a sound from watch played and Police officer stated, that's you [family member] right there. Resident #1 stated, I don't care. Police officer said, you don't want to talk to your [family member]? Resident #1 pulled a pen out of her left shorts pocket and stated, I wanna stab that bitch and CNA D stated, let's go on a walk, let's remove ourselves from the situation and we don't have to be ugly let's remove and go on a walk and calm down. We don't need to do the extra stuff. Resident #1 started walking towards the entrance of the nurse's station and CNA D walked with her and LVN C is seen at a med cart on the computer. Police and CNA D walk with Resident #1. CNA D put herself in the entry and police asked if she wanted to go walk with CNA D and Resident #1 said No and police said, we are not going over there with her and touched Resident #1's arm. Resident #1 shook police officer off and said move. The police officer said, back up, you're not going over there. Resident #1 tried to walk around CNA D and CNA D said [Resident #1], I'm not letting you in there, we can go for a walk, we can remove ourselves but that is not happening and Resident #1 stopped and stood still. Someone unknown stated, she's not supposed to be out here and Resident #1 stated yes I can. CNA D stated Let's go for a walk. LVN A is heard explaining Resident #1's actions to someone. The police officer asked Resident #1 if she wants to go outside, and she said no. CNA D stated I need you to back up, you are in my bubble and Resident #1 stepped back. CNA D thanked her. Someone from the nurse's station attempted to give Resident #1 the phone and CNA D stated your [family member] wants to talk to you. Resident #1 hung up the phone. The police officer stated How can we help you if you won't talk to anybody. We are here to help you. CNA D asked Resident #1 if she wants to go get a soda and Resident #1 shook her head no. LVN A asked CNA D she hung up? and CNA D said, oh yeah she hung up the phone. Resident #1 starts walking away. End video. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675128	A. Building B. Wing	06/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Midwestern Healthcare Center	601 Midwestern Pkwy Wichita Falls, TX 76302

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	In an interview on 5/18/25 at 10:45 am with the Police Officer, she stated she went out to the facility for a call for a welfare check on Resident #1 by LVN A. Resident #1 was very upset, and the Police officer got her to calm down. The Police officer stated that LVN B told the Police Officer she needed to take her [Resident #1] ass to jail. Resident #1 was right there so she heard LVN B. LVN B stated Resident #1's [family member] needed to come get her and Resident #1 needed to be in her room on 1:1. The Police officer stated Resident #1 stated she did not have to be in her room and LVN B flipped off Resident #1 and Resident #1 flipped off LVN B and then LVN B stated that's why nobody wants you. That's why she (family member) dropped you off to Resident #1. The police officer stated that Resident #1 said she was going to hit LVN B and LVN B said, do it. The Police officer said she got in between them and there were lots of staff around and nobody removed LVN B. The Police Officer stated it was not against the law, there was no immediate threat for Resident #1, and she had another nurse, and the police de-escalate the situation, so it was not enough to take LVN B in. LVN A was the nurse that called 911 to come check on Resident #1. In an interview on 5/18/25 at 1:30pm with DON, the DON stated she had never been told about the incident with LVN B by anyone until right then. Resident #1 was trying to hurt herself while she was at the facility and was there for 5 days, and was never without staff supervision. The DON stated she was never told about LVN B acting that way and would report it now and start an investigation now. She would have reported it at the time had she been made aware. The DON stated the Administrator, at the time, was no longer there. The DON stated he was the abuse coordinator and DON was the backup abuse coordinator at that time. In an interview on 5/18/25 at 5:50pm with LVN A, she stated she spoke with the police and witnessed Resident #1 trying to get at LVN B, but she did not know what initiated it. LVN A stated the aides prevented Resident #1 from getting LVN B so Resident #1 started throwing things down the hall. LVN A stated Resident #1 did calm down, went back to her room with her 1:1 staff, and went to sleep. LVN A stated she called Guardian A, and she was out of town, so LVN A tried to call Guardian B and he did not answer, so she called 911. LVN A stated she called because Resident #1 had grabbed an ink pen and started carving her arm and the police were right there. LVN A stated she told Resident #1 to stop, and she did. LVN A stated there was no injury. LVN A stated she did not see LVN B flip off Resident #1 or curse at her or tell her she was not wanted anywhere. In an interview on 5/18/25 at 6:48pm with CNA D, she stated that on 5/4/25, Resident #1 was frustrated and agitated, was trying to get out of the facility, and was on 1:1. CNA D stated the police had been called and LVN B said to Resident #1, you are here because your [family member] can't deal with you and you need to go to jail. Resident #1 said shut up, bitch and flipped off LVN B. LVN B flipped off Resident #1 and said, I can do it too. Resident #1 called LVN B a bitch and LVN B said, you need to go to jail and need to go to a mental hospital to Resident #1. CNA D stated Resident #1 said, shut up bitch, I'm gonna punch you and LVN B said, come on and punch me and I want you to punch me and CNA D stated she got up and tried to redirect Resident #1 and LVN B kept talking trash to Resident #1. CNA D stated she thought other nurses would have reported. CNA D stated she had been trained on abuse and neglect and she should have reported to the DON immediately because the DON was the Abuse coordinator and failure to report would not happen again. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675128	A. Building B. Wing	06/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Midwestern Healthcare Center	601 Midwestern Pkwy Wichita Falls, TX 76302

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	In an interview on 5/18/25 at 7:05pm with CNA C, she stated LVN B was agitating Resident #1 and told Resident #1 she needed to go to jail, and her [family member] dropped her off because nobody wanted her. CNA C stated Resident #1 got upset and said, shut up bitch and flipped off LVN B and LVN B kept going and flipped her off back. CNA C stated she could not believe this was happening right in front of the cops. CNA C stated Resident #1 went after LVN B and the aides intervened, and the cops didn't do anything. CNA C stated she thought the police would do something and take care of it. CNA C stated she came into work the next day to report it to the DON, but she was not there and then CNA C was off for a couple of days and time just went by. CNA C stated she did not report the incident because she thought others would and she should have reported it herself immediately. CNA C stated she had been trained on abuse and neglect and she should report to the DON, the abuse coordinator. CNA C stated she feels she can report to the DON and has in the past. In an interview on 5/19/25 at 12:24pm with Guardian A, she stated she did not want this writer to speak to Resident #1 as there were no current effects, but Guardian A did not want to upset Resident #1 and cause behaviors. Guardian A stated Resident #1 did tell her after discharge from the facility that a nurse flipped her off and told her they wanted her to go to jail. Resident #1 told Guardian A that the police saw the nurse do it. In an interview on 5/19/25 at 12:56pm with the ADON, she stated that all staff had been trained on abuse and neglect. The ADON stated all staff had been trained on what abuse would look like and who to report to. The ADON stated that they should report to the DON, abuse coordinator. The ADON stated she was not aware and had not heard anything about LVN B being abusive. The ADON stated what she had been told was that Resident #1 was throwing computers and laptops and swinging at nurses. The ADON stated she was told that by LVN A and LVN B. The ADON stated she spoke with the DON about it and the DON told the ADON she had went and checked on Resident #1 the next morning and she was fine and did not report anything. The ADON stated Guardian B requested Resident #1 be sent to the state hospital. The ADON stated LVN B would be terminated, and CNA C and CNA D were placed on final warning for not reporting it. In an interview on 5/19/25 at 4:54pm with LVN B, she stated Resident #1 was trying to get at patients and knocking things off the nurse's station and was psycho and 300 pounds. LVN B stated [Resident #1] was supposed to be on 1:1 in her room for suicide watch and coming to the front agitating other patients. LVN B stated, Resident #1 was [AGE] years old acting like a smart ass and would not mind staff. LVN B stated she was passing medications, parked her cart, and Resident #1 threw her the finger and LVN B did the same thing back. LVN B stated that Resident #1 needed to be in a mental institution and the facility was not appropriate, and staff were just babysitting. LVN B stated she told Resident #1 to go to her room and Resident #1 flipped her off and LVN B could not handle disrespectful children. LVN B stated she did flip off Resident #1 but did not say anything. LVN B stated it was a reaction because Resident #1 was pushing buttons. LVN B then stated she did tell the police they needed to take Resident #1 because she would not calm down. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675128	A. Building B. Wing	06/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Midwestern Healthcare Center	601 Midwestern Pkwy Wichita Falls, TX 76302

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	In a follow up interview on 5/20/25 at 12:48pm with the DON, she stated all staff had been trained on abuse and neglect a bunch of times. The DON stated she had her number posted and was the abuse coordinator. The DON stated at the time of the incident with LVN B, the abuse coordinator was the administrator, and the DON was back up abuse coordinator. The DON stated she had never heard of, and no one reported abuse from LVN B to Resident #1. The DON stated she had started 1:1 training with each staff member to prevent this in the future. The DON stated staff failed to report and she had retrained, counseled, and wrote up the staff that failed to report. The DON stated LVN B was suspended as soon as this writer informed DON about allegation, and LVN B was now terminated. LVN B worked approximately 10 shifts between 05/04/2025 and 05/18/2025. In an interview on 6/3/25 at 3:35pm with LVN C, she stated she was on another hall, and walked up to the nurse's station. LVN C stated she saw Resident #1 yelling at LVN B and LVN B was yelling back at her. LVN C stated she was attending to the other residents and LVN B was talking to Resident #1 about how she hated taking care of residents like her and stuff like that, something to that affect. LVN C stated LVN B did say Resident #1 needed to go to jail. LVN B said Resident #1's [family member] dropped her at the facility because she couldn't handle her. LVN C stated she did not see LVN B flip off Resident #1. LVN C stated, it was verbal abuse. LVN C stated she was going to report to the DON, but LVN A, the night nurse, was on the phone with her at that time, right after the incident, and she said, yes I'm talking to her right now. So, LVN C stated she didn't and thought LVN A reported it. LVN C stated LVN A said she was on the phone with the DON after the incident, but she did not know what she reported. LVN C stated she was covering the shift and was late to her shift because she got called in and never worked the night shift before. LVN C stated she said to LVN A, you got this, you are reporting it and LVN A said yes, she was talking to the DON right then. LVN C stated she went back to passing meds. In a follow up interview on 6/3/25 at 4:11pm with the DON, she stated LVN A did call her that night at 7:24pm and said Resident #1 was having behaviors, throwing things at the nurse's station, and grabbing pens and the cops were there. The DON advised LVN A to call the [family member] because the cops would not take Resident #1 but maybe they would calm her. The DON said LVN A never told her about LVN B, and LVN B was never even mentioned, and she wasn't even the patients nurse, so the DON did not think to ask anything about that. The DON stated she went to see Resident #1 the next morning and checked on her first thing that morning and Resident #1 never told the DON that happened either. In an interview on 6/4/25 at 8:40am with CNA E, she stated she was Resident #1's 1:1 on the evening of the incident and it was her first time working with Resident #1. Resident #1 was throwing everything, books, and pens off the nurse's station. Resident #1 would be yelling, and she called CNA E a bitch for following her and she said she didn't need a 1:1. CNA E stated other residents did see, maybe 2 or 3 residents at the nurse's station. They were staring at Resident #1, and one lady said we (staff) needed to call the cops. CNA E stated she did not see Resident #1 try to hurt herself. CNA E stated Resident #1 went outside because she did not want to be there at the facility. CNA E stated there were CNAs, residents, and nurses around during the incident. CNA E stated Resident #1 was calling LVN B a bitch and flipped her off. She stated LVN B flipped her off back, Resident #1 tried to hit LVN B, and another aide got in between them. CNA E stated she had moved back so she did not see everything. She stated the cops calmed Resident #1 down. Then CNA D stepped in between them. CNA E stated she heard LVN B say, I can do that too and flipped off Resident #1. LVN B told Resident #1 to go to her room. CNA E stated she should have reported, but there was a lot going on and a lot of people involved so she thought they would report because she felt they had a better account of the situation. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675128	A. Building B. Wing	06/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Midwestern Healthcare Center	601 Midwestern Pkwy Wichita Falls, TX 76302

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	In an interview on 6/4/25 at 4:15pm with the DON and the ADM when shown the body cam footage, the ADM stated it was abuse and feels staff thought LVN A reported and that was why they didn't report. The DON stated it was abuse and she feels all staff felt the others would report. The DON stated she did get a report from LVN A, but it was only what she saw and not all of what happened or what LVN B did. In an interview on 6/5/25 at 12:12pm with Resident #11, he stated he had not seen any staff be rude or rough to any resident. Resident #11 stated Resident #1 was very upset. Staff calmed her down. Resident #11 stated he wheeled by the nurse's station, and Resident #1 was cursing and upset. Police were there and they took her back to her room and she calmed down. Resident #11 stated he didn't see the nurse flip her off. Resident #11 stated he had never seen staff do or say anything like that. He stated he had no concerns about his care at the facility. In an interview on 6/5/25 at 12:22pm with Resident #12, he shook his head no when asked if he had ever seen staff be rude or rough with a resident. Resident #12 shook his yes when asked if he remembers the incident. Resident shook his head no, when asked if he saw the nurse be rude or say mean things to the resident. Resident shook his head no, when asked if he saw the nurse flip off the resident. Shook his head yes when asked if he felt safe. Resident #12 shook his head yes when asked if he felt staff acted appropriately. Resident #12 shook his head yes when asked if he felt staff acted quickly to keep everyone safe. Shook his head no, when asked if anyone was hurt. Resident #12 shook his head yes when asked if he was removed from the incident. In an interview on 6/5/25 at 12:33pm with Resident #13, she stated she remembered the incident. Resident #13 stated that staff were trying to get something Resident #1 had taken and Resident #1 got mean. She stated Resident #1 was cursing and throwing things. Resident #13 stated she did not see the nurse say anything rude or flip off Resident #1. Resident #13 stated she felt safe, staff took care of it, and the police came. In an interview on 6/5/25 at 1:30pm with CNA F, she stated she came out of the break room to prepare to do a round and saw Resident #1 trying to get at LVN B. She stated she saw staff got in between Resident #1 and LVN B and cops calmed her down. CNA F stated then the police left, and Resident #1 started throwing things and going after LVN B again. CNA F stated she got in between them. CNA F stated the cops came back in and they stayed for a couple of hours, and they got Resident #1 to calm and then they left. CNA F stated LVN B made comments about how the police needed to take Resident #1 and she would not calm, and she would keep doing this. CNA F stated she did not see her flip off Resident #1. CNA F stated she did here LVN B tell her multiple times she needed to go to her room. CNA F stated she did not hear abuse but did feel LVN B was agitating Resident #1. Resident #1 was very disruptive and agitated and was throwing things and staff, including CNA F removed the other residents from the area the second time the police came in and we removed the residents for their safety. CNA F stated staff didn't remove the other residents the first time when Resident #1 was just saying she would hurt LVN B. CNA F stated she did hear about LVN B flipping off Resident #1 after LVN B had been fired. Record review of LVN B employee file revealed Abuse and Neglect training on 8/7/24. Record review of In-Service Training Report dated 4/3/25 revealed LVN A, LVN B, CNA C, and CNA D had been trained on abuse and neglect. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675128	A. Building B. Wing	06/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Midwestern Healthcare Center	601 Midwestern Pkwy Wichita Falls, TX 76302

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of Resident Rights policy dated 4/2017 revealed .Residents shall .b. be treated as individuals in a manner that supports their dignity .g. Be free from mental, emotional, and physical abuse and neglect . On 6/04/25 at 2:09pm, an Immediate Jeopardy (IJ) was identified. The ADM was notified. The ADM was provided with the IJ template, and a Plan of Removal (POR) was requested at that time. The following Plan of Removal was submitted by the facility and accepted on 06/05/25 at 4:35 pm and included: Social worker, or designee made life satisfaction rounds to residents that can be interviewed to ensure free from abuse and neglect. Staff caring for residents who are unable to be interviewed have been interviewed for any noted changes in residents' behavior. Any abuse or neglect identified will be immediately reported to the abuse coordinator and then HHSC by who ever witnessed or heard about the incident. Completed 6/5/2025.No findings of abuse reported. Administrator trained and is initiating the implementation of Neighbor rounds completing assessments on their residents for potential abuse on 6/5/2025. This will be completed daily by the leadership team during the week and Manager on Duty on weekends. Neighbor rounds are reported daily to the IDT team and will be reviewed during monthly QAPI meeting. This systemic change will ensure that all residents, whether they are able to be interviewed or not, are free from abuse. On May 18, 2025, LVN B was suspended pending the outcome of the investigation. Upon completion of the investigation, LVN B was terminated May 21,2025. On May 19, 2025, Corporate Clinical specialist in-serviced DON regarding Abuse and Neglect policies and procedures, with emphasis on definition of verbal abuse and different scenarios. Competency was verified by a quiz. DON in-serviced staff regarding Abuse and Neglect policies and procedures, with emphasis on definition of verbal abuse and scenario example discussed. Competency was verified with a quiz. Staff will not be allowed to work until they have passed the quiz. Verbal abuse quiz and in-service will be added to the new hire abuse training. Staff were trained over Approaches, Activities and Interventions in Response to Behaviors of people with Mental Health or Psychiatric Needs including how to manage different behaviors, deescalating the situation, removing aggressive resident from the area where other residents may be present or removing the other residents from the area of situation, and to immediately report incident to facility Abuse Coordinator. Completed 6/5/2025. Peer interviews over knowledge of facility's Abuse and Neglect Policy and Procedures, will be conducted weekly, with no less than 10 staff members, by Social Worker, and/or designee for 8 weeks. Following 8 weeks follow up, monthly Peer Interviews will be conducted by Social Worker and/or designee. The abuse coordinator, or designee, shall be responsible for monitoring this corrective action. Any negative findings will be reported to the facility's QA committee for review and corrective action. Completed 6/5/25. Monitoring of the Plan of Removal from 6/05/25 - 6/06/25 included the following: Record review of Inservice dated 6/5/25 with leadership team of 12 staff for neighbor rounds revealed staff are to assess residents for changes in behavior/mood; auditing/asking staff about any signs of abuse and whether sexual, physical, or verbal abuse. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675128	A. Building B. Wing	06/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Midwestern Healthcare Center	601 Midwestern Pkwy Wichita Falls, TX 76302

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	In an interview on 6/5/25 at 5:56pm with the ADON, she stated the SW interviewed her on abuse and what she should do to check her knowledge. The ADON stated she had been trained on neighbor rounds. She stated staff will be dividing certain hallways, certain rooms, and do morning rounds. The ADON stated staff would talk to those residents and assess for any issue. She stated staff would see if they had any issues or concerns, and address the concerns, and bring to the morning IDT meetings. The ADON stated staff also did a drill on how to clear the room of other residents, keep everyone safe, and how to approach and deescalate a resident that is aggressive or displaying behaviors. The ADON stated the facility Inserviced all staff on abuse & neglect, reiterated differences and examples of each, and who to report to and when. The ADON stated the DON was going to randomly audit staff on their training. In an interview on 6/5/25 at 6:15pm with SW, she stated she had completed resident and staff interviews regarding abuse and specifically verbal abuse and staff interviews going forward and upping the neighbor rounds program. SW stated she was to round on the second half of A hall every morning and check with residents to see how things are going. She stated she was to see if residents are well and check environmentally and if they have concerns write grievances for that, The SW stated staff are to build rapport to find the abuse if it was happening. The SW stated she had completed life satisfaction rounds and found no concerns of abuse. In an interview on 6/6/25 at 10:35 am with the Administrator and the DON, the ADM stated this day was the first day for Neighbor rounds. The ADM stated staff are assigned rooms and report on the rooms daily (no one has more than 6 rooms each), utilizing a check list. The ADM provided the checklist to the investigator. The DON stated this day was the first day. It went well, and no issues of abuse or neglect was identified. The ADM stated the rounds sheets are reviewed in the morning round each morning daily. The ADM stated on the weekend, the Manager on Duty completes the review of the sheets and reports to the Administrator directly if there is a concern. In an observation on 6/6/25 at 10:35am observed the checklist with staff to use for Neighbor rounds. Record review of Neighbor round observations for 6/6/25 at 10:54 am. All rooms and residents were observed in facility. No concerns regarding abuse and neglect identified. In an interview on 6/6/25 at 11:03 am with Resident # 15, she stated this morning a staff told her she was her neighbor and would be checking on her every day. Resident #15 stated she feels safe and had no concerns with care. In an interview on 6/6/25 at 11:08 am with Resident #16, she stated staff told her this morning that she was her neighbor and would be checking on her every day. Resident #16 stated she feels safe[TRUNCATED]

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675128	A. Building B. Wing	06/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Midwestern Healthcare Center	601 Midwestern Pkwy Wichita Falls, TX 76302

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 - Immediate jeopardy to resident health or safety Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to report all allegations of abuse, neglect exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures for 1 (Resident #1) of 16 residents reviewed. CNA B, CNA C, CNA E, and CNA D failed to report verbal abuse of Resident #1 to the administrator or the DON. There was police intervention between the staff and resident. As a result of not reporting, the administrative staff were not aware until surveyor intervention. Include the incident happened on 5/4/25 and administration were not aware of the verbal abuse until 5/18/25. This failure resulted in the identification of Immediate Jeopardy (IJ) on 6/04/25 at 2:09 pm. While the immediacy was removed on 6/06/25 at 1:02 pm, the facility remained out of compliance at scope of pattern and severity no actual harm due to the facility's need to monitor the implementation of the plan of removal. This failure could put the residents at risk of compromised protection and oversight, and mental anguish. Findings included: Record review of Resident #1's electronic health record revealed a [AGE] year-old female, admission date 4/30/25. Her diagnoses included: Autistic Disorder (neurodevelopmental disorder with difficulties in social interaction and social communication), Fetal Alcohol Syndrome (life-long physical, cognitive, and behavioral issues), long-term drug therapy, epilepsy (seizure disorder), tachycardia (rapid heart rate). Resident was discharged [DATE]. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675128	A. Building B. Wing	06/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Midwestern Healthcare Center	601 Midwestern Pkwy Wichita Falls, TX 76302

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 - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of police report dated 5/4/25 at 6:59pm revealed When [Police officer] arrived, [Police officer] made contact with the reporting party, [LVN A], she stated they received a new patient [Resident #1] approximately 2 days ago. [LVN A] stated [Resident #1] was a psych patient who had been having a hard time adjusting to the facility. [LVN A] requested that [Police officer] speak with [Resident #1] to see if she met criteria to be assessed by [LIDDA] for a psych evaluation. [Police officer] made contact with [Resident #1] at the nurse's station, [Resident #1] was very upset at the time and was refusing to speak with [Police officer]. While [Police officer] was speaking to [Resident #1] in an attempt to build a rapport [LVN B] began walking towards the nurse's station. When [LVN B] approached the area, she began making statements like, Y'all need to take her ass somewhere. and Her [family member] needs to come get her! [LVN B] was very agitated and extremely rude. [Police officer] began asking [LVN B] for more background information on [Resident #1] because she did not speak to me. [LVN B] stated She is trying her crap. after she stated this [Resident #1] yelled at [LVN B] to shut up. [LVN B] stated, You don't scare me none, you might your [family member] but not me. I began explaining to [LVN B] our criteria and that I would not just be able to take her. [LVN B] began talking and said, Well then she needs to go to her room because she is one on one. [Resident #1] then yelled, I don't have to if I don't fucking want to! [LVN B] then turned to [Resident #1] pointed at her and yelled very angrily Go to your room! and then held her middle finger up towards [Resident #1]. That was when [Resident #1] stated I can punch you! and [LVN B] turned to [Resident #1] and waved her fingers as if inviting her over and stated, Come on! [Resident #1] stood aggressively and began walking towards [LVN B]. An aide and I stood between the two to keep things from escalating. [LVN B] stated She needs to go to jail mam! she then stated, Her [family member] dropped her here because she can't take care of her. another nurse stated neither of [Resident #1's] [family members] was answering the phone and [LVN B's] response was They don't want to have anything to do with her. [Resident #1] responded Shut up! and [LVN B] replied, Just telling the truth honey. This upset [Resident #1] to the point where she wanted to hurt [LVN B]. An aide and I continued following [Resident #1] and trying to keep her calm and away from [LVN B]. I was finally able to get [Resident #1] to separate and have a seat in the living area of the facility .[Police officer] contacted crisis line to see if she could be assessed by [LIDDA] .[LIDDA] came to the facility for the assessment and put in a referral to [Behavioral health hospital] and was denied due to [Resident #1's] IQ. LIDDA attempted an emergency detention order to the state hospital, and they refused the order. Officers remained until [Resident #1] was in bed and no longer a threat to the staff. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675128	A. Building B. Wing	06/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Midwestern Healthcare Center	601 Midwestern Pkwy Wichita Falls, TX 76302

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 - Immediate jeopardy to resident health or safety Residents Affected - Some	Observation of body cam footage from police officer dated 5/4/25 from 7:12pm-7:19pm revealed the Police officer entered the building of the facility and went to the nurse's station and asked for the nurse that called and was directed down the hall to LVN A at her med cart. LVN A stated Resident #1 is a psych patient and need to see about an evaluation. LVN A pointed towards the nurse's station and stated the Police Officer could ask and aide where Resident #1 is. The Police officer walked to the nurse's station and CNA E showed Police officer who Resdient #1 was. Resident #1 was sitting in chair against the wall at the nurse's station quiet and looking around shaking her left leg and 1:1 aide (CNA E) was three chairs down from resident. Three residents sitting in chairs next to resident. Police officer attempted to speak to Resident #1, and she would not speak to the police officer. Resident #1 stated shut up to someone behind the police officer not seen on camera. Police officer turned around and LVN B wheeled her cart to the nurse's station and stated to the police officer, She's trying her crap & she needs to go to jail and Resident #1 stated shut up, shut up. LVN B stated, Don't scare me none, might your [family member] but not me. The police officer attempted to explain to LVN B that she can't just take her, and Resident #1 is not speaking to her. LVN B stated, she needs to go to her room, she's 1:1 and looks towards Resident #1. Resident #1 said, I don't have to if I don't fucking want to. LVN B stated, you need to go to your room loudly towards Resident #1 (Resident #1 not in camera view). LVN B flips Resident #1 off and states, I can do it too and Resident #1 stated, I can punch you and LVN B stated, come on and waved her fingers gesturing towards her to come, you punch me you're going to jail as Resident #1 is seen getting up and walking towards LVN B. Police officer says uh-uh and CNA D puts herself between LVN B and Resident #1. LVN B no longer in camera view. Resident #1 stated I don't care and Police officer tells her to go sit down. LVN B stated, she needs to go to jail ma'am, her [family member] left her here because she can't take care of her. They don't want to have anything to do with her. Resident #1 stated shut up and appeared to be tearing up. LVN B said, just telling the truth honey. CNA D stated, let's go for a walk, want to go for a walk with me and Resident #1 states, No, I want to punch that bitch. CNA D and Police officer said no, we are not doing that, and we have to respect our elders. CNA D stated again, want to go for a walk and LVN B (no longer in camera view) stated she's not to be out of her room for one thing. Resident #1 stated, yes I can and LVN B stated, she's on 1:1. CNA D encouraged Resident #1 to practice breathing. Resident #1 looks at her watch and a sound from watch played and Police officer stated, that's you [family member] right there. Resident #1 stated, I don't care. Police officer said, you don't want to talk to your [family member]? Resident #1 pulled a pen out of her left shorts pocket and stated, I wanna stab that bitch and CNA D stated, let's go on a walk, let's remove ourselves from the situation and we don't have to be ugly let's remove and go on a walk and calm down. We don't need to do the extra stuff. Resident #1 started walking towards the entrance of the nurse's station and CNA D walked with her and LVN C is seen at a med cart on the computer. Police and CNA D walk with Resident #1. CNA D put herself in the entry and police asked if she wanted to go walk with CNA D and Resident #1 said No and police said, we are not going over there with her and touched Resident #1's arm. Resident #1 shook police officer off and said move. The police officer said, back up, you're not going over there. Resident #1 tried to walk around CNA D and CNA D said [Resident #1], I'm not letting you in there, we can go for a walk, we can remove ourselves but that is not happening and Resident #1 stopped and stood still. Someone unknown stated, she's not supposed to be out here and Resident #1 stated yes I can. CNA D stated Let's go for a walk. LVN A is heard explaining Resident #1's actions to someone. The police officer asked Resident #1 if she wants to go outside, and she said no. CNA D stated I need you to back up, you are in my bubble and Resident #1 stepped back. CNA D thanked her. Someone from the nurse's station attempted to give Resident #1 the phone and CNA D stated your [family member] wants to talk to you. Resident #1 hung up the phone. The police officer stated How can we help you if you won't talk to anybody. We are here to help you. CNA D asked Resident #1 if she wants to go get a soda and Resident #1 shook her head no. LVN A asked CNA D she hung up? and CNA D said, oh yeah she hung up the phone. Resident #1 starts walking away. End video. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675128	A. Building B. Wing	06/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Midwestern Healthcare Center	601 Midwestern Pkwy Wichita Falls, TX 76302

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 - Immediate jeopardy to resident health or safety Residents Affected - Some	In an interview on 5/18/25 at 10:45 am with Police Officer, she stated she went out to the facility for a call for a well-fare check on Resident #1. Resident #1 was very upset, and the Police officer got her to calm down. Police officer stated that LVN B told the Police Officer she needed to take her [Resident #1] ass to jail. Resident #1 was right there so she heard LVN B. LVN B stated Resident #1's [family member] needed to come get her and Resident #1 needed to be in her room on 1:1. The Police officer stated Resident #1 stated she did not have to be in her room and LVN B flipped off Resident #1 and Resident #1 flipped off LVN B and then LVN B stated that's why nobody wants you. That's why she [[family member]] dropped you off to Resident #1. The police officer stated that Resident #1 said she was going to hit LVN B and LVN B said, do it. Police officer said she got in between them and there were lots of staff around and nobody removed LVN B. The Police Officer stated it was not against the law and there was no immediate threat for Resident #1, and she had another nurse, and the police de-escalated the situation, so it was not enough to take LVN B in. LVN A was the nurse that called 911 to check on Resident #1. In an interview on 5/18/25 at 1:30pm with DON, The DON stated she had never been told about the incident with LVN B by anyone until right now. Resident #1 was trying to hurt herself while she was here and was here for 5 days and was never without staff supervision. DON stated she was never told about LVN B acting that way and would report it now and start an investigation now. DON stated she would have reported it had she been made aware. DON stated the previous administrator was no longer at the facility and the new administrator starts tomorrow. In an interview on 5/18/25 at 4:20pm with CNA A, she stated she had been trained on abuse and neglect and she would report it to her abuse coordinator which is the administrator or DON. CNA A stated the facility has had some administrator changes so the current abuse coordinator is the DON. In an interview on 5/18/25 at 6:35pm with CNA B, she stated she did not see the abuse to Resident #1, but she was told about it by other aides. CNA B stated she had been trained on abuse and neglect and she would contact her abuse coordinator. CNA B stated she did not report the allegation from the other aides because she thought they would. In an interview on 5/18/25 at 6:48pm with CNA D, she stated that on 5/4/25, Resident #1 was frustrated and agitated and was trying to get out of the facility and was on 1:1. CNA D stated the police had been called and LVN B said to Resident #1, you are here because your mother can't deal with you and you need to go to jail. Resident #1 said shut up, bitch and flipped off LVN B. LVN B flipped off Resident #1 and said, I can do it too. Resident #1 called LVN B a bitch and LVN B said, you need to go to jail and need to go to a mental hospital to Resident #1. CNA D stated Resident #1 said, shut up bitch, I'm gonna punch you and LVN B said, come on and punch me and I want you to punch me and CNA D stated she got up and tried to redirect Resident #1 and LVN B kept talking trash to Resdient #1. CNA D stated she failed and should have reported LVN B to the DON. CNA D stated she thought other nurses would have reported. CNA D stated she had been trained on abuse and neglect and she should have reported to DON because DON is Abuse coordinator and failure to report would not happen again. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675128	A. Building B. Wing	06/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Midwestern Healthcare Center	601 Midwestern Pkwy Wichita Falls, TX 76302

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 - Immediate jeopardy to resident health or safety Residents Affected - Some	In an interview on 5/18/25 at 7:05pm with CNA C, she stated LVN B was agitating Resident #1 and told Resident #1 she needed to go to jail, and her [family member] dropped her off because nobody wanted her. CNA C stated Resident #1 got upset and said, shut up bitch and flipped off LVN B and LVN B kept going and flipped her off back. CNA C stated she could not believe this was happening right in front of the cops. CNA C stated Resident #1 went after LVN B and facility staff intervened and the cops didn't do anything. CNA C stated she thought the police would do something and take care of it. CNA C stated she came into work the next day to report it to the DON, but DON was not there and then CNA C was off for a couple of days and time just went by. CNA C stated she did not report the incident because she thought others would and she should have reported it herself. CNA C stated she has been trained on abuse and neglect and she should report to the DON, the abuse coordinator. CNA C stated she feels she can report to the DON and has in the past. In an observation on 5/19/25 at 9:44am, sign on the wall in the lobby revealed Abuse Coordinator as DON and her contact phone number. In an interview on 5/19/25 at 4:54pm with LVN B, she stated Resident #1 was trying to get at patients and knocking things off the nurse's station and was psycho and 300 pounds. LVN B stated [Resident #1] was supposed to be on 1:1 in her room for suicide watch and coming to the front agitating other patients. LVN B stated, Resident #1 was [AGE] years old acting like a smart ass and would not mind staff. LVN B stated she was passing medications, parked her cart, and Resident #1 threw her the finger and LVN B did the same thing back. LVN B stated that Resident #1 needed to be in a mental institution and the facility was not appropriate, and staff were just babysitting. LVN B stated she told Resident #1 to go to her room and Resident #1 flipped her off and LVN B could not handle disrespectful children. LVN B stated she did flip off Resident #1 but did not say anything. LVN B stated it was a reaction because Resident #1 was pushing buttons. LVN B then stated she did tell the police they needed to take Resident #1 because she would not calm down. In an interview on 6/4/25 at 8:40am with CNA E, she stated she was Resident #1's 1:1 on the evening of the incident and it was her first time working with Resident #1. Resident #1 was throwing everything, books, and pens off the nurse's station. Resident #1 would be yelling, and she called CNA E a bitch for following her and she said she didn't need a 1:1. CNA E stated other residents did see, maybe 2 or 3 residents at the nurse's station. They were staring at Resident #1, and one lady said we needed to call the cops. CNA E stated she did not see Resident #1 try to hurt herself. CNA E stated Resident #1 went outside because she did not want to be there. CNA E stated there were CNA's, residents, and nurses around during the incident. CNA E stated Resident #1 was calling LVN B a bitch and flipped her off and LVN B flipped her off back and Resident #1 tried to hit LVN B, and another aide got in between them. CNA E stated she had moved back so she did not see everything. The cops calmed Resident #1 down. Then CNA D stepped in between them. CNA E stated she heard LVN B say, I can do that too and flipped off Resident #1. LVN B told Resident #1 to go to her room. CNA E stated she had been trained on abuse and neglect and should report to ADM Immediately. CNA E stated she should have reported but there was a lot going on and a lot of people involved so she thought they would report because she felt they had a better account of the situation. In an interview on 5/19/25 at 12:56pm with ADON, she stated that all staff have been trained on abuse and neglect. ADON stated all staff have been trained on what abuse would look like and who to report to. ADON stated that they report to the DON, abuse coordinator. ADON stated she was not aware and had not heard anything about LVN B being abusive. ADON stated LVN B should be terminated for abuse, and CNA C and CNA D were placed on final warning for not reporting it. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675128	A. Building B. Wing	06/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Midwestern Healthcare Center	601 Midwestern Pkwy Wichita Falls, TX 76302

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 - Immediate jeopardy to resident health or safety Residents Affected - Some	In a follow up interview on 5/20/25 at 12:48pm with DON, she stated all staff had been trained on abuse and neglect a bunch of times. DON stated she had her number posted and was the abuse coordinator. DON stated at the time of the incident with LVN B, the abuse coordinator was administrator and DON was back up abuse coordinator. DON stated she had never heard of, and no one reported abuse form LVN B to Resdient #1. DON stated she had started 1:1 training with each staff member to prevent this in the future. DON stated staff failed to report and she had retrained, counseled, and wrote up the staff that failed to report. LVN B worked approximately 10 shifts between 05/04/2025 and 05/18/2025. Record review of In-Service Training Report dated 4/3/25 revealed CNA C, and CNA D had been trained on abuse and neglect. Record review of Abuse Prohibition Policy dated 5/17/2024 revealed, .Identification: 1. Any allegation of abuse/neglect, made by residents/staff/visitors shall be reported to the Abuse Coordinator and investigated immediately .Reporting/Response: 1. Any employee who becomes aware of an allegation of abuse, neglect, or misappropriation of resident property, shall report the incident to the Abuse Coordinator immediately. Failure to do so will result in disciplinary action, up to and including termination. On 6/04/25 at 2:09pm, an Immediate Jeopardy (IJ) was identified. The ADM was notified. The ADM was provided with the IJ template, and a Plan of Removal (POR) was requested at that time. The following Plan of Removal was submitted by the facility and accepted on 06/05/25 at 4:35 pm and included: Social worker, or designee made life satisfaction rounds to residents that can be interviewed to ensure free from abuse and neglect. Staff caring for residents who are unable to be interviewed have been interviewed for any noted changes in residents' behavior. Any abuse or neglect identified will be immediately reported to the abuse coordinator and then HHSC by who ever witnessed or heard about the incident. Completed 6/5/2025.No findings of abuse reported. Administrator trained and is initiating the implementation of Neighbor rounds completing assessments on their residents for potential abuse on 6/5/2025. This will be completed daily by the leadership team during the week and Manager on Duty on weekends. Neighbor rounds are reported daily to the IDT team and will be reviewed during monthly QAPI meeting. This systemic change will ensure that all residents, whether they are able to be interviewed or not, are free from abuse. On May 18, 2025, LVN B was suspended pending the outcome of the investigation. Upon completion of the investigation, LVN B was terminated May 21,2025. On May 19, 2025, Corporate Clinical specialist in-serviced DON regarding Abuse and Neglect policies and procedures, with emphasis on definition of verbal abuse and different scenarios. Competency was verified by a quiz. DON in-serviced staff regarding Abuse and Neglect policies and procedures, with emphasis on definition of verbal abuse and scenario example discussed. Competency was verified with a quiz. Staff will not be allowed to work until they have passed the quiz. Verbal abuse quiz and in-service will be added to the new hire abuse training. Staff were trained over Approaches, Activities and Interventions in Response to Behaviors of people with Mental Health or Psychiatric Needs including how to manage different behaviors, deescalating the situation, removing aggressive resident from the area where other residents may be present or removing the other residents from the area of situation, and to immediately report incident to facility Abuse Coordinator. Completed 6/5/2025. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675128	A. Building B. Wing	06/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Midwestern Healthcare Center	601 Midwestern Pkwy Wichita Falls, TX 76302

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 - Immediate jeopardy to resident health or safety Residents Affected - Some	Peer interviews over knowledge of facility's Abuse and Neglect Policy and Procedures, will be conducted weekly, with no less than 10 staff members, by Social Worker, and/or designee for 8 weeks. Following 8 weeks follow up, monthly Peer Interviews will be conducted by Social Worker and/or designee. The abuse coordinator, or designee, shall be responsible for monitoring this corrective action. Any negative findings will be reported to the facility's QA committee for review and corrective action. Completed 6/5/25. Monitoring of the Plan of Removal from 6/05/25 included the following: Record review of Inservice dated 6/5/25 with leadership team of 12 staff for neighbor rounds revealed staff are to assess residents for changes in behavior/mood; auditing/asking staff about any signs of abuse and whether sexual, physical, or verbal abuse. In an interview on 6/5/25 at 5:56pm with the ADON, she stated the SW interviewed her on abuse and what she should do to check her knowledge. The ADON stated she had been trained on neighbor rounds. She stated staff will be dividing certain hallways, certain rooms, and do morning rounds. The ADON stated staff would talk to those residents and assess for any issue. She stated staff would see if they had any issues or concerns, and address the concerns, and bring to the morning IDT meetings. The ADON stated staff also did a drill on how to clear the room of other residents, keep everyone safe, and how to approach and deescalate a resident that is aggressive or displaying behaviors. The ADON stated the facility Inserviced all staff on abuse & neglect, reiterated differences and examples of each, and who to report to and when. The ADON stated the DON was going to randomly audit staff on their training. In an interview on 6/5/25 at 6:15pm with SW, she stated she had completed resident and staff interviews regarding abuse and specifically verbal abuse and staff interviews going forward and upping the neighbor rounds program. SW stated she was to round on the second half of A hall every morning and check with residents to see how things are going. She stated she was to see if residents are well and check environmentally and if they have concerns write grievances for that, The SW stated staff are to build rapport to find the abuse if it was happening. The SW stated she had completed life satisfaction rounds and found no concerns of abuse. In an interview on 6/6/25 at 10:35 am with the Administrator and the DON, the ADM stated this day was the first day for Neighbor rounds. The ADM stated staff are assigned rooms and report on the rooms daily (no one has more than 6 rooms each), utilizing a check list. The ADM provided the checklist to the investigator. The DON stated this day was the first day. It went well, and no issues of abuse or neglect was identified. The ADM stated the rounds sheets are reviewed in the morning round each morning daily. The ADM stated on the weekend, the Manager on Duty completes the review of the sheets and reports to the Administrator directly if there is a concern. In an observation on 6/6/25 at 10:35am observed the checklist with staff to use for Neighbor rounds. Record review of Neighbor round observations for 6/6/25 at 10:54 am. All rooms and residents were observed in facility. No concerns regarding abuse and neglect identified. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675128	A. Building B. Wing	06/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Midwestern Healthcare Center	601 Midwestern Pkwy Wichita Falls, TX 76302

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 - Immediate jeopardy to resident health or safety Residents Affected - Some	In an interview on 6/6/25 at 11:03 am with Resident # 15, she stated this morning a staff told her she was her neighbor and would be checking on her every day. Resident #15 stated she feels safe and had no concerns with care. In an interview on 6/6/25 at 11:08 am with Resident #16, she stated staff told her this morning that she was her neighbor and would be checking on her every day. Resident #16 stated she feels safe and had no concerns with care. In an interview on 6/6/25 at 11:09 am with Resident #17, she stated a staff told her this morning that she was her neighbor and would be checking on her every day. Resident #17 stated she feels safe and had no concerns with care. In an interview on 6/6/25 at 11:10 am with Resident #14, she stated a staff told her this morning that she was her neighbor and would be checking on her every day. Resident #14 stated she feels safe and had no concerns with care. In an interview on 6/6/25 at 11:12 am with Resident #18, he stated a staff member met with him this morning and stated they were his Neighbor and would be meeting with him every morning to make sure he was ok. He stated he feels safe and there were no concerns with care. In an interview on 6/6/25 at 11:14 am with Resident #19, she stated a staff met with her this morning and stated they were her neighbor and would be checking on her every morning to make sure she was good. She stated she feels safe and there were no concerns with care. Record review of Life Satisfaction rounds dated 6/5/25 revealed One staff completed satisfaction rounds for hall A for 11 residents with no concerns found. Second staff completed satisfaction rounds for hall B for 14 residents with no concerns noted. C Hall staff satisfaction round for 14 residents found no concerns. D hall satisfaction rounds for 18 residents found no current concerns. F hall satisfaction rounds for 4 residents with no concerns found. NON-Verbal rounds: A hall satisfaction rounds for 3 residents with no concerns. Random B/C/E hall satisfaction round for 12 residents with no concerns noted. D hall satisfaction rounds for 6 residents with no concerns notes. Record review of Inservice dated 5/19/25 for abuse & neglect for DON. Record review of Verbal competency quiz dated 6/5/25 for 18 staff. All staff passed. Record review of Verbal competency quiz dated 5/20/25 for 19 staff. All staff passed. Record review of Verbal competency quiz dated 5/18/25-5/19/25 for 49 staff. All staff passed. In an interview on 6/5/25 at 4:41pm with LVN E, she stated she had been trained on abuse and neglect. Verbal abuse is any cuss words, gestures, or words that are meant to hurt someone. LVN E stated she was just trained on this day and about a couple of weeks ago. She stated she was quizzed and made 100%. LVN E stated she had been trained on residents with mental health and aggressive behaviors and remove the resident and the other residents in the area. LVN E stated if she was told or see or hear about any allegation of abuse, report it to the ADM immediately, no matter the time of day. The ADM & the DON went over scenarios about different types of abuse and examples. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675128	A. Building B. Wing	06/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Midwestern Healthcare Center	601 Midwestern Pkwy Wichita Falls, TX 76302

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 - Immediate jeopardy to resident health or safety Residents Affected - Some	In an interview on 6/5/25 at 5:12pm with LVN D, she stated she was trained on abuse and neglect on that day, and she stated staff did it a week and half ago, also. LVN D stated if anyone alleges abuse, she was to tell the ADM immediately and call anytime as soon as it happens. LVN D stated they trained on types of abuse like verbal abuse: yelling at them, and/or gesturing. She stated neglect is not changing residents. LVN D stated she was quizzed and passed. LVN D stated she had been trained on behavioral patients, and to use a calm voice, and remove other residents if you can't redirect them. She stated to also give them their space because too many people asking questions and getting at them can cause issue to. In an interview on 6/5/25 at 5:25pm with CNA H stated he had been trained on abuse and neglect. We did one last week and one today. CNA H stated he was trained on types of abuse. Example of abuse is derogatory marks or cursing at residents and gesturing. They quizzed CNA H and he passed. CNA H stated he had been trained on deescalating conflict and individuals with behaviors. If they are aggressive, we try to guide the individual away for the situation and try to help them and calm. But if that doesn't work, we try to remove the other residents and have staff assist me. Then if it is abuse, I report to ADM immediately. In an interview on 6/5/25 at 5:35pm with the ADM, she stated she added the verbal abuse quiz to emphasize it on the new hire check list. Record review of New Hire, Rehire & Transfer information form revised 6/02/25 revealed verbal abuse competency quiz was added. Record review Inservice for Clear the area drill dated 6/5/25 for all direct care staff. Record review of Inservice dated 6/5/25 for approaching, activities & interventions in response to behavior and people with mental health/psychiatric needs. Record review of Inservice dated 5/18/25 for verbal abuse scenario/drill for 52 staff. Record review of Inservice dated 5/18/25 for abuse & neglect - policy & procedure for 47 staff. In an interview on 6/6/25 at 11:02 am with CMA, she stated she had received training on ANE, how to clear an area and steps to help deescalate and respond to behaviors. She stated if she sees a concern she is to report it to the Abuse Coordinator or the DON. CMA stated she would report a nurse if needed. CMA stated that 1:1 residents can come out of their rooms. CMA stated she is aware of the Neighbor Program that started this morning. In an interview on 6/6/25 at 11:05 am with CNA I, she stated she had received training on ANE, how to clear an area and steps to help deescalate and respond to behaviors. She stated if she sees a concern she is to report it to the Abuse Coordinator or the DON. CNA I stated she would report a nurse if needed and she is aware of the Neighbor Program that started this morning. In an interview on 6/6/25 at 11:07 am with CNA J, she stated she has received training on ANE, how to clear an area and steps to help deescalate and respond to behaviors. She stated if she sees a concern she is to report it to the Abuse Coordinator or the DON. She stated she would report a nurse if needed. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675128	A. Building B. Wing	06/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Midwestern Healthcare Center	601 Midwestern Pkwy Wichita Falls, TX 76302

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 - Immediate jeopardy to resident health or safety Residents Affected - Some	In an interview on 6/6/25 at 11:11am with CNA K. sitting as 1:1 with a resident stated she has received training on ANE, how to clear an area and steps to help deescalate and respond to behaviors. She stated if she sees a concern she is to report it to the Abuse Coordinator or the DON. She stated she would report a nurse if needed. CNA K stated 1:1 residents can come out of their rooms and she is aware of the Neighbor Program that started this morning. In an interview on 6/6/25 at 11:15 am with CNA L, she stated she has received training on ANE, how to clear an area and steps to help deescalate and respond to behaviors. She stated if she sees a concern she is to report it to[TRUNCATED]