STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675152	A. Building B. Wing	06/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Dogwood Trails Manor	647 US Hwy 190 W Woodville, TX 75979

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 47879 Based on interview and record review, the facility failed to ensure that all alleged violations involving abuse of residents were reported to HHSC within the 2-hour period for 2 of 5 residents (Resident #1 and #2) reviewed for abuse. The facility failed to report an allegation of physical abuse within 2 hours to the State Agency when Resident #1 struck Resident #2 in left upper arm with a closed fist. This failure could place residents at risk of abuse, physical harm, mental anguish, and emotional distress. Findings included: Record review of a face sheet dated 6/19/2024 indicated Resident #1 was 69-years-old female, initially admitted to the facility on [DATE] with readmitted [DATE]. Her diagnoses included cerebral infarction (occurs as a result of disrupted blood flow to the brain due to problems with blood vessels that supply it), hemiplegia and hemiparesis following cerebral infarction (paralysis of partial or total body function on one side of the body, and/or one?sided weakness, but without complete paralysis caused by stroke), anxiety disorder (persistent and excessive worry that interferes with daily activities) and major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest). Record review of a MDS assessment dated [DATE] indicated Resident #1 was able to make herself understood and understand others. She had a BIMS of 14 (cognitively intact). Her behaviors included verbal behavioral symptoms directed toward others (e.g., threatening others, screaming at others, cursing others) that occurred 1 to 3 days (out of 7 day look back periodShe). She was independent with ADLs but required supervision shower/bath and tub/shower transfers. She was continent of bladder and bowel. Record review of Resident #1's care plan revision dated 01/22/2024 indicated she had history of making false accusations. Interventions included when conflict arises, remove resident to a calm safe environment and allow to vent/share feelings. (continued on next page)

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

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

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #1's care plan dated 01/29/2024 indicated she used anti-anxiety medications. Interventions included to transfer resident to (facility) inpatient as needed for mood/behaviors. Record review of Resident #1's care plan revision dated 6/14/2024 indicated Resident #1 had potential to demonstrate physical behaviors. Interventions included to analyze of key times, places, circumstances, triggers and what de-escalated the behavior and document, give the resident as many choices as possible about care and activities, if the resident had physical behaviors toward another resident, immediately intervene to protect the residents involved and call for assistance, if intervening would be unsafe, call out for staff assistance immediately, monitor/document/report to MD of danger to self and others, notify the charge nurse of any physically abusive behaviors, when the resident becomes agitated: intervene before agitation escalates; Guide away from source of distress; engage calmly in conversation; if response is aggressive, staff to walk calmly away, and approach later. Record review of Resident #1's progress note indicated that on 5/16/2024 at 6:00 pm resident was transferred to another inpatient facility related to resident was physically aggressive with another resident striking her with closed fist to left upper arm. Record review of Resident #1's event nurses' note - behavior authored by LVN A indicated that on 5/16/2024 at 4:00 p.m., the nurse was preparing for residents to go smoke when she turned to make sure all residents were ready, she witnessed Resident #1 strike Resident #2 with closed fist to left upper arm, no verbal altercation was heard between the two. Record review of a face sheet dated 1/9/2024 indicated Resident #2 was a 66-years-old female, initially admitted to the facility on [DATE] with readmitted [DATE]. Her diagnoses included Alcohol Dependence with Alcohol-induced persisting dementia (type of alcohol-related brain damage), Type 2 Diabetes (a disease that occurs when your blood glucose, also called blood sugar, is too high), Schizophrenia (a serious mental disorder in which people interpret reality abnormally), anxiety disorder (persistent and excessive worry that interferes with daily activities) and major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest). Record review of a MDS assessment dated [DATE] indicated Resident #2 was able to make himself understood and understand others. She had a BIMS of 15 (cognitively intact). No behavioral symptoms had occurred during the 7 day look back period. She required supervision for most ADLs. She was continent of bowel and occasionally incontinent of bladder. Record review of Resident #2's care plan revision dated 2/24/2023 indicated Resident #1 had potential to demonstrate physical and verbal behaviors anger, poor impulse control. Interventions included to analyze of key times, places, circumstances, triggers and what de-escalates behavior and document, COMMUNICATION: provide physical and verbal cues to alleviate anxiety; give positive feedback, assist verbalization of source of agitation, assist to set goals for more pleasant behavior, encourage seeking out of staff member when agitated, give the resident as many choices as possible about care and activities, if the resident has physical behaviors toward another resident, immediately intervene to protect the residents involved and call for assistance, if intervening would be unsafe, call out for staff assistance immediately, monitor/document/report to MD of danger to self and others, notify the charge nurse of any physically abusive behaviors, when the resident becomes agitated: intervene before agitation escalates; Guide away from source of distress; engage calmly in conversation; if response is aggressive, staff to walk calmly away, and approach later. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #2's event nurses' note - behavior authored by LVN A indicated that on 5/16/2024 at 4:00 p.m., that the nurse was preparing for residents to go smoke when she turned to make sure all residents were ready, she witnessed Resident #2 being struck closed fist to left upper arm by Resident #1 causing resident to shift to right in her wheelchair after the blow. No bruising noted at this time. Resident states It just hurts a little. During an interview on 6/18/2024 at 11:09 a.m., Resident #1 said she recalled the incident involving her and Resident #2 that happened on 5/16/2024. Resident #1 said Resident #2 ran over her foot with her wheelchair, so she hit her, she said Resident #2 always trying to be the first one out to smoke and get her cigarettes first, now they go out to smoke at different times, so she did not see her much. She said that she was sent to another facility for hitting another resident and was aware that she was not supposed to hit other residents. During an interview on 6/18/2024 at 1:09 p.m., Resident #2 said she does not recall the incident involving her and Resident #2 that happened on 5/16/2024. Resident #2 said that she does go out before or after the other residents now for smoke times but that is so I can get in or out with my wheelchair, takes me longer than others sometimes. During an interview on 6/19/2024 at 1:30 p.m., LVN A said she recalled the incident between Resident #1 and Resident #2. She said the weather was bad, so she was having to relocate the location for smoke time, said she was preparing the residents to go smoke, and when turned around to inform the residents that they would be going to the front porch area to smoke, she witnessed Resident #1 struck with closed fist by Resident #2 on left upper arm. LVN A said she intervened and separated the two residents, she said she did not see Resident #2 move her wheelchair or run over Resident #1's foot/toes as she claimed. She said she does not recall seeing any marks or abrasions on the residents when she intervened and separated them. She said she has been trained on abuse and neglect and was aware to report any allegations of abuse to the administrator/AC immediately which she did. Record review of TULIP intake for Resident #1 and Resident #2 indicated information date received on 5/20/2024 at 11:27 a.m., read that the allegation of abuse occurred on 5/16/2024 at 4:00 p.m. Caller information indicated the reporter of the allegation was the Administrator. During an interview on 6/19/2024 at 2:45 p.m., the Administrator said she became aware of the allegation of abuse between Resident #1 and Resident #2, immediately after it happened on 5/16/2024, she had left the facility and was in route home in inclement weather, she intended to report the allegation of abuse when she arrived home but was unable to due to the inclement weather caused power and internet outage at her personal residence, when she returned to the facility the next day, power was out and facility on backup generator power, she became involved with the inclement weather and power outage at facility and personal residence and forgot to report the allegation of abuse. She said when she realized on 5/20/2024 that she had forgotten to report the allegation of abuse from 5/16/2024 that she reported to HHSC at that time. She said she takes full responsibility for the delayed reporting of abuse allegation from 5/16/2024. She said that she was aware that the timeframe for reporting allegations of abuse to the HHSC/state agency was to report within 2 hours of the allegation. The administrator said the expectations was for the facility staff to report all suspicions or allegations of abuse immediately to her, as the abuse coordinator. She said the timeframe for reporting allegations of abuse to the state agency was to report within 2 hours of the allegation. The administrator said she should have reported allegation of abuse to the state agency within 2 hours of the allegation. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the facility's Abuse and Neglect policy dated 3/29/18 indicated . Facility employees must report all allegations of abuse, neglect, exploitation, mistreatment of residents, misappropriation of resident property or injury of unknown source to the facility administrator. The facility administrator or designee will report to HHSC all incidents that meet the criteria of Provider Letter 19-17 dated 7/10/19. If the allegations involve abuse or result in serious bodily injury, the report is to be made within 2hours of the allegation.