STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675217	A. Building B. Wing	03/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Elkhart Oaks Care Center	214 Jones Rd Elkhart, TX 75839

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31675 Based on interview and record review, the facility failed to ensure residents were free from abuse for 1 of 11 residents (Resident #1) reviewed for abuse, neglect, and exploitation. The facility failed to ensure Resident #1 was free of abuse from HSK-A. On 06/25/24 HSK A yelled and cursed at Resident #1. The noncompliance was determined to be PNC. The noncompliance began on 06/25/24 and ended on 06/26/24. The facility had corrected the noncompliance before the survey began. This failure could place residents at risk of verbal abuse. Findings included: Record review of Resident #1's undated face sheet reviewed on 03/06/25 indicated he was a [AGE] year-old male, admitted on [DATE], and his diagnoses included unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety (Primary),. schizophrenia (chronic mental disorder), and hypertension (high blood pressure). Record review of Resident #1's annual MDS assessment dated [DATE] indicated he was independent in performing most ADLS and needed supervision and verbal cues with showering. He was able to make himself understood and understood others, and he had severe cognitive impairment (BIMS-5). Record review of Resident #1's care plan dated 06/26/24 indicated behavioral problems started on 08/24/23. He had verbal behavioral symptoms directed toward others (e.g., threatening others, screaming at others, cursing at others). On 06/25/24 Resident #1 struck staff twice on the back while in his room. Interventions included asking permission before providing care, attempt to clean his room or address maintenance issues when he is not in his room. If he becomes agitated, notify the charge nurse or nursing management to assist, maintain a professional demeanor with resident to avoid reacting defensively or escalating the situation, (continued on next page)

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

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

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of progress note dated 06/25/24 at 8:42 a.m. LVN A indicated she heard an altercation coming from the hall. On investigation, she saw HSK A standing at Resident #1's doorway arguing with Resident #1. LVN A immediately intervened. LVN A escorted HSK A to the nurse's station. Resident #1 was placed on one-on-one observation and skin and pain assessment was completed. Administrator was notified and HSK A was escorted out of the building by the administrator. Resident #1 had no RP to notify. Record review of a skin assessment dated [DATE] at 11:51 AM, conducted by LVN B, showed a scratch to the back of right shoulder. Record review of progress notes dated 06/25/24 at 12:04 PM, DON documented a telehealth call with counselor at psychiatric facility. New orders to increase Seroquel to 100 mg BID and to monitor Resident #1 one-on-one until tomorrow morning. May remove Resident #1 from one-on-one supervision if no other behaviors. Medical Director (PCP) was notified of the recommendation for medication change and agreed. Record review of progress notes dated 06/25/24 at 12:34 PM LVN B indicated Resident #1 complained of pain to his right shoulder. Resident was given Tylenol. Record review of progress notes dated 06/26/24 at 8:10 AM, DON documented Resident #1 was removed from one-on-one. Will continue to monitor for 72-hours. Seroquel 100 mg BID yesterday. Resident #1 was smiling and self-propelling in wheelchair in the AM. Record review of a Resident Monitoring Checks form dated 06/25/24 to 06/26/24 showed Resident #1 was monitored every 15 minutes from 8:45 AM on 06/25/24 till 6:00 AM on 06/26/24. No behaviors were noted. Record review of consolidated physician orders dated 06/01/24 to 06/30/25 showed on 06/25/24, Resident #1's Seroquel was changed from 50 mg, BID, to 100 mg, BID for Schizophrenia. Record review of facility investigation dated 06/25/24 indicated on 06/25/24 HSK A went to clean Resident #1's room. Resident #1 allegedly hit HSK A after he asked HSK A to leave his room and HSK A refused. HSK A alleged Resident #1 hit him in his back two times. There were no witnesses to the incident inside Resident #1's room. Staff reported hearing yelling and cursing as HSK A left the room and headed down the hallway to the nurse's station. Staff reported HSK A was angry and threatening to hurt Resident #1. HSK A was removed from the facility by the administrator. HSK A was terminated. Staff was in-serviced on Abuse/Neglect, Dementia/Behaviors, and how to approach Resident #1. Record review of a written statement dated 06/25/24, the administrator indicated, at approximately 9:00 AM, he heard loud yelling from the back door of his office. He said he saw HSK A in front of Resident #1's room, saying, I am going to whoop your ass to Resident #1. HSK A's housekeeping cart was outside of Resident #1's room and he was in the hallway speaking to Resident #1. HSK A said Resident #1 hit him twice in the back. The administrator drew HSK A way from the situation toward the nurse's station. HSK A continued to maintain a loud voice and threatened to get him back in whatever way he could-out on the street, etc. to return the hurt. HSK A continued to yell and administrator asked HSK A to come to his office. HSK A was advised he could not continue to make verbal treats toward Resident #1, and yet he continued to say he would. The administrator told HSK A he was terminated and was escorted off the property. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of a written statement dated 06/25/24 by CNA A indicted she was at the nurse's station when she heard and saw HSK A at the end of Hall 1 yelling and cursing at Resident #1. HSK A came to the nurse's station and was yelling derogatory things regarding Resident #1. Record review of a written statement dated 06/25/24 by LVN C indicated she was in the conference room and heard yelling. She stepped out of the room and saw HSK A grab a glass off his housekeeping cart and walk to the front of the facility. The administrator intervened and met with HSK A at the front door. LVN C did not witness anything between Resident #1 and HSK A inside Resident #1's room. Record review of a written statement dated 06/25/24 by LVN A indicated she was at the nurse's station when she saw and heard HSK A hollering in the hallway. HSK A was walking down the hall toward the nurse's station. HSK A said Resident #1 hit him. HSK A was cursing and threatening to beat up Resident #1. The administrator intervened, but HSK A continued to holler about what he wanted to do to Resident #1. The administrator asked HSK A to leave the facility. Record review of a written statement dated 06/25/24 by LVN B indicated HSK A was upset with Resident #1 and started yelling, cursing, and making treats toward Resident #1. The administrator immediately intervened and HSK A left the facility. Record review of a written statement dated 06/25/24 by Receptionist A said HSK A came to the front office cursing about Resident #1. HSK A was irate and kept making comments about what he wanted to do to Resident #1. HSK A met with the administrator and was asked to leave the building. Record review of a witness statement dated 06/25/24 at 9:00 AM of HSK A, taken by RN A over the telephone showed, I got to work like normal and started cleaning. When I got to Resident #1's hall he was sitting at the front of the hall and when I made my way to his room he came in shortly after. He started making comments about the tile in his bathroom, so I went in there and started looking at it. I had my back turned to him, and he had gotten up out of his wheelchair and started punching me in the back about three times before I could turn around. When I turned around, I pushed him off me and he was trying to hit me in the head. I started yelling for someone to come help me. After I got out of his room, I went to the nurse's station and talked to the administrator and told him what happened, and he walked me outside. Record review of HSK A's employee records showed he was terminated on 06/25/24 for inappropriate behavior. Two attempts were made on 03/06/25 at 12:50 PM and 03/07/25 at 11:20 AM to interview HSK A via telephone. There was no answer. An automated recording said, The mailbox is full and cannot receive messages. Unable to contact AP. During an attempted interview on 03/06/25 at 10:50 a.m., Resident #1 was not able to recall or answer questions regarding the incident with HSK A on June 25, 2024. Unable to interview due to cognitive ability. Review of In-service records dated 01/01/2024 showed HSK A received training on Resident Abuse. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 03/07/25 at 10:10 a.m., CNA A said on 06/25/24, she was working the morning shift on 06/25/24. CNA A said she heard HSK A, yelling and cursing as he was walking up hall 1 toward the nurses' station. She said HSK A said Resident #1 hit him, and he was not going to Fucking put his hands on me, and I will hurt him. CNA A said Resident #1 was not in the hallway. CNA A said Resident #1 was in his room. CNA A said she had been trained on identifying abuse and neglect and to report any abuse or neglect to the administrator, who is the abuse coordinator. CNA A said she had also been trained on how to handle behaviors of residents and to give them space when they are upset and report the behavior to the nurse immediately. CNA A said the yelling and cursing from HSK A on that day was verbal abuse. During an interview on 03/07/25 at 10:19 a.m., LVN C said she was working on 06/25/24 around 9:00 a.m. she said she was in the conference room and heard someone yelling and cursing. LVN C said she went out into the hall and saw HSK A, grab a personal cup off the housekeeping cart and walk to the front, yelling and cursing as he came up the hall. LVN C said she did not see Resident #1 in the hallway. LVN C said she backed up when HSK A walked past her, because she did not know what he was going to do. LVN C said HSK A went to the front door, where the administrator stopped him. LVN C said she did not remember anything HSK A said but that he was yelling and cursing. LVN C said she had been trained on how to handle behaviors of residents and to give them space when they are to report the behavior to the charge nurse immediately. During an interview on 03/07/25 at 10:57 a.m., the Administrator said on 06/25/24 around 9:00 AM, he was in his office when he heard yelling in the hall. He said his office has a door that goes into Hall-1. He said he looked out of the door into the hall to see what the yelling was about, and he saw HSK A coming out of Resident #1's room. He said HSK A was in the hallway yelling toward Resident #1's room. He was yelling Get the F away from me. He said HSK A walked up the hallway toward the nurse's station. He said he told HSK A to come inside his office. He said HSK A said that he was cleaning the bathroom inside Resident #1's room when Resident #1 started hitting him in his back. He said HSK A said he pushed Resident #1 away from him and left the room. He said HSK A said he did not remember if Resident #1 fell when his pushed him, but he was just trying to get out of the room. He said HSK A was immediately terminated and escorted out of the facility. He said he interviewed Resident #1, but due to his cognitive ability was not a good historian. He said when he asked him if the white man pushed him, he nodded his head up and down, indicating Yes. He said the allegation of Resident Abuse was confirmed and the police were contacted. He said staff received In-service training on Abuse/Neglect, behaviors, Resident Rights and Approaching Resident #1. He said Resident #1 was placed on watch to insure there were no other incidents and he was referred to psych services for evaluation. He said the issue was discussed in the QAPI meeting and the DON and Medical Director attended the QAPI Meeting. He said there have not been any other incidents involving Resident #1. During an interview on 03/07/25 at 11:27 a.m., LVN B said she was working on the morning of 06/25/24. She said she was at the nurse's station when she heard yelling from down the hall. LVN said she witnessed HSK A yelling and cursing toward Resident #1's room. LVN B said the HSK A came up the hall yelling very loudly and cursing. LVN B said she conducted a skin assessment of Resident #1 and there was a small abrasion on his back. LVN B said Resident #1 was not able to say what caused the abrasion. LVN B said she does not know if Resident #1, fell , but if so, he would have been able to get himself up. LVN B said since there were no witnesses to the incident, and Resident #1 was not able to say what happened to cause the abrasion on his back, she could not determine what caused the abrasion. LVN B said she had received training on abuse and resident behaviors and had received specialized training on approaching Resident #1. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 03/07/25 at 11:34 a.m., RN A said she no longer works for the facility, but was employed as a Regional Nurse on 06/25/24, the date of the incident between Resident #1 and HSK A. She said she was not at the facility at the time of the incident but did contact HSK A via telephone to get a statement. She said when she spoke with HSK A, he was very hostile to her on the phone. RN A said she read HSK A's statement to him over the phone, and he agreed that what she recorded was accurate. She said HSK A was terminated on the day of the incident. RN A said since she was not at the facility at the time of the incident, she had no firsthand knowledge of what happened. During an interview on 03/07/25 at 11:38 a.m., DON said she was not at the facility at the time of the incident in June between Resident #1 and HSK-A. DON said she assisted in the investigation after the fact. She said HSK A was terminated, and staff received training on abuse, neglect, Dealing with Resident #1, and Resident Rights. DON said the incident was discussed at the QAPI meeting in June and Resident #1's care plan was updated to include interventions when dealing with Resident #1. During all interviews with staff on 03/06/25 and 03/07/25, including 2-RN's 3 LVN's and 5 CNA's. staff were able to give examples of abuse and were able to identify interventions when dealing with behaviors for Resident #1. They said they had received training on identifying and reporting abuse to the abuse coordinator, which was the administrator. Review of the facility's Abuse and Neglect Policy dated 04/08/2021 indicated It is the policy of this facility that rights will be protected of alleged victims of abuse, neglect, misappropriation or mistreatment, as well as the rights of staff who are accused of abuse, neglect, misappropriation or mistreatment-as well as those who report it.A corrective action plan will be developed, and an internal investigation will be conducted for findings. Review of safe surveys showed safety surveys were conducted on 06/25/24 by the ADON showing there were no concerns with other residents and residents felt safe at the facility. Review of QAPI minutes showed a QAPI meeting was conducted with Administrator, DON, ADON, Dietary Manager, Maintenance Director, and Medical Director on 07/22/2024. Concerns addressed at the meeting included incident between Resident #1 and HSK A on 06/25/24. Review of In-services records showed on 06/25/24 and 06/26/24, all staff received In-service training on Abuse/Neglect, behaviors, and approaching Resident #1. All education was completed with all staff that were working 06/26/2024. The noncompliance was determined to be PNC. The noncompliance began on 06/25/24 and ended on 06/26/24. The facility had corrected the noncompliance before the survey began.