STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675291	A. Building B. Wing	02/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Crosbyton Nursing and Rehabilitation Center	222 N Farmer Crosbyton, TX 79322

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** 43344 Based on observation, interview and record review, the facility failed to ensure the rights of the residents to be free from abuse for 2 of 7 residents (Resident #1 and #2) reviewed for abuse. The facility failed to keep Resident #2 safe from Resident #1 on 1/08/25 when a resident-to-resident altercation occurred resulting in Resident #1 hitting Resident #2. This failure could place residents at risk for serious psychosocial harm from abuse, humiliation, intimidation, fear, shame, agitation, and decreased quality of life. Findings included: Resident #1 Record Review of Resident #1's face sheet, dated 02/04/25, revealed a [AGE] year-old male that was admitted to the facility on [DATE], with a diagnosis of Hepatitis C (a contagious viral liver infection). Record Review of Resident #1's Comprehensive MDS assessment dated [DATE], revealed under Section C, Cognitive Patterns, a BIMS score of 07, indicating the resident was severely cognitively impaired. Section E revealed Resident #1 did not exhibit physical behavior (hitting, kicking, pushing, scratching, grabbing, abusing) during the review period [E0200]. Section I Resident #1 had viral Hepatitis. Record review of Resident #1's Physician Order Summary Report, dated 02/04/25, revealed that Resident #1 was not taking any medications for Hepatitis C. Record review of Resident #1's progress notes, dated 12/03/24-2/4/25 revealed the following: *1/08/25 at 4:18 PM LVN A documented: LVN A was sitting at nursing station when another resident (unknown) yelled out, There is a fight in here! BOM and LVN A entered dining area and did not see any physical or verbal altercation. LVN A was informed by another resident (unknown) that Resident #1 hit Resident #2. BOM watched video, and it was verified Resident #1 initiated physical aggression while Resident #2 was sitting in her wc near the table he ate at. Resident #2 was not disturbing the table or making physical contact with anyone upon Resident pulling/pushing Resident #2's wc and swinging his fist backwards towards Resident #2. Resident #2 became agitated but quickly left the area. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	*1/08/25 at 5:10 PM LVN A documented: Resident #1 was educated on not placing hands on other residents and informed to get staff if there was an incident that needs to be addressed. Resident #1 voiced understanding. Record review of Resident #1's care plan, dated 12/12/24, did not reveal a care plan regarding aggressive behavior but revealed his dx of hepatitis. His care plan did not reveal any revisions regarding the incident on 1/08/25. Record review of facility incident report, dated 1/08/25 revealed the following: Incident description: LVN A was sitting at nursing station when another resident (unknown) yelled out, There is a fight in here! BOM and LVN A entered dining area and did not see any physical or verbal altercation. LVN A was informed by another resident (unknown) that Resident #1 hit Resident #2. BOM watched video, and it was verified Resident #1 initiated physical aggression while Resident #2 was sitting in her wc near the table he ate at. Resident #2 was not disturbing the table or making physical contact with anyone upon Resident pulling/pushing Resident #2's wc and swinging his fist backwards towards Resident #2. Resident #2 became agitated but quickly left the area. Action taken: Stated Resident #2 was assessed with no injuries. Injuries Observed at the time of the incident: No injuries at the time of the incident. Predisposing Environmental Factors: Crowding Agencies/People Notified: Physician C, DON and Family Member D. Record review of the facility incident report, dated 2/4/25, revealed Resident #1 had a physical aggression-initiated incident on 1/08/25. During an interview on 2/4/25 at 12:57 PM, LVN A stated the abuse preventionist was the ADM. She said if she suspected or witnessed abuse, she had been trained to contact the ADM immediately. She said she had abuse training at the facility. She said she had been trained to separate the residents, perform a nursing assessment for injuries, and ensure everyone was safe if there was a resident-to-resident altercation. She stated she had been trained to report all resident-to-resident altercations to the ADM. On 1/08/25, she said she was not in the dining room when the incident occurred with Residents #1 and #2. She stated she had to look back at the video footage. She said when she looked at the footage, she observed Resident #2 sitting at the dining room table, and for some reason unknown to her, Resident #1 became frustrated. She said she observed Resident #1 push Resident #2's wheelchair, and Resident #2 rolled backward. She said Resident #2 rolled backward and did not come into contact with anything. She said Residents #1 and #2 did not make contact with each other. She said as a result, they ensured both residents (Resident #1 and #2) were separated and safe. She said she did an incident report, assessed the residents, and then reported everything she observed on the video footage to the DON. She said this was the first time Resident #1 had acted that way and did not have a history of physically aggressive behavior. She reported the incident to the DON and appropriate parties, such as doctors and family contact. (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 2/4/25 at 1:48 PM, Resident #1 could not recall specifics about the incident on 1/08/25. He stated he might have pushed them, but they asked for it. He said he did not know the other resident's name. He could not report if the other resident were male or female. He stated that they went crying to momma. He said he would handle his issues with [NAME] and [NAME]. He verified that [NAME] and [NAME] were his left and right hands. During an interview on 2/4/25 at 2:23 PM, the ADON stated the ADM was the abuse preventionist. She said if she suspected or witnessed abuse, she had been trained to remove the resident from the area where the abuse was occurring. She said she would go to the ADM, and if he were unavailable, she would go to the DON. She said if a resident-to-resident altercation had occurred, she had been trained to separate the residents, assess for injuries, and report the incident to the ADM and the DON. She stated regarding the incident on 1/08/25, it was her understanding that Resident #2 was attempting to grab something off the dining room table. Resident #1 did not like it, and some yanking and pulling was involved. The ADON stated that she did not witness the incident. During an interview on 2/4/25 at 2:43 PM, the DON stated she understood on 1/08/25 Resident #2 was attempting to remove a decoration from the dining room table. She stated she was unsure if Resident #1 had told Resident #2 a couple of times about the table decoration, but maybe the way Resident #1 approached Resident #2 made her (Resident #2) mad. She said she did not report the incident to HHSC because LVN A reported no physical contact between Resident #1 and Resident #2. She stated she considered a person's wheelchair an extension of their body because it was a part of their mobility, but she was never told Resident #1 made contact with Resident #2's wheelchair. She stated LVN A reported Resident #1 attempted to swing at Resident #2 but did not make contact. She stated she (the DON) did not observe any camera footage. She stated the camera video surveillance was located in the BOM's office, which would be the only way LVN A could have observed the footage. The DON stated she had no documentation to show she looked into the incident on 1/08/25. She stated she spoke with the ADM that evening about the incident between Resident #1 and Resident #2 because he was not in the facility. She stated she did not remember what she reported to him (the ADM), but it had to be what was reported to her by LVN A. Resident #2 Record Review of Resident #2's face sheet, dated 2/04/25, revealed a [AGE] year-old female that was admitted to the facility on [DATE], with a diagnosis of Alzheimer's (memory loss), Restless leg syndrome (irresistible urge to move legs), intermittent explosive disorder (explosive outburst of anger). Record Review of Resident #2's Comprehensive MDS assessment dated [DATE], revealed under Section C, Cognitive Patterns, a BIMS score of 99, indicating the resident was unable to complete the interview. Section E revealed Resident #2 did not exhibit physical behavior (hitting, kicking, pushing, scratching, grabbing, abusing) during the review period [E0200]. Resident #2 did exhibit a presence and frequency of wandering 4-6 days but less than daily [E0900]. Resident #1's wandering did place her at significant risk of getting to a potentially dangerous place and significantly intruded on the privacy of others [E1000.] Record review of Resident #2's care plan, dated 10/12/24, revealed that she had an identified wandering behavior and took medication (Depakote) related to be being combative. There was no care plan addressing aggressive behavior towards residents. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #2's Physician's Order, dated 02/04/25, revealed: An order and start date of 1/20/25 for Depakote 250 MG 1 tablet by mouth 2 times a day for intermittent explosive disorder. Record review of Resident #2's progress notes, dated 10/01/24- 02/04/2025 revealed the following: *10/07/24 at 3:26 PM LVN A documented: Resident #2 wandering up and down the hallways. Resident #2 was agitated. LVN A redirecting Resident #2 from entering other residents (unidentified) rooms. Resident #2 cognitive impairment and decreased ability to understand/follow directions. *11/02/25 at 5:52 PM LVN G documented: Resident #2 getting into other resident bed and when moved she pinched staff and yelled out that they were hitting staff. *11/08/24 at 11:10 AM LVN A documented: Resident #2 became agitated upon CNA (unidentified) removing items from residents wc that residents (unidentified) room. When CNA (unidentified) removed items, resident threw water on CNA (unidentified). Resident #2 proceeded to the dining room and picked up a cup of juice and threw it on the CNA (unidentified). *11/09/24 at 12:12 PM LVN A documented: Resident #2 getting into roommate's snacks/drinks. Upon staff attempting to retrieve items, Resident #2 became agitated and attempted physical aggression. *11/09/24 1:14 PM LVN A documented: Resident #2 wandered into another resident's (unidentified) room and took his peanut M&M bag; DON notified and stated she would replace it for the resident (identified). Resident (unidentified) informed and voiced frustration of not being able to keep things in his room d/t Resident #2 going in his room attempting to take things. *11/11/24 at 11:53 PM LVN G documented: Resident #2 kept going into other residents (unidentified) rooms and would get into their drawers and get their snacks or their personal. *12/01/24 at 5:39 PM LVN B documented: Resident #1 spent most of shift going into others rooms. Resident #2 was redirected with no improvement. Resident #2 was playing with a chain attached to a door and when asked to stop she took the chain swinging it striking the aide on the arm. *12/21/24 at 2:59 PM LVN A documented: Resident #2 agitated and following other residents around. *1/05/25 at 11:33 AM LVN A documented: Resident #2 has become more agitated, defensive upon staff attempting to redirect, actively going into rooms taking other Residents belongings, and appears anxious with inability to relax. Upon reviewing residents' orders, LVN A noted Depakote was discontinued 11/24/24. If behaviors continue, LVN A will contact PCP to see if Depakote can be resumed. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	*1/12/25 at 5:12 PM LVN B documented: Resident #2 wanders in hallways and goes into other resident's room throughout shift. This is a common behavior for her. She will go in the room look around and come out. Rightly so the other residents are not happy with her behavior and do not want her to go into their room's. Family, administration and staff are aware and frequently redirect resident, she is compliant the majority of the time. However, some residents have taken it upon themselves to yell at her causing her to become defensive. This evening as residents were gathering in dining room she went into dining room as well. A male resident (unidentified) yelled at her to get out. This nurse redirected resident to hallway, gave her some crackers to keep her distracted. This nurse was coming out of another resident's room and saw resident wheel into dining room. Then nurse heard a male Resident (unidentified) yell out. This nurse went into dining room and removed resident from dining room. the same before mentioned male resident stated, She pulled my hair. A female resident stated, She did pull his hair, and she pulled her hair also. Residents' family member notified of her actions. The ADON notified as well. *1/12/25 at 5:33 PM LVN B documented: a Psychiatric referral was made. *1/20/25 at 5:18 PM The Psychiatric Provider Documented: Meeting with facility staff indicates the patient has: Normal appetite. No anxiety and no irritability, and no hostility toward peer(s). No hostility toward caregivers. *1/20/25 at 3:18 PM LVN B documented: The Psychiatric Provider in house for rounds. New order for Depakote 125mg BID received at this time. *1/31/25 at 2:59 PM The Psychiatric Provider Documented: Meeting with facility staff indicates the patient has: Normal appetite. No anxiety and no irritability, and no hostility toward peer(s). No hostility toward caregivers *2/03/25 at 3:15 PM LVN B documented: The Psychiatric Provider in house for rounds. No New orders received at this time. Will continue to monitor Resident #2. *2/03/25 at 4:03 PM The Psychiatric Provider Documented: Meeting with staff reveals: Meeting with facility staff indicates the patient has: Normal appetite. No anxiety and no hostility towards peer(s). No hostility towards caregivers. Record review of facility incident report, dated 11/08/24 revealed the following: Incident description: Nursing (unidentified) witnessed Resident #2 throw water on CNA (unidentified) d/t CNA (unidentified) removing belongings from residents wc that Resident #2 had taken from another residents (unidentified) room. And Resident #2 was unable to give a description of what happened. Action taken: Resident #2 was redirected but it was unsuccessful. Injuries Observed at the time of the incident: No injuries at the time of the incident. Agencies/People Notified: Physician I, DON, ADON and Family Member H. (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 facility incident report, dated 1/08/25 revealed the following: Incident description: LVN A was sitting at nursing station when another resident (unknown) yelled out, There is a fight in here! BOM and LVN A entered dining area and did not see any physical or verbal altercation. LVN A was informed by another resident (unknown) that Resident #1 hit Resident #2. BOM watched video, and it was verified Resident #1 initiated physical aggression while Resident #2 was sitting in her wc near the table he eats at. Resident #2 was not disturbing the table or making physical contact with anyone upon Resident pulling/pushing Resident #2's wc and swinging his fist backwards towards Resident #2. Resident #2 became agitated but quickly left the area. Action taken: Stated Resident #2 was assessed with no injuries. Injuries Observed at the time of the incident: No injuries at the time of the incident. Predisposing Environmental Factors: Crowding Agencies/People Notified: Physician I, DON and Family Member H. Record review of the facility incident report, dated 2/4/25, revealed the following: During an observation of the video provided by the BOM, the following was observed by the HHSC investigator: At the start of the video, from the start of the video to .29 seconds, Resident #1 is seated at the left side of the table while Resident #2 is rolling back and forth to his left. No contact was being made between Resident #1 and Resident #2. :29 seconds Resident #1 takes his left hand and grabs the push handle (right side) of Resident #2. Resident #2 appears startled as she looks around, uses her right hand, and attempts to grab the table. :35 seconds Resident #1 takes his left hand, grabs Resident #2's right armrest, and pushes her back. :35-:45 seconds Resident #1 appeared to say something verbally to Resident #2 (the exact wording is unknown due to the lack of audio, but the Resident's mouth was observed moving). :45 seconds Resident #1 takes his left arm and quickly swings back at Resident #2. It is difficult to see if Resident #1 made contact, but Resident #2's right arm moved back quickly. :46 seconds Resident #2 swings back with her right hand twice. The first time, she hit Resident #1 on his left arm, and the second hit him again but held on for a short duration. :50 seconds observed Resident #2 swing back again. It is unclear if contact was made in Resident #2's face, but it was in the vicinity. An unknown object fell to the floor. :51 seconds-1:00 minute Resident #2 grabs the back of Resident #1's chair and jerking back and forth. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1:00 minute Resident #1 begins to exit the dining room. The video ends at 1 minute and 5 seconds. During an interview on 2/4/25 at 2:04 PM, Resident #2 could not recall the incident on 1/08/25. She could not state if another resident, specifically Resident #1, had pushed her. During an interview on 2/4/25 at 2:54 PM, the BOM stated on 1/08/25 at 6:44 PM, she was in her office when she heard another resident (unknown) yelling, They are fighting! She said another resident (unknown) said, Someone hit your grandma! She stated that she asked Resident #1 if he was okay. She thought Resident #2 had hit him because she has a history of doing things (being physical with other residents) of that nature. The BOM stated Resident #1 told her that he did not hit her (Resident #2). She stated that she told LVN A that she would check the camera footage. She stated that once she had observed the camera footage, she had shown LVN A, and they both had observed Resident #1 swing at Resident #2 first. She said she observed physical contact between Resident #1 and #2 . She said she asked LVN A to make a note of the incident. She said she was told by LVN A that she would notate and take care of notifications. The BOM said she was unsure if LVN A called the ADM and DON or just one of them. She said she believed that LVN A just called the DON because the ADM had been out due to having multiple surgeries. She stated the ADM was not in the facility and reported to LVN A, the charge nurse at the time. She said she was unsure if the DON was in the facility at the time of the incident. She said she was also trained to check the cameras if there was any further concern, which was why she checked the cameras. She said she had been trained that resident-to-resident altercation was a form of abuse. The BOM stated she had a copy of the video surveillance footage and would provide it. She said she used her best judgment and saved a copy of the video because their system would erase it after several days. During an interview on 2/5/25 at 8:30 AM, LVN A stated regarding the incident that occurred on 1/08/25 with Resident #1 and #2, she did not report it to the ADM. She said she was familiar with management reviewing the documented incident and had reported the incident to the DON. She stated she did not feel that the behavior she observed regarding Resident #1 was intentional but more of an agitation. She admitted that she reviewed the surveillance with the BOM but did not observe any physical contact with Residents #1 and #2. During an interview on 2/4/25 at 4:00 PM, the DON stated The DON stated she was familiar with and had been trained on the facility's abuse policy. She said she was unaware of physical contact between Resident #1 and #2. She stated that their monitoring system related to the abuse policy and reporting was that she would check the 24-hour report if it were a weekday, and if it were a Monday, she would run a 72-hour report. She stated that if she was not at work, she was unsure if anyone will check the reports for concerning incidents. She said she also checked the resident progress notes daily. She stated everyone was responsible for following the abuse policy. She stated all staff were responsible for following the abuse policy. She stated she had been trained to keep all residents free from abuse and expected all staff to keep residents safe from abuse. The DON stated the potential negative outcome for residents was the failure could lead to further incidents between residents. (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 2/4/25 at 4:30 PM, the ADM stated on 1/08/25, he received a call from the DON, who explained Residents #1 and #2 had an incident. He stated he asked her if there were any injuries. He was told by the DON that there were no injuries. He said he did not remember the specifics of what was reported by the DON but that whatever was reported was not alarming to him. He stated he read the incident report. He stated by the HHSC definition of abuse, the resident-to-resident altercation did not meet the definition of abuse. He stated that he did not observe the camera footage because he was not concerned about what was reported to him by the DON or what he read in the incident report. He stated that the two residents involved did not have the cognitive ability to be affected psychosocially and that even if the two residents were cognitively intact by HHSC standards, the definition of abuse was not met. The ADM said he read that the BOM reviewed the cameras and asked her about the altercation. When he asked her about the incident, the BOM reported that Resident #1 did swing back but did not make any contact. The ADM stated that even if Resident #1 had made contact, he would not have reported it because there was no bruise. He stated Resident #1 did not know what he was doing. Record review of the facility policy, Resident Right, undated, revealed the following: Inservice Objective The purpose of this program is to provide you with a basic understanding of the rights of nursing home residents. A basic understanding of residents' rights is essential to a nurse aides' ability to provide quality care and avoid mistakes that place a resident's safety or well-being at risk. The following is an outline of the information covered in this inservice program. Abuse & Neglect: The right to be free of abuse and neglect Record review of the facility policy, Abuse, Neglect, Exploitation and Misappropriation Prevention Program, Revised April 2021, revealed the following: Policy Statement Residents have the right to be free from abuse and neglect. This includes but not limited to verbal and physical abuse. Policy Interpretation and Implementation The resident abuse and neglect prevention program consist of a facility-wide commitment and resource allocation to support the following objectives: Protect residents from abuse and neglect by anyone including, but not necessarily limited to . Other residents Develop and implement policies and protocols to prevent and identify Abuse or mistreatment of residents Neglect of residents (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Establish and maintain a culture of compassion and caring for all residents and particularly those with behavioral, cognitive or emotional problems.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0607 Level of Harm - Minimal harm or potential for actual harm 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** 43344 Based on interviews and record review, the facility failed to implement written policies and procedures that prohibit and prevent abuse and neglect for 4 of 7 residents (Resident #1, #2, #3 and #4) reviewed for abuse. The ADM (Abuse Preventionist) failed to follow the facility's abuse policy by not reporting the allegation of abuse to HHSC and documenting his investigation regarding the Resident-to-Resident altercation (Between Resident #1 and Resident #2) that occurred and was reported on 1/08/25 by the DON and LVN A. The ADM failed to follow the facility's abuse policy by not reporting the allegation of abuse to HHSC and documenting his investigation regarding the Resident-to-Resident altercation (Between Resident #2, #3 and #4) that occurred and was reported on 1/12/25 by LVN B to the ADON. The ADM (Abuse Preventionist) failed to follow the facility's abuse policy by not reporting the allegation of abuse to include injury of unknown origin to HHSC and documenting his investigation regarding the bruising that was identified on 1/14/25. The ADON and LVN B failed to follow the facility's abuse policy by not reporting the allegation of abuse to the ADM (Abuse preventionist) regarding the Resident-to-Resident altercation (Between Resident #2, #3 and #4) that occurred and was reported on 1/12/25 by LVN B to the ADON. The ADM and DON failed to report to the Psychiatric Provider that Resident #2 had physical and verbal aggression towards staff and residents after she had referred to psychiatric services as of 1/20/25. These failures could place residents as risk for abuse and neglect. Findings include: Record review of the facility policy, Abuse, Neglect, Exploitation and Misappropriation Prevention Program, Revised April 2021, revealed the following: Policy Statement Residents have the right to be free from abuse and neglect. This includes but not limited to verbal and physical abuse. Policy Interpretation and Implementation The resident abuse and neglect prevention program consist of a facility-wide commitment and resource allocation to support the following objectives: Protect residents from abuse and neglect by anyone including, but not necessarily limited to Facility staff (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Crosbyton Nursing and Rehabilitation Center	222 N Farmer Crosbyton, TX 79322

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Other residents Develop and implement policies and protocols to prevent and identify Abuse or mistreatment of residents Neglect of residents Establish and maintain a culture of compassion and caring for all residents and particularly those with behavioral, cognitive or emotional problems. Investigate and report any allegations within timeframes required by federal requirements. Record review of the facility policy, Abuse and Neglect, Revised March 2018, revealed the following: Cause Identification The staff will investigate alleged abuse and neglect to clarify what happened and identify possible causes. Record review of the facility policy, Abuse, Neglect, Exploitation or Misappropriation-Reporting and Investigating, Revised September 2022, revealed the following: Policy Statement All reports of resident abuse (including injuries of unknown) and neglect are reported to local, state and federal agencies (as required by current regulations) and thoroughly investigated by facility management. Findings of all investigations are documented and reported. Policy Interpretation and Implementation Reporting Allegations to Administer and Authorities If resident abuse and neglect or injury of unknown origin is suspected, the suspicion must be reported immediately to the administrator and other officials according to state law. The administrator or the individual making the allegation immediately reports his or her suspicion to the following persons or agencies: The state licensing/certification agency responsible for surveying/licensing the facility Immediately is defined as: Within two hours of an allegation involving abuse or result in serious bodily injury Within 24 hours of an allegation that does not involve abuse or result in serious bodily injury (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Upon receiving any allegations of abuse, neglect and injury of unknown origin, the administrator is responsible for determining what actions (if any) are needed for protection of residents. Investigating Allegations All allegations are thoroughly investigated. The Administrator initiates investigations. Investigations may be assigned to an individual trained in reviewing, investigating and reporting such allegations. The administrators provides supporting documents and evidence related to the alleged incident to the individual in charge of the investigation. The individual conducting the investigation as a minimum: Reviews the documentation and evidence Reviews the resident's medical record to determine the resident's physical and cognitive status at the time of the incident and since the incident. Interviews the person(s) reporting the incident. Interviews witnesses to the incident. Interviews resident (as medically appropriate) or the resident's representative. Interview staff members (on all shifts) who have had contact with the resident during the period of the alleged incident. Interview resident roommate, family members, and visitors; Review all incidents leading up to the incident Documents the investigation completely and thoroughly Record review of the facility policy, Resident-to-Resident Altercation , Revised September 2022, revealed the following: Policy Statement All altercations, including those that may represent resident-to-resident abuse, are investigated and reported to the nursing supervisor, the director of nursing services and to the administrator. Policy Interpretation and Implementation Facility Staff monitor residents for aggressive/inappropriate behavior towards other residents and staff. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Behaviors that may provoke a reaction by residents or others include verbally aggressive behavior and physically aggressive behavior. Occurrences of such incidents are promptly reported to the nurse supervisor, director of nursing and to the administrator. The Administrator will report the incident in accordance with the criteria established under Abuse, Neglect-Reporting and Investigating. If two residents are involved in an altercation, staff: Identify what happened Review the events with nursing supervisor, director of nursing and evaluate effectiveness of interventions. Consult with attending physician to identify treatable conditions such as acute psychosis Consult with psychiatric services as needed for assistance in assessing the resident. Report incidents, findings, and corrective measures taken in the resident's medical record. Inquiries concerning resident-to-resident altercations are referred to the director of nurses or to the administrator. Record review of the facility policy, Resident Right, undated, revealed the following: Inservice Objective The purpose of this program is to provide you with a basic understanding of the rights of nursing home residents. A basic understanding of residents' rights is essential to a nurse aides' ability to provide quality care and avoid mistakes that place a resident's safety or well-being at risk. The following is an outline of the information covered in this inservice program. Abuse & Neglect: The right to be free of abuse and neglect Resident #1 Record Review of Resident #1's face sheet, dated 02/04/25, revealed a [AGE] year-old male that was admitted to the facility on [DATE], with a diagnosis of Hepatitis C (a contagious viral liver infection). Record Review of Resident #1's Comprehensive MDS assessment dated [DATE], revealed under Section C, Cognitive Patterns, a BIMS score of 07, indicating the resident was severely cognitively impaired. Section E revealed Resident #1 did not exhibit physical behavior (hitting, kicking, pushing, scratching, grabbing, abusing) during the review period [E0200]. Section I Resident #1 had viral Hepatitis. Record review of Resident #1's Physician Order Summary Report, dated 02/04/25, revealed that Resident #1 was not taking any medications for Hepatitis C. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #1's progress notes, dated 12/03/24-2/4/25 revealed the following: *1/08/25 at 4:18 PM LVN A documented: LVN A was sitting at nursing station when another resident (unknown) yelled out, There is a fight in here! BOM and LVN A entered dining area and did not see any physical or verbal altercation. LVN A was informed by another resident (unknown) that Resident #1 hit Resident #2. BOM watched video, and it was verified Resident #1 initiated physical aggression while Resident #2 was sitting in her wc near the table he ate at. Resident #2 was not disturbing the table or making physical contact with anyone upon Resident pulling/pushing Resident #2's wc and swinging his fist backwards towards Resident #2. Resident #2 became agitated but quickly left the area. *1/08/25 at 5:10 PM LVN A documented: Resident #1 was educated on not placing hands on other residents and informed to get staff if there was an incident that needs to be addressed. Resident #1 voiced understanding. Record review of Resident #1's care plan, dated 12/12/24, did not reveal a care plan regarding aggressive behavior but revealed his dx of hepatitis. His care plan did not reveal any revisions regarding the incident on 1/08/25. Record review of facility incident report, dated 1/08/25 revealed: Incident description: exact note that LVN A documented in Resident #1's progress note on 1/08/25. Action taken: Stated Resident #2 was assessed with no injuries. Injuries Observed at the time of the incident: No injuries at the time of the incident. Predisposing Environmental Factors: Crowding Agencies/People Notified: Physician C, DON and Family Member D. Record review of the facility incident report, dated 2/4/25, revealed: Resident #1 had a physical aggression-initiated incident on 1/08/25. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 2/4/25 at 12:57 PM, LVN A stated the abuse preventionist was the ADM. She said if she suspected or witnessed abuse, she had been trained to contact the ADM immediately. She said she had abuse training at the facility. She said she had been trained to separate the residents, perform a nursing assessment for injuries, and ensure everyone was safe if there was a resident-to-resident altercation. She stated she had been trained to report all resident-to-resident altercations to the ADM. On 1/08/25, she said she was not in the dining room when the incident occurred with Residents #1 and #2. She stated she had to look back at the video footage. She said when she looked at the footage, she observed Resident #2 sitting at the dining room table, and for some reason unknown to her, Resident #1 became frustrated. She said she observed Resident #1 push Resident #2's wheelchair, and Resident #2 rolled backward. She said Resident #2 rolled backward and did not come into contact with anything. She said Residents #1 and #2 did not make contact with each other. She said as a result, they ensured both residents (Resident #1 and #2) were separated and safe. She said she did an incident report, assessed the residents, and then reported everything she observed on the video footage to the DON. She said this was the first time Resident #1 had acted that way and did not have a history of physically aggressive behavior. She reported the incident to the DON and appropriate parties, such as doctors and family contact. During an interview on 2/4/25 at 1:48 PM, Resident #1 could not recall specifics about the incident on 1/08/25. He stated he might have pushed them, but they asked for it. He said he did not know the other resident's name. He could not report if the other resident were male or female. He stated that they went crying to momma. He said he would handle his issues with [NAME] and [NAME]. He verified that [NAME] and [NAME] were his left and right hands. During an interview on 2/4/25 at 2:23 PM, the ADON stated the ADM was the abuse preventionist. She said if she suspected or witnessed abuse, she had been trained to remove the resident from the area where the abuse was occurring. She said she would go to the ADM, and if he were unavailable, she would go to the DON. She said if a resident-to-resident altercation had occurred, she had been trained to separate the residents, assess for injuries, and report the incident to the ADM and the DON. She stated regarding the incident on 1/08/25, it was her understanding that Resident #2 was attempting to grab something off the dining room table. Resident #1 did not like it, and some yanking and pulling was involved. The ADON stated that she did not witness the incident. During an interview on 2/4/25 at 2:43 PM, the DON stated she understood on 1/08/25 Resident #2 was attempting to remove a decoration from the dining room table. She stated she was unsure if Resident #1 had told Resident #2 a couple of times about the table decoration, but maybe the way Resident #1 approached Resident #2 made her (Resident #2) mad. She said she did not report the incident to HHSC because LVN A reported no physical contact between Resident #1 and Resident #2. She stated she considered a person's wheelchair an extension of their body because it was a part of their mobility, but she was never told Resident #1 made contact with Resident #2's wheelchair. She stated LVN A reported that Resident #1 attempted to swing at Resident #2 but did not make contact. She stated she (the DON) did not observe any camera footage. She stated the camera video surveillance was located in the BOM's office, which would be the only way LVN A could have observed the footage. The DON stated she had no documentation to show she looked into the incident on 1/08/25. She stated she spoke with the ADM that evening about the incident between Resident #1 and Resident #2 because he was not in the facility. She stated she did not remember what she reported to him (the ADM), but it had to be what was reported to her by LVN A. Resident #2 (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record Review of Resident #2's face sheet, dated 2/04/25, revealed a [AGE] year-old female that was admitted to the facility on [DATE], with a diagnosis of Alzheimer's (memory loss), Restless leg syndrome (irresistible urge to move legs), intermittent explosive disorder (explosive outburst of anger). Record Review of Resident #2's Comprehensive MDS assessment dated [DATE], revealed under Section C, Cognitive Patterns, a BIMS score of 99, indicating the resident was unable to complete the interview. Section E revealed Resident #2 did not exhibit physical behavior (hitting, kicking, pushing, scratching, grabbing, abusing) during the review period [E0200]. Resident #2 did exhibit a presence and frequency of wandering 4-6 days but less than daily [E0900]. Resident #1's wandering did place her at significant risk of getting to a potentially dangerous place and significantly intruded on the privacy of others [E1000.] Record review of Resident #2's care plan, dated 10/12/24, revealed that she had an identified wandering behavior and also took medication (Depakote) related to be being combative. There was no care plan addressing aggressive behavior towards residents or the incident that occurred on 1/08/25. Record review of Resident #2's care plan, dated 10/12/24, revealed that she had a new care plan implemented 2/06/25 with a focus that addressed that Resident #2 had a potential to be physically aggressive when she feels threatened and or if someone had something that belonged to her and this was related to her dementia. The goal for the review period (2/06/25) revealed that Resident #2 would not harm self or others. The interventions implemented as of 2/06/25 revealed it was expected that staff attempt to redirect Resident #2 to another place or engage her in activities. The interventions also included recognizing Resident #2's trigger are when staff attempt to redirect her or when voices are raised. Other interventions included keeping her as busy as possible and administering medications as ordered. Record review of Resident #2's Physician's Order, dated 02/04/25, revealed: An order and start date of 1/20/25 for Depakote 250 MG 1 tablet by mouth 2 times a day for intermittent explosive disorder. Record review of Resident #2's progress notes, dated 10/01/24- 02/04/2025 revealed the following: *10/07/24 at 3:26 PM LVN A documented: Resident #2 wandering up and down the hallways. Resident #2 was agitated. LVN A redirecting Resident #2 from entering other residents (unidentified) rooms. Resident #2 cognitive impairment and decreased ability to understand/follow directions. *11/02/25 at 5:52 PM LVN G documented: Resident #2 getting into other resident bed and when moved she pinched staff and yelled out that they were hitting staff. *11/08/24 at 11:10 AM LVN A documented: Resident #2 became agitated upon CNA (unidentified) removing items from residents wc that residents (unidentified) room. When CNA (unidentified) removed items, resident threw water on CNA (unidentified). Resident #2 proceeded to the dining room and picked up a cup of juice and threw it on the CNA (unidentified). *11/09/24 at 12:12 PM LVN A documented: Resident #2 getting into roommate's snacks/drinks. Upon staff attempting to retrieve items, Resident #2 became agitated and attempted physical aggression. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	*11/09/24 1:14 PM LVN A documented: Resident #2 wandered into another resident's (unidentified) room and took his peanut M&M bag; DON notified and stated she would replace it for the resident (identified). Resident (unidentified) informed and voiced frustration of not being able to keep things in his d/t Resident #2 going in his room attempting to take things. *11/11/24 at 11:53 PM LVN G documented: Resident #2 kept going into other residents (unidentified) rooms and would get into their drawers and get their snacks or their personal. *12/01/24 at 5:39 PM LVN B documented: Resident #1 spent most of shift going into others rooms. Resident #2 was redirected with no improvement. Resident #2 was playing with a chain attached to a door and when asked to stop she took the chain swinging it striking the aide on the arm. *12/21/24 at 2:59 PM LVN A documented: Resident #2 agitated and following other residents around. *1/05/25 at 11:33 AM LVN A documented: Resident #2 has become more agitated, defensive upon staff attempting to redirect, actively going into rooms taking other Residents belongings, and appears anxious with inability to relax. Upon reviewing residents' orders, LVN A noted Depakote was discontinued 11/24/24. If behaviors continue, LVN A will contact PCP to see if Depakote can be resumed. *1/12/25 at 5:12 PM LVN B documented: Resident #2 wanders in hallways and goes into other resident's room throughout shift. This is a common behavior for her. She will go in the room look around and come out. Rightly so the other residents are not happy with her behavior and do not want her to go into their room's. Family, administration and staff are aware and frequently redirect resident, she is compliant the majority of the time. However, some residents have taken it upon themselves to yell at her causing her to become defensive. This evening as residents were gathering in dining room she went into dining room as well. A male resident (unidentified) yelled at her to get out. This nurse redirected resident to hallway, gave her some crackers to keep her distracted. This nurse was coming out of another resident's room and saw resident wheel into dining room. Then nurse heard a male Resident (unidentified) yell out. This nurse went into dining room and removed resident from dining room. the same before mentioned male resident stated, She pulled my hair. A female resident stated, She did pull his hair, and she pulled her hair also. Residents' family member notified of her actions. The ADON notified as well. *1/12/25 at 5:33 PM LVN B documented: a Psychiatric referral was made. *1/14/25 at 10:49 AM LVN A documented: Upon Skin Assessment during Shower, CNA (unidentified) informed LVN A resident had multiple bruises BUE. Resident has behavior of wondering, self transfers, attempting to ambulate w/o assist with unsteady gait. Staff to continue to monitor resident to assure safe environment. *1/16/25 at 10:14 AM the ADON Documented: Resident #2 doesn't c/o pain from bruising , The ADON did note that when she (Resident #2) is using her arms to wheel her chair she does so with very big/hard strokes and the inside part of her arms are hitting the arm of the wheelchair. When the ADON asked where the bruises come from she just smiles and points up and says the lord jesus did it. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	*1/20/25 at 5:18 PM The Psychiatric Provider Documented: Meeting with facility staff indicates the patient has: Normal appetite. No anxiety and no irritability, and no hostility toward peer(s). No hostility toward caregivers. *1/20/25 at 3:18 PM LVN B documented: The Psychiatric Provider in house for rounds. New order for Depakote 125mg BID received at this time. *1/31/25 at 2:59 PM The Psychiatric Provider Documented: Meeting with facility staff indicates the patient has: Normal appetite. No anxiety and no irritability, and no hostility toward peer(s). No hostility toward caregivers *2/03/25 at 3:15 PM LVN B documented: The Psychiatric Provider in house for rounds. No New orders received at this time. Will continue to monitor Resident #2. *2/03/25 at 4:03 PM The Psychiatric Provider Documented: Meeting with staff reveals: Meeting with facility staff indicates the patient has: Normal appetite. No anxiety and no hostility towards peer(s). No hostility towards caregivers. Record review of facility incident report, dated 11/08/24 revealed the following: Incident description: Nursing (unidentified) witnessed Resident #2 throw water on CNA (unidentified) d/t CNA (unidentified) removing belongings from residents wc that Resident #2 had taken from another residents (unidentified) room. And Resident #2 was unable to give a description of what happened. Action taken: Resident #2 was redirected but it was unsuccessful. Injuries Observed at the time of the incident: No injuries at the time of the incident. Agencies/People Notified: Physician I, DON, ADON and Family Member H. Record review of facility incident report, dated 1/08/25 revealed the following: Incident description: LVN A was sitting at nursing station when another resident (unknown) yelled out, There is a fight in here! BOM and LVN A entered dining area and did not see any physical or verbal altercation. LVN A was informed by another resident (unknown) that Resident #1 hit Resident #2. BOM watched video, and it was verified Resident #1 initiated physical aggression while Resident #2 was sitting in her wc near the table he ate at. Resident #2 was not disturbing the table or making physical contact with anyone upon Resident pulling/pushing Resident #2's wc and swinging his fist backwards towards Resident #2. Resident #2 became agitated but quickly left the area. Action taken: Stated Resident #2 was assessed with no injuries. Injuries Observed at the time of the incident: No injuries at the time of the incident. Predisposing Environmental Factors: Crowding Agencies/People Notified: Physician I, DON and Family Member H. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of facility incident report, dated 1/14/25 revealed the following: Incident description: upon Resident #2's shower, CNA (unidentified) reported scattered bruising BUE and one large Bruise RUE noted: Deep Purple/Deep. Resident #2 unable to give a description. Immediate Action taken: Assessed areas with no warmth, surrounding redness or increased tenderness noted. Predisposing Physiological Factors: Confused, gait balance, impaired memory, and incontinent Agencies/People Notified: Physician I, DON, ADON and Family Member H. Record review of the facility incident report, dated 2/4/25, revealed the following: Resident #2 had a physical aggression-initiated incident on 11/08/24 (x2) and 12/26/24. Resident #2 had a bruise identified on 1/14/25. Record review of the picture provided by the BOM on 2/4/25 titled Picture #1 of Resident #2 revealed the following: Resident #2's left eye was dark red around the iris Resident #2 had a large bruise on the right arm Record review of the picture provided by the BOM on 2/4/25 titled Picture #2 of Resident #2 revealed the following: Resident #2 had a large dark purple bruise on the upper right arm. Observed a small dark purple bruise on the right elbow. Observed one light, fading circular bruise near the right wrist. Resident #2 had three small, light purple circular bruises on their left arm near the elbow. Observed four small dark purple bruises scattered down towards Resident #2's left wrist. During an observation of the video provided by the BOM, the following was observed by the HHSC investigator: At the start of the video, from the start of the video to .29 seconds, Resident #1 is seated at the left side of the table while Resident #2 is rolling back and forth to his left. No contact was being made between Resident #1 and Resident #2. :29 seconds Resident #1 takes his left hand and grabs the push handle (right side) of Resident #2. Resident #2 appears startled as she looks around, uses her right hand, and attempts to grab the table. :35 seconds Resident #1 takes his left hand, grabs Resident #2's right armrest, and pushes her back. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	:35-:45 seconds Resident #1 appeared to say something verbally to Resident #2 (the exact wording is unknown due to the lack of audio, but the Resident's mouth was observed moving). :45 seconds Resident #1 takes his left arm and quickly swings back at Resident #2. It is difficult to see if Resident #1 made contact, but Resident #2's right arm moved back quickly. :46 seconds Resident #2 swings back with her right hand twice. The first time, she hit Resident #1 on his left arm, and the second hit him again but held on for a short duration. :50 seconds observed Resident #2 swing back again. It is unclear if contact was made in Resident #2's face, but it was in the vicinity. An unknown object fell to the floor. :51 seconds-1:00 minute Resident #2 grabs the back of Resident #1's chair and jerking back and forth. 1:00 minute Resident #1 begins to exit the dining room. The video ends at 1 minute and 5 seconds. On 02/05/25 at 1:08 PM, Resident #2 was observed self-propelling down the hallway. The observation revealed That She was using both hands to turn the wheels on her wheelchair. No observations were made where her arms made contact with the wheelchair. On 02/05/25 at 1:18 PM, Resident #2 was observed self-propelling down the hallway. The observation revealed that she used both hands to turn the wheels on her wheelchair. No observations were made where her arms made contact with the wheelchair. During an interview on 2/4/25 at 2:04 PM, Resident #2 could not recall the incident on 1/08/25. She could not state if another resident, specifically Resident #1, had pushed her. When asked about the bruising on her arms, she could not recall where the bruising came from. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Crosbyton Nursing and Rehabilitation Center	222 N Farmer Crosbyton, TX 79322

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 2/4/25 at 2:54 PM, the BOM stated on 1/08/25 at 6:44 PM, she was in her office when she heard another resident (unknown) yelling, They are fighting! She said another resident (unknown) said, Someone hit your grandma! She stated that she asked Resident #1 if he was okay. She thought Resident #2 had hit him because she has a history of doing things (being physical with other residents) of that nature. The BOM stated Resident #1 told her that he did not hit her (Resident #2). She stated that she told LVN A that she would check the camera footage. She stated that once she had observed the camera footage, she had shown LVN A, and they both had observed Resident #1 swing at Resident #2 first. She said she observed physical contact between Resident #1 and #2. She said she asked LVN A to make a note of the incident. She said she was told by LVN A that she would notate and take care of notifications. The BOM said she was unsure if LVN A called the ADM and DON or just one of them. She said she believed that LVN A just called the DON because the ADM had been out due to having multiple surgeries. She said this was why she did not text or notify the ADM; she knew he was out and because LVN A was making the notifications. The BOM said she did not inform the DON because she observed LVN A on the phone with who she assumed was the DON. She stated she was not close enough to LVN A to know what she reported to the DON. The BOM stated she had been trained to report all allegations of abuse to the ADM, and if the ADM was unavailable, she had been trained to report to the charge nurse. She stated that is what she did on 1/08/25. She stated the ADM was not in the facility and reported to LVN A, the charge nurse at the time. She said she was unsure if the DON was in the facility at the time of the incident. She said she was also trained to check the cameras if there was any further concern, which was why she checked the cameras. She said no one (including the ADM and DON) had questioned her about what she observed on the cameras or about the bruising that was identified on 1/14/25. She stated that the maintenance and the ADM had access to her office, so if the ADM wanted to check the cameras, they could do so without her presence. She said she had been trained that resident-to-resident altercation was a form of abuse. The BOM stated she had a copy of the video surveillance footage and would provide it. She said she used her best judgment and saved a copy of the video because their system would erase it after several days. The BOM stated that she could not remember the date, but after the incident on 1/08/25, she followed up with the ADM. She said that Resident #2 had bruises on her arms and a busted blood vessel in her left eye. The BOM said that she took pictures of Resident #1 arms and eyes. She stated the pictures she took have a date of 1/16/25. She said she would provide the pictures to the investigator. She stated that when she spoke with the ADM about the bruising, he stated that the bruising did not coincide with the time of the incident on 1/08/25 but was concerned about the bruising inside the eye. She said that the ADM was looking at the bruising at the time, and no one knew where the bruising came from, but she expressed concern about the cause of the bruising. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 2/4/25 at 4:00 PM, the DON stated regarding following the facility policy, specifically not reporting abuse to include resident-to-resident altercation and injury of unknown origin to HHSC and the abuse preventionist, that a potential negative outcome for residents could be a severe injury. She said the purpose of having an abuse policy and following it was to ensure that the residents are given the quality of care that they need. The DON stated she was familiar with and had been trained on the facility's abuse policy. She said she was unaware of physical contact between Resident #1 and #2. She stated that their monitoring system related to the abuse policy and reporting was that she would check the 24-hour report if it were a weekday, and if it were a Monday, she would run a 72-hour report. She stated that if she is not at work, she is unsure if anyone will check the reports for concerning incidents. She said that she also checks the resident progress notes daily. The DON stated she was unaware of the bruising identified on 1/14/25. She said she would have been at work that day, but no one ever reported that Resident #2 had bruising on her arms. The DON stated that she and all of her staff had been trained on the abuse policy and that she was unaware of any staff who had not been trained. She also stated that she had been trained to report reportable incidents to HHSC. The DON stated that she expected all staff to follow the abuse policy and report all reportable incidents to HHSC. S [TRUNCATED]

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F 0609 Level of Harm - Minimal harm or potential for actual harm 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** 43344 Based on interviews and record review, the facility failed to ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, were reported immediately, but not later than 2 hours if the alleged violation involved abuse or neglect and resulted in bodily injury, to other officials (including the State Agency) and the Abuse Preventionist for 4 of 7 residents (Resident #1, #2, #3 and #4) reviewed for abuse. The ADM (Abuse Preventionist) failed to report the allegation of abuse to HHSC regarding the Resident-to-Resident altercation (Between Resident #1 and Resident #2) that occurred and was reported on 1/08/25 by the DON and LVN A within the appropriate time frame. The ADON and LVN B failed to report the allegation of abuse to the ADM (Abuse Preventionist) regarding the Resident-to-Resident altercation (Between Resident #2, #3 and #4) that occurred and was reported on 1/12/25 by LVN B to the ADON within the appropriate timeframe. The ADM (Abuse Preventionist) failed to report the allegation of abuse to include injury of unknown origin to HHSC regarding the bruising that was identified on Resident #2 on 1/14/25 within the appropriate timeframe. These failures could place residents as risk for abuse and neglect. Findings included: Record review of the facility policy, Abuse, Neglect, Exploitation or Misappropriation-Reporting and Investigating, Revised September 2022, revealed the following: Policy Statement All reports of resident abuse (including injuries of unknown) and neglect are reported to local, state and federal agencies (as required by current regulations) . Policy Interpretation and Implementation Reporting Allegations to Administer and Authorities If resident abuse and neglect or injury of unknown origin is suspected, the suspicion must be reported immediately to the administrator and other officials according to state law. The administrator or the individual making the allegation immediately reports his or her suspicion to the following persons or agencies: The state licensing/certification agency responsible for surveying/licensing the facility (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Immediately is defined as: Within two hours of an allegation involving abuse or result in serious bodily injury Within 24 hours of an allegation that does not involve abuse or result in serious bodily injury Record review of the facility policy, Resident-to-Resident Altercation , Revised September 2022, revealed the following: Policy Statement All altercations, including those that may represent resident-to-resident abuse, are reported to the nursing supervisor, the director of nursing services and to the administrator. Policy Interpretation and Implementation Occurrences of such incidents are promptly reported to the nurse supervisor, director of nursing and to the administrator. The Administrator will report the incident in accordance with the criteria established under Abuse, Neglect-Reporting and Investigating. Inquiries concerning resident-to-resident altercations are referred to the director of nurses or to the administrator. Resident #1 Record Review of Resident #1's face sheet, dated 02/04/25, revealed a [AGE] year-old male that was admitted to the facility on [DATE], with a diagnosis of Hepatitis C (a contagious viral liver infection). Record Review of Resident #1's Comprehensive MDS assessment dated [DATE], revealed under Section C, Cognitive Patterns, a BIMS score of 07, indicating the resident was severely cognitively impaired. Section E revealed Resident #1 did not exhibit physical behavior (hitting, kicking, pushing, scratching, grabbing, abusing) during the review period [E0200]. Section I Resident #1 had viral Hepatitis. Record review of Resident #1's Physician Order Summary Report, dated 02/04/25, revealed that Resident #1 was not taking any medications for Hepatitis C. Record review of Resident #1's care plan, dated 12/12/24, did not reveal a care plan regarding aggressive behavior but revealed his dx of hepatitis. His care plan did not reveal any revisions regarding the incident on 1/08/25. Record review of facility incident report, dated 1/08/25 revealed the following: Incident description: exact note that LVN A documented in Resident #1's progress note on 1/08/25. Action taken: Stated Resident #2 was assessed with no injuries. Injuries Observed at the time of the incident: No injuries at the time of the incident. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Predisposing Environmental Factors: Crowding Agencies/People Notified: Physician C, DON and Family Member D. Record review of the facility incident report, dated 2/4/25, revealed Resident #1 had a physical aggression-initiated incident on 1/08/25. Record review of Resident #1's progress notes, dated 12/03/24-2/4/25 revealed the following: *1/08/25 at 4:18 PM LVN A documented: LVN A was sitting at nursing station when another resident (unknown) yelled out, There is a fight in here! BOM and LVN A entered dining area and did not see any physical or verbal altercation. LVN A was informed by another resident (unknown) that Resident #1 hit Resident #2. BOM watched video, and it was verified Resident #1 initiated physical aggression while Resident #2 was sitting in her wc near the table he eats at. Resident #2 was not disturbing the table or making physical contact with anyone upon Resident pulling/pushing Resident #2's wc and swinging his fist backwards towards Resident #2. Resident #2 became agitated but quickly left the area. *1/08/25 at 5:10 PM LVN A documented: Resident #1 was educated on not placing hands on other residents and informed to get staff if there is an incident that needs to be addressed. Resident #1 voiced understanding. During an interview on 2/4/25 at 12:57 PM, LVN A stated the abuse preventionist was the ADM. She said that if she suspected or witnessed abuse, she had been trained to contact the ADM immediately. She said she had abuse training at the facility. She said she had been trained to separate the residents, perform a nursing assessment for injuries, and ensure that everyone was safe if there was a resident-to-resident altercation. She stated she had been trained to report all resident-to-resident altercations to the ADM. On 1/08/25, she said she was not in the dining room when the incident occurred with Resident #1 and #2. She stated that she had to look back at the video footage. She said when she looked at the footage, she observed Resident #2 sitting at the dining room table, and for some reason unknown to her, Resident #1 became frustrated. She said she observed Resident #1 push Resident #2's wheelchair, and Resident #2 rolled backward. She said Resident #2 rolled backward and did not come into contact with anything. She said Residents #1 and #2 did not make contact with each other. She said as a result, they ensured that both residents (Resident #1 and #2) were separated and safe. She said she did an incident report, assessed the residents, and then reported everything she observed on the video footage to the DON. She said that this was the first time Resident #1 had acted that way and did not have a history of physically aggressive behavior. She reported the incident to the DON and appropriate parties, such as doctors and family contact. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 2/4/25 at 2:43 PM, the DON stated that she understood that 1/08/25 Resident #2 was attempting to remove a decoration from the dining room table. She stated she was unsure if Resident #1 had told Resident #2 a couple of times about the table decoration, but maybe the way Resident #1 approached Resident #2 made her (Resident #2) mad. She said she did not report the incident to HHSC because LVN A reported no physical contact between Resident #1 and Resident #2. She stated that she considered a person's wheelchair an extension of their body because it was a part of their mobility, but she was never told that Resident #1 made contact with Resident #2's wheelchair. She stated that LVN A reported that Resident #1 attempted to swing at Resident #2 but did not make contact. She stated she spoke with the ADM that evening about the incident between Resident #1 and Resident #2 because he was not in the facility. She stated she did not remember what she reported to him (the ADM), but it had to be what was reported to her by LVN A. Resident #2 Record Review of Resident #2's face sheet, dated 2/04/25, revealed a [AGE] year-old female that was admitted to the facility on [DATE], with a diagnosis of Alzheimer's (memory loss), Restless leg syndrome (irresistible urge to move legs), intermittent explosive disorder (explosive outburst of anger). Record Review of Resident #2's Comprehensive MDS assessment dated [DATE], revealed under Section C, Cognitive Patterns, a BIMS score of 99, indicating the resident was unable to complete the interview. Section E revealed Resident #2 did not exhibit physical behavior (hitting, kicking, pushing, scratching, grabbing, abusing) during the review period [E0200]. Resident #2 did exhibit a presence and frequency of wandering 4-6 days but less than daily [E0900]. Resident #1's wandering did place her at significant risk of getting to a potentially dangerous place and significantly intruded on the privacy of others [E1000.] Record review of Resident #2's care plan, dated 10/12/24, revealed that she had an identified wandering behavior and also took medication (Depakote) related to be being combative. There was no care plan addressing aggressive behavior towards residents or the incident that occurred on 1/08/25. Record review of Resident #2's care plan, dated 10/12/24, revealed that she had a new care plan implemented 2/06/25 with a focus that addressed that Resident #2 had a potential to be physically aggressive when she feels threatened and or if someone had something that belonged to her and this was related to her dementia. The goal for the review period (2/06/25) revealed that Resident #2 would not harm self or others. The interventions implemented as of 2/06/25 revealed it was expected that staff attempt to redirect Resident #2 to another place or engage her in activities. The interventions also included recognizing Resident #2's trigger are when staff attempt to redirect her or when voices are raised. Other interventions included keeping her as busy as possible and administering medications as ordered. Record review of Resident #2's Physician's Order, dated 02/04/25, revealed: An order and start date of 1/20/25 for Depakote 250 MG 1 tablet by mouth 2 times a day for intermittent explosive disorder. Record review of facility incident report, dated 1/08/25 revealed the following: (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Incident description: LVN A was sitting at nursing station when another resident (unknown) yelled out, There is a fight in here! BOM and LVN A entered dining area and did not see any physical or verbal altercation. LVN A was informed by another resident (unknown) that Resident #1 hit Resident #2. BOM watched video, and it was verified Resident #1 initiated physical aggression while Resident #2 was sitting in her wc near the table he eats at. Resident #2 was not disturbing the table or making physical contact with anyone upon Resident pulling/pushing Resident #2's wc and swinging his fist backwards towards Resident #2. Resident #2 became agitated but quickly left the area. Action taken: Stated Resident #2 was assessed with no injuries. Injuries Observed at the time of the incident: No injuries at the time of the incident. Predisposing Environmental Factors: Crowding Agencies/People Notified: Physician I, DON and Family Member H. During an observation of the video provided by the BOM, the following was observed by the HHSC investigator: At the start of the video, from the start of the video to .29 seconds, Resident #1 is seated at the left side of the table while Resident #2 is rolling back and forth to his left. No contact was being made between Resident #1 and Resident #2. :29 seconds Resident #1 takes his left hand and grabs the push handle (right side) of Resident #2. Resident #2 appears startled as she looks around, uses her right hand, and attempts to grab the table. :35 seconds Resident #1 takes his left hand, grabs Resident #2's right armrest, and pushes her back. :35-:45 seconds Resident #1 appeared to say something verbally to Resident #2 (the exact wording is unknown due to the lack of audio, but the Resident's mouth was observed moving). :45 seconds Resident #1 takes his left arm and quickly swings back at Resident #2. It is difficult to see if Resident #1 made contact, but Resident #2's right arm moved back quickly. :46 seconds Resident #2 swings back with her right hand twice. The first time, she hit Resident #1 on his left arm, and the second hit him again but held on for a short duration. :50 seconds observed Resident #2 swing back again. It is unclear if contact was made in Resident #2's face, but it was in the vicinity. An unknown object fell to the floor. :51 seconds-1:00 minute Resident #2 grabs the back of Resident #1's chair and jerking back and forth. 1:00 minute Resident #1 begins to exit the dining room. The video ends at 1 minute and 5 seconds. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of facility incident report, dated 1/14/25 revealed the following: Incident description: upon Resident #2's shower, CNA (unidentified) reported scattered bruising BUE and one large Bruise RUE noted: Deep Purple/Deep. Resident #2 unable to give a description. Immediate Action taken: Assessed areas with no warmth, surrounding redness or increased tenderness noted. Predisposing Physiological Factors: Confused, gait balance, impaired memory, and incontinent Agencies/People Notified: Physician I, DON, ADON and Family Member H. Record review of the facility incident report, dated 2/4/25, revealed Resident #2 had a bruise identified on 1/14/25. Record review of the picture provided by the BOM on 2/4/25 titled Picture #1 of Resident #2 revealed the following: *Resident #2's left eye was dark red around the iris *Resident #2 had a large bruise on the right arm Record review of the picture provided by the BOM on 2/4/25 titled Picture #2 of Resident #2 revealed the following: *A large dark purple bruise on the upper right arm. * A small dark purple bruise on the right elbow. Observed one light, fading circular bruise near the right wrist. * Three small, light purple circular bruises on their left arm near the elbow. *Four small dark purple bruises scattered down towards Resident #2's left wrist. Record review of Resident #2's progress notes revealed the following: *1/12/25 at 5:12 PM LVN B documented: Resident #2 wanders in hallways and goes into other resident's room throughout shift. This is a common behavior for her. She will go in the room look around and come out. Rightly so the other residents are not happy with her behavior and do not want her to go into their room's. Family, administration and staff are aware and frequently redirect resident, she is compliant the majority of the time. However, some residents have taken it upon themselves to yell at her causing her to become defensive. This evening as residents were gathering in dining room she went into dining room as well. A male resident (unidentified) yelled at her to get out. This nurse redirected resident to hallway, gave her some crackers to keep her distracted. This nurse was coming out of another resident's room and saw resident wheel into dining room. Then nurse heard a male (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident (unidentified) yell out. This nurse went into dining room and removed resident from dining room. the same before mentioned male resident stated, She pulled my hair. A female resident stated, She did pull his hair, and she pulled her hair also. Residents' family member notified of her actions. The ADON notified as well. *1/14/25 at 10:49 AM LVN A documented: Upon Skin Assessment during Shower, CNA (unidentified) informed LVN A resident had multiple bruises BUE. Resident has behavior of wondering, self transfers, attempting to ambulate w/o assist with unsteady gait. Staff to continue to monitor resident to assure safe environment. *1/16/25 at 10:14 AM the ADON Documented: Resident #2 doesn't c/o pain from bruising , The ADON did note that when she (Resident #2) is using her arms to wheel her chair she does so with very big/hard strokes and the inside part of her arms are hitting the arm of the wheelchair. When the ADON asked where the bruises come from she just smiles and points up and says the lord jesus did it. During an interview on 2/4/25 at 2:54 PM, the BOM stated on 1/08/25 at 6:44 PM, she was in her office when she heard another resident (unknown) yelling, They are fighting! She said another resident (unknown) said, Someone hit your grandma! She stated that she asked Resident #1 if he was okay. She thought Resident #2 had hit him because she has a history of doing things (being physical with other residents) of that nature. The BOM stated that Resident #1 told her that he did not hit her (Resident #2). She stated that she told LVN A that she would check the camera footage. She stated that once she had observed the camera footage, she had shown LVN A, and they both had observed Resident #1 swing at Resident #2 first. She said she observed physical contact between Resident #1 and #2. She said she asked LVN A to make a note of the incident. She said she was told by LVN A that she would notate and take care of notifications. The BOM said she was unsure if LVN A called the ADM and DON or just one of them. She said she believed that LVN A just called the DON because the ADM had been out due to having multiple surgeries. She said this was why she did not text or notify the ADM; she knew he was out and because LVN A was making the notifications. The BOM said she did not inform the DON because she observed LVN A on the phone with who she assumed was the DON. She stated she was not close enough to LVN A to know what she reported to the DON. The BOM stated she had been trained to report all allegations of abuse to the ADM, and if the ADM was unavailable, she had been trained to report to the charge nurse. She stated that is what she did on 1/08/25. She stated the ADM was not in the facility and reported to LVN A, the charge nurse at the time. She said she was unsure if the DON was in the facility at the time of the incident. She said she was also trained to check the cameras if there was any further concern, which was why she checked the cameras. She said no one (including the ADM and DON) had questioned her about what she observed on the cameras or about the bruising that was identified on 1/14/25. She stated that the maintenance and the ADM had access to her office, so if the ADM wanted to check the cameras, they could do so without her presence. She said she had been trained that resident-to-resident altercation was a form of abuse. The BOM stated she had a copy of the video surveillance footage and would provide it. She said she used her best judgment and saved a copy of the video because their system would erase it after several days. The BOM stated that she could not remember the date, but after the incident on 1/08/25, she followed up with the ADM. She said that Resident #2 had bruises on her arms and a busted blood vessel in her left eye. The BOM said that she took pictures of Resident #1 arms and eyes. She stated the pictures she took have a date of 1/16/25. She stated that when she spoke with the ADM about the bruising, he stated that the bruising did not coincide with the time of the incident on 1/08/25 but was concerned about the bruising inside the eye. She said that the ADM was looking at the bruising at the time, and no one knew where the bruising came from, but she expressed concern about the cause of the bruising. (continued on next page)

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	675291	A. Building B. Wing	02/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Crosbyton Nursing and Rehabilitation Center	222 N Farmer Crosbyton, TX 79322

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 2/4/25 at 4:00 PM, the DON stated the potential negative outcome of not reporting reportable incidents to HHSC was that the incidents may not have been adequately investigated at the correct time. She stated failure to report to HHSC could lead to further incidents between residents. She stated that reporting incidents to HHSC was to protect the residents. She stated she was familiar with and had been trained to report reportable incidents to HHSC. She stated that she was unaware until her interview with the investigator that the bruising identified on Resident #2 on 1/14/25 was not reported to HHSC. She stated that the altercation with Resident #1 and #2 was not reported to HHSC. She stated that their system for monitoring and ensuring that reportable incidents are reported to HHSC was that they conducted in-service to staff. She stated they monitored risk management closely. She stated they also monitored the incident and accident report. She stated that if the staff had entered the bruising for Resident #2 had an unknown injury, that would have triggered her to look into it further, but instead, the staff entered the data as bruise. She stated she did not observe the bruising on Resident #2 because she was unaware that she had bruising. She stated she had been trained to report all allegations of ANE to HHSC. The DON stated she expected all allegations of abuse, including resident-to-resident altercations and injury of unknown origin, to be reported to HHSC. She stated that all staff members were responsible for reporting allegations to HHSC because anyone could report them, but she or the ADM could ultimately report them (allegations of ANE) to HHSC. She stated she did not report the injuries of unknown origin because she was unaware of the incident. She stated she did not report the altercation between the residents because it was reported that no contact was made between them (Residents #1 and #2). (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 2/4/25 at 4:30 PM, the ADM stated that on 1/08/25, he received a call from the DON, who explained that Residents #1 and #2 had an incident. He stated he asked her if there were any injuries. He was told by the DON that there were no injuries. He said he did not remember the specifics of what was reported by the DON but that whatever was reported was not alarming to him. He stated he read the incident report. He stated by the HHSC definition of abuse, the resident-to-resident altercation did not meet the definition of abuse and did not need to be reported. He stated that also, by HHSC standards, there were no injuries, so the incident involving Resident #1 and #2 on 1/08/25 did not have to be reported to HHSC. He stated that he did not observe the camera footage because he was not concerned about what was reported to him by the DON or what he read in the incident report. He stated the two residents involved did not have the cognitive ability to be affected psychosocially and that even if the two residents were cognitively intact, he would not have reported the incident to HHSC because, by HHSC standards, the definition of abuse was not met. The ADM said he read that the BOM reviewed the cameras and asked her about the altercation. When he asked her about the incident, the BOM reported that Resident #1 did swing back but did not make any contact. The ADM stated even if Resident #1 had made contact, he would not have reported it because there was no bruise. He stated Resident #1 did not know what he was doing. The ADM stated Resident #2 did have bruising all over her arm, but by HHSC definition, he did not report it. He stated HHSC said the injury had to be suspicious. He stated that if Resident #2's bruising had been suspicious, that would have been concerning to him. He stated a lot of residents are going to have bruising, especially on their arms. He stated he and the BOM both looked at the bruising. He stated that there was confusion about Resident #2 having a black eye, but when they observed her, she did not have a black eye. He said her eye was red but not concerning to him. He stated that as it relates to any incident, he expected all incidents to be reported to him. He stated if it was alarming, meets the definition of abuse, and there are injuries, he would report the incidents to HHSC. He stated the reason why he did not report the incident that occurred on 1/08/25 between Resident #1 and #2 was that it did not meet the definition of abuse, and there were no injuries. He stated he did not report the injury of unknown origin because it was not suspicious in nature or in a suspicious location. He stated he had been trained to report all allegations of abuse to HHSC. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 2/5/25 at 8:30 AM, LVN A stated on 1/14/25, she and the ADON were at the nursing station. She stated that she was informed by CNA C that when she (CNA C) showered Resident #2 on 1/14/25, she noticed the bruising on her (Resident #2's) arms. She (LVN A) stated she assessed Resident #2. She stated Resident #2 had bruising on both of her upper extremities. She stated there was scattered bruising on both arms. She described the bruising as BUE and dark purple with some yellow color. She stated the darker purple was on the inside of her arms. She stated before this stage that the bruising would have had some redness if it had been fresh. She stated she did not see any bruising to her eye at the time. LVN A stated in her nursing experience that bruising of that (dark purple with some yellow) color meant the bruising was about 3-4 days old. She stated the bruising was resolving and not fresh. LVN A stated she had worked the previous Friday (1/10/25), and the bruising was not there as no one brought it to her attention. She stated that she was off over the weekend. She stated she did not report the incident to the ADM because she was familiar with all documented incidents being reviewed by management. She stated that Resident #2 has a behavior of wandering and attempting to transfer herself. LVN A stated Resident #2 could not say what happened to her and that she (LVN A) had not witnessed what had caused or could have caused the bruising. LVN A stated that regarding the incident that occurred on 1/08/25 with Resident #1 and #2, she did not report it to the ADM. She said similar to the injury of unknown origin, she was familiar with management reviewing the documented incident and had reported the incident to the DON. She stated she did not feel that the behavior she observed regarding Resident #1 was intentional but more of an agitation. She admitted that she reviewed the surveillance with the BOM but did not observe any physical contact with Residents #1 and #2. During an interview on 2/5/25 at 9:14 AM, the ADON stated on 1/14/25, she and LVN A were standing at the nurse's station. She stated a certified nurse's aide (unsure who it was) came and requested for LVN A to look at bruising on Resident #2. The ADON stated she also observed the area, and on Resident #2 arm (right), she observed where her muscle was, and there was a bruise. She stated on Resident #2's arm (left), there were multiple bruises. She was unsure how many. She stated she had LVN A write an incident report. The ADON stated she had difficulty remembering that far back as it related to the details of that day. She stated she did observe Resident #2 moving in her wheelchair and believed that was where the bruise could have come from. She stated that Resident #2 would also dig in boxes, and the bruises on her left arm could have come from her digging in boxes. She stated that she felt nothing alarming when she observed the bruising. She stated that the bruising she observed was mixed blue and yellow. She stated that Resident #2 had never had bruising like she had observed before. She stated she did not observe bruising on Resident #2's eye that day (1/16/25). She stated that on 1/16/25, the ADM did have her look at Resident #2 because of the bruising and potential eye injury. She stated there was no bruising to the eye. She stated she could not remember the ADM's exact wording when he spoke to her, but it was enough for her to take a look at Resident #2 bruising and eye. She stated that when she looked at Resident #2's left eye, it was a little bloodshot, but it appeared red from the moment she woke up. She stated as it related to the bruising on her arms, Resident #2 would look up and say, The Lord Jesus Christ did it when asked what happened. The ADON stated Resident #2was not cognitive enough to recall. She stated that if it were a concerning bruise, they would report it to HHSC. She stated concerning areas such as the face, breast area, back, or groin area are areas they would consider suspicious if bruising appeared in those areas. She stated injuries in those areas would alarm her. She stated that they look at each individual separately, but if they have a history of bruising on their forearms, they try to prevent the bruising. She stated she had been trained on the abuse policy, and she stated the potential negative outcome for not reporting injuries of unknown origin to HHSC or the abuse preventionist was the injury could go without treatment and cause further injury. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 2/5/25 at 1:35 PM, the ADM stated that Resident #2's eye was red on 1/16/25. He stated it did not concern him. He stated it looked like something could have gotten in her eye, and maybe Resident #2 rubbed it. He stated the potential negative outcome of not reporting incidents to HHSC was that it could jeopardize the safety of the residents. During an interview on 2/6/25 at 11:30 AM, CNA C stated she was the shower aide and provided all showers for the residents at the NF. She said the abuse preventionist was the ADM, and if she suspected or witnessed abuse, she had been trained to separate the resident from the abuser and report it to the charge nurse. She stated she had received abuse training. CNA C stated that 1/14/25, she was the staff member who got Resident #2 up for the morning. She stated that Resident #2 had bruising on the inside of her left arm. She stated the bruising was still on Resident #2's arm. She stated she did not know how Resident #2 received the bruising. She reported the bruising to LVN B as she had been trained to do. She stated LVN B asked her what happened to Resident #2, and she explained to LVN B that she did not know. CNA C stated Resident #2 could not remember what happened. CNA C stated Resident #2 was not in any pain on 1/14/25. CNA C stated that LVN A did an assessment on her computer of Resident #2. CNA C stated she knew nothing that could have caused Resident #2's arm bruising. She stated that Resident #2 received her showers on Tuesdays, Thursdays, and Saturdays. She stated the bruises were identified on Tuesday (1/14/25) and did not shower Resident #2 on Saturday (1/12/25) as she called in that day. She stated that the previous Thursday (1/09/25), she showered Resident #2, but the bruising was not present. CNA C stated she does not document showers or skin assessments, but if she does find anything, she reports it to the CNAs and the nurses. She stated she did not have a reason why she did not report the injuries to the ADM. During an interview on 2/4/25 at 9:57 AM, LVN B stated on 1/12/25, she heard another resident yelling. She stated she went to the dining room, and a resident (unknown) reported that Resident #2 had pulled Resident #3 and Resident #4's hair. LVN B stated she immediately redirected Resident #2 out of the dining room. She stated she assessed all three residents to ensure they were okay. She stated she did not note any injuries. She stated she immediately notified the ADON and all appropriate parties, such as the family, of what happened. Resident #3 Record Review of Resident #3's face sheet, dated 02/04/25, revealed a [AGE] year-old male that was admitted to the facility on [DATE], with a diagnosis of anxiety (increased worry) and lack of coordination. Record Review of Resident #3's Comprehensive MDS assessment dated [DATE], revealed under Section C, Cognitive Patterns, a BIMS score of 08, indicating the resident was moderately cognitively impaired. Section E revealed Resident #3 did not exhibit physical behavior (hitting, kicking, pushing, scr [TRUNCATED]

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43344 Based on interviews and record reviews the facility failed to have evidence all allegations of abuse, neglect or mistreatment were thoroughly investigated for 3 of 7 residents (Resident #1, #2, #3 and #4) reviewed for abuse. The ADM (Abuse Preventionist) failed to document and conduct an investigation regarding the Resident-to-Resident altercation (Between Resident #1 and Resident #2) that occurred and was reported on 1/08/25 by the DON and LVN A. The ADM (Abuse Preventionist) failed to document and conduct an investigation regarding the Resident-to-Resident altercation (Between Resident #2, #3 and #4) that occurred and was reported on 1/12/25 by LVN B to the ADON. The ADM (Abuse Preventionist) failed to document and investigate regarding the bruising that was identified on Resident #2 on 1/14/25. These failures could place residents as risk for abuse and neglect by not investigating allegations of abuse, neglect, exploitation, or mistreatment. Findings included: Resident #1 Record Review of Resident #1's face sheet, dated 02/04/25, revealed a [AGE] year-old male that was admitted to the facility on [DATE], with a diagnosis of Hepatitis C (a contagious viral liver infection). Record Review of Resident #1's Comprehensive MDS assessment dated [DATE], revealed under Section C, Cognitive Patterns, a BIMS score of 07, indicating the resident was severely cognitively impaired. Section E revealed Resident #1 did not exhibit physical behavior (hitting, kicking, pushing, scratching, grabbing, abusing) during the review period [E0200]. Section I Resident #1 had viral Hepatitis. Record review of Resident #1's Physician Order Summary Report, dated 02/04/25, revealed that Resident #1 was not taking any medications for Hepatitis C. Record review of Resident #1's progress notes, dated 12/03/24-2/4/25 revealed the following: *1/08/25 at 4:18 PM LVN A documented: LVN A was sitting at nursing station when another resident (unknown) yelled out, There is a fight in here! BOM and LVN A entered dining area and did not see any physical or verbal altercation. LVN A was informed by another resident (unknown) that Resident #1 hit Resident #2. BOM watched video, and it was verified Resident #1 initiated physical aggression while Resident #2 was sitting in her wc near the table he ate at. Resident #2 was not disturbing the table or making physical contact with anyone upon Resident pulling/pushing Resident #2's wc and swinging his fist backwards towards Resident #2. Resident #2 became agitated but quickly left the area. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	*1/08/25 at 5:10 PM LVN A documented: Resident #1 was educated on not placing hands on other residents and informed to get staff if there was an incident that needs to be addressed. Resident #1 voiced understanding. Record review of Resident #1's care plan, dated 12/12/24, did not reveal a care plan regarding aggressive behavior but revealed his dx of hepatitis. His care plan did not reveal any revisions regarding the incident on 1/08/25. Record review of facility incident report, dated 1/08/25 revealed the following: Incident description: exact note that LVN A documented in Resident #1's progress note on 1/08/25. Action taken: Stated Resident #2 was assessed with no injuries. Injuries Observed at the time of the incident: No injuries at the time of the incident. Predisposing Environmental Factors: Crowding Agencies/People Notified: Physician C, DON and Family Member D. Record review of the facility incident report, dated 2/4/25, revealed the following: Resident #1 had a physical aggression-initiated incident on 1/08/25. During an interview on 2/4/25 at 12:57 PM, LVN A stated the abuse preventionist was the ADM. She said if she suspected or witnessed abuse, she had been trained to contact the ADM immediately. She said she had abuse training at the facility. She said she had been trained to separate the residents, perform a nursing assessment for injuries, and ensure everyone was safe if there was a resident-to-resident altercation. On 1/08/25, she said she was not in the dining room when the incident occurred with Residents #1 and #2. She stated she had to look back at the video footage. She said when she looked at the footage, she observed Resident #2 sitting at the dining room table, and for some reason unknown to her, Resident #1 became frustrated. She said she observed Resident #1 push Resident #2's wheelchair, and Resident #2 rolled backward. She said Resident #2 rolled backward and did not come into contact with anything. She said Residents #1 and #2 did not make contact with each other. She said as a result, they ensured both residents (Resident #1 and #2) were separated and safe. She said she did an incident report, assessed the residents, and then reported everything she observed on the video footage to the DON. She said this was the first time Resident #1 had acted that way and did not have a history of physically aggressive behavior. She reported the incident to the DON and appropriate parties, such as doctors and family contact. During an interview on 2/4/25 at 1:48 PM, Resident #1 could not recall specifics about the incident on 1/08/25. He stated he might have pushed them, but they asked for it. He said he did not know the other resident's name. He could not report if the other resident were male or female. He stated that they went crying to momma. He said he would handle his issues with [NAME] and [NAME]. He verified that [NAME] and [NAME] were his left and right hands. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 2/4/25 at 2:23 PM, the ADON stated the ADM was the abuse preventionist. She said if she suspected or witnessed abuse, she had been trained to remove the resident from the area where the abuse was occurring. She said she would go to the ADM, and if he were unavailable, she would go to the DON. She said if a resident-to-resident altercation had occurred, she had been trained to separate the residents, assess for injuries, and report the incident to the ADM and the DON. She stated regarding the incident on 1/08/25, it was her understanding that Resident #2 was attempting to grab something off the dining room table. Resident #1 did not like it, and some yanking and pulling was involved. The ADON stated that she did not witness the incident. During an interview on 2/4/25 at 2:43 PM, the DON stated she understood on 1/08/25 Resident #2 was attempting to remove a decoration from the dining room table. She stated she was unsure if Resident #1 had told Resident #2 a couple of times about the table decoration, but maybe the way Resident #1 approached Resident #2 made her (Resident #2) mad. She stated she considered a person's wheelchair an extension of their body because it was a part of their mobility, but she was never told Resident #1 made contact with Resident #2's wheelchair. She stated that LVN A reported that Resident #1 attempted to swing at Resident #2 but did not make contact. She stated she (the DON) did not observe any camera footage. She stated the camera video surveillance was located in the BOM's office, which would be the only way LVN A could have observed the footage. The DON stated she had no documentation to show she looked into the incident on 1/08/25. She stated she spoke with the ADM that evening about the incident between Resident #1 and Resident #2 because he was not in the facility. She stated she did not remember what she reported to him (the ADM), but it had to be what was reported to her by LVN A. Resident #2 Record Review of Resident #2's face sheet, dated 2/04/25, revealed a [AGE] year-old female that was admitted to the facility on [DATE], with a diagnosis of Alzheimer's (memory loss), Restless leg syndrome (irresistible urge to move legs), intermittent explosive disorder (explosive outburst of anger). Record Review of Resident #2's Comprehensive MDS assessment dated [DATE], revealed under Section C, Cognitive Patterns, a BIMS score of 99, indicating the resident was unable to complete the interview. Section E revealed Resident #2 did not exhibit physical behavior (hitting, kicking, pushing, scratching, grabbing, abusing) during the review period [E0200]. Resident #2 did exhibit a presence and frequency of wandering 4-6 days but less than daily [E0900]. Resident #1's wandering did place her at significant risk of getting to a potentially dangerous place and significantly intruded on the privacy of others [E1000.] Record review of Resident #2's care plan, dated 10/12/24, revealed that she had an identified wandering behavior and also took medication (Depakote) related to be being combative. Resident #2's care plan also revealed that she had a new care plan implemented 2/06/25 with a focus that addressed that Resident #2 had a potential to be physically aggressive when she feels threatened and or if someone had something that belonged to her and this was related to her dementia. The goal for the review period (2/06/25) revealed that Resident #2 would not harm self or others. The interventions implemented as of 2/06/25 revealed it was expected that staff attempt to redirect Resident #2 to another place or engage her in activities. The interventions also included recognizing Resident #2's trigger are when staff attempt to redirect her or when voices are raised. Other interventions included keeping her as busy as possible and administering medications as ordered. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #2's Physician's Order, dated 02/04/25, revealed: An order and start date of 1/20/25 for Depakote 250 MG 1 tablet by mouth 2 times a day for intermittent explosive disorder. Record review of Resident #2's progress notes, dated 10/01/24- 02/04/2025 revealed the following: *10/07/24 at 3:26 PM LVN A documented: Resident #2 wandering up and down the hallways. Resident #2 was agitated. LVN A redirecting Resident #2 from entering other residents (unidentified) rooms. Resident #2 cognitive impairment and decreased ability to understand/follow directions. *11/02/25 at 5:52 PM LVN G documented: Resident #2 getting into other resident bed and when moved she pinched staff and yelled out that they were hitting staff. *11/08/24 at 11:10 AM LVN A documented: Resident #2 became agitated upon CNA (unidentified) removing items from residents wc that residents (unidentified) room. When CNA (unidentified) removed items, resident threw water on CNA (unidentified). Resident #2 proceeded to the dining room and picked up a cup of juice and threw it on the CNA (unidentified). *11/09/24 at 12:12 PM LVN A documented: Resident #2 getting into roommate's snacks/drinks. Upon staff attempting to retrieve items, Resident #2 became agitated and attempted physical aggression. *11/09/24 1:14 PM LVN A documented: Resident #2 wandered into another resident's (unidentified) room and took his peanut M&M bag; DON notified and stated she would replace it for the resident (identified). Resident (unidentified) informed and voiced frustration of not being able to keep things in his d/t Resident #2 going in his room attempting to take things. *11/11/24 at 11:53 PM LVN G documented: Resident #2 kept going into other residents (unidentified) rooms and would get into their drawers and get their snacks or their personal. *12/01/24 at 5:39 PM LVN B documented: Resident #1 spent most of shift going into others rooms. Resident #2 was redirected with no improvement. Resident #2 was playing with a chain attached to a door and when asked to stop she took the chain swinging it striking the aide on the arm. *12/21/24 at 2:59 PM LVN A documented: Resident #2 agitated and following other residents around. *1/05/25 at 11:33 AM LVN A documented: Resident #2 has become more agitated, defensive upon staff attempting to redirect, actively going into rooms taking other Residents belongings, and appears anxious with inability to relax. Upon reviewing residents' orders, LVN A noted Depakote was discontinued 11/24/24. If behaviors continue, LVN A will contact PCP to see if Depakote can be resumed. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Crosbyton Nursing and Rehabilitation Center	222 N Farmer Crosbyton, TX 79322

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	*1/12/25 at 5:12 PM LVN B documented: Resident #2 wanders in hallways and goes into other resident's room throughout shift. This is a common behavior for her. She will go in the room look around and come out. Rightly so the other residents are not happy with her behavior and do not want her to go into their room's. Family, administration and staff are aware and frequently redirect resident, she is compliant the majority of the time. However, some residents have taken it upon themselves to yell at her causing her to become defensive. This evening as residents were gathering in dining room she went into dining room as well. A male resident (unidentified) yelled at her to get out. This nurse redirected resident to hallway, gave her some crackers to keep her distracted. This nurse was coming out of another resident's room and saw resident wheel into dining room. Then nurse heard a male Resident (unidentified) yell out. This nurse went into dining room and removed resident from dining room. the same before mentioned male resident stated, She pulled my hair. A female resident stated, She did pull his hair, and she pulled her hair also. Residents' family member notified of her actions. The ADON notified as well. *1/12/25 at 5:33 PM LVN B documented: a Psychiatric referral was made. *1/14/25 at 10:49 AM LVN A documented: Upon Skin Assessment during Shower, CNA (unidentified) informed LVN A resident had multiple bruises BUE. Resident has behavior of wondering, self transfers, attempting to ambulate w/o assist with unsteady gait. Staff to continue to monitor resident to assure safe environment. *1/16/25 at 10:14 AM the ADON Documented: Resident #2 doesn't c/o pain from bruising , The ADON did note that when she (Resident #2) is using her arms to wheel her chair she does so with very big/hard strokes and the inside part of her arms are hitting the arm of the wheelchair. When the ADON asked where the bruises come from she just smiles and points up and says the lord jesus did it. *1/20/25 at 5:18 PM The Psychiatric Provider Documented: Meeting with facility staff indicates the patient has: Normal appetite. No anxiety and no irritability, and no hostility toward peer(s). No hostility toward caregivers. *1/20/25 at 3:18 PM LVN B documented: The Psychiatric Provider in house for rounds. New order for Depakote 125mg BID received at this time. *1/31/25 at 2:59 PM The Psychiatric Provider Documented: Meeting with facility staff indicates the patient has: Normal appetite. No anxiety and no irritability, and no hostility toward peer(s). No hostility toward caregivers *2/03/25 at 3:15 PM LVN B documented: The Psychiatric Provider in house for rounds. No New orders received at this time. Will continue to monitor Resident #2. *2/03/25 at 4:03 PM The Psychiatric Provider Documented: Meeting with staff reveals: Meeting with facility staff indicates the patient has: Normal appetite. No anxiety and no hostility towards peer(s). No hostility towards caregivers. Record review of facility incident report, dated 11/08/24 revealed the following: (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Incident description: Nursing (unidentified) witnessed Resident #2 throw water on CNA (unidentified) d/t CNA (unidentified) removing belongings from residents wc that Resident #2 had taken from another residents (unidentified) room. And Resident #2 was unable to give a description of what happened. Action taken: Resident #2 was redirected but it was unsuccessful. Injuries Observed at the time of the incident: No injuries at the time of the incident. Agencies/People Notified: Physician I, DON, ADON and Family Member H. Record review of facility incident report, dated 1/08/25 revealed the following: Incident description: LVN A was sitting at nursing station when another resident (unknown) yelled out, There is a fight in here! BOM and LVN A entered dining area and did not see any physical or verbal altercation. LVN A was informed by another resident (unknown) that Resident #1 hit Resident #2. BOM watched video, and it was verified Resident #1 initiated physical aggression while Resident #2 was sitting in her wc near the table he eats at. Resident #2 was not disturbing the table or making physical contact with anyone upon Resident pulling/pushing Resident #2's wc and swinging his fist backwards towards Resident #2. Resident #2 became agitated but quickly left the area. Action taken: Stated Resident #2 was assessed with no injuries. Injuries Observed at the time of the incident: No injuries at the time of the incident. Predisposing Environmental Factors: Crowding Agencies/People Notified: Physician I, DON and Family Member H. Record review of facility incident report, dated 1/14/25 revealed the following: Incident description: upon Resident #2's shower, CNA (unidentified) reported scattered bruising BUE and one large Bruise RUE noted: Deep Purple/Deep. Resident #2 unable to give a description. Immediate Action taken: Assessed areas with no warmth, surrounding redness or increased tenderness noted. Predisposing Physiological Factors: Confused, gait balance, impaired memory, and incontinent Agencies/People Notified: Physician I, DON, ADON and Family Member H. Record review of the facility incident report, dated 2/4/25, revealed the following: Resident #2 had a physical aggression-initiated incident on 11/08/24 (x2) and 12/26/24. Resident #2 had a bruise identified on 1/14/25. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the picture provided by the BOM on 2/4/25 titled Picture #1 of Resident #2 revealed the following: Resident #2's left eye was dark red around the iris Resident #2 had a large bruise on the right arm Record review of the picture provided by the BOM on 2/4/25 titled Picture #2 of Resident #2 revealed the following: Resident #2 had a large dark purple bruise on the upper right arm. Observed a small dark purple bruise on the right elbow. Observed one light, fading circular bruise near the right wrist. Resident #2 had three small, light purple circular bruises on their left arm near the elbow. Observed four small dark purple bruises scattered down towards Resident #2's left wrist. During an observation of the video provided by the BOM, the following was observed by the HHSC investigator: At the start of the video, from the start of the video to .29 seconds, Resident #1 is seated at the left side of the table while Resident #2 is rolling back and forth to his left. No contact was being made between Resident #1 and Resident #2. :29 seconds Resident #1 takes his left hand and grabs the push handle (right side) of Resident #2. Resident #2 appears startled as she looks around, uses her right hand, and attempts to grab the table. :35 seconds Resident #1 takes his left hand, grabs Resident #2's right armrest, and pushes her back. :35-:45 seconds Resident #1 appeared to say something verbally to Resident #2 (the exact wording is unknown due to the lack of audio, but the Resident's mouth was observed moving). :45 seconds Resident #1 takes his left arm and quickly swings back at Resident #2. It is difficult to see if Resident #1 made contact, but Resident #2's right arm moved back quickly. :46 seconds Resident #2 swings back with her right hand twice. The first time, she hit Resident #1 on his left arm, and the second hit him again but held on for a short duration. :50 seconds observed Resident #2 swing back again. It is unclear if contact was made in Resident #2's face, but it was in the vicinity. An unknown object fell to the floor. :51 seconds-1:00 minute Resident #2 grabs the back of Resident #1's chair and jerking back and forth. 1:00 minute Resident #1 begins to exit the dining room. The video ends at 1 minute and 5 seconds. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 02/05/25 at 1:08 PM, Resident #2 was observed self-propelling down the hallway. The observation revealed That She was using both hands to turn the wheels on her wheelchair. No observations were made where her arms made contact with the wheelchair. On 02/05/25 at 1:18 PM, Resident #2 was observed self-propelling down the hallway. The observation revealed that she used both hands to turn the wheels on her wheelchair. No observations were made where her arms made contact with the wheelchair. During an interview on 2/4/25 at 2:04 PM, Resident #2 could not recall the incident on 1/08/25. She could not state if another resident, specifically Resident #1, had pushed her. When asked about the bruising on her arms, she could not recall where the bruising came from. During an interview on 2/4/25 at 2:54 PM, the BOM stated on 1/08/25 at 6:44 PM, she was in her office when she heard another resident (unknown) yelling, They are fighting! She said another resident (unknown) said, Someone hit your grandma! She stated that she asked Resident #1 if he was okay. She thought Resident #2 had hit him because she has a history of doing things (being physical with other residents) of that nature. The BOM stated Resident #1 told her that he did not hit her (Resident #2). She stated that she told LVN A that she would check the camera footage. She stated that once she had observed the camera footage, she had shown LVN A, and they both had observed Resident #1 swing at Resident #2 first. She said she observed physical contact between Resident #1 and #2. She said she asked LVN A to make a note of the incident. She said she was told by LVN A that she would notate and take care of notifications. The BOM said she was unsure if LVN A called the ADM and DON or just one of them. She said she believed that LVN A just called the DON because the ADM had been out due to having multiple surgeries. She said this was why she did not text or notify the ADM; she knew he was out and because LVN A was making the notifications. The BOM said she did not inform the DON because she observed LVN A on the phone with who she assumed was the DON. She stated she was not close enough to LVN A to know what she reported to the DON. She said she was also trained to check the cameras if there was any further concern, which was why she checked the cameras. She said no one (including the ADM and DON) had questioned her about what she observed on the cameras or about the bruising that was identified on 1/14/25. She stated that the maintenance and the ADM had access to her office, so if the ADM wanted to check the cameras, they could do so without her presence. She said she had been trained that resident-to-resident altercation was a form of abuse. The BOM stated she had a copy of the video surveillance footage and would provide it. She said she used her best judgment and saved a copy of the video because their system would erase it after several days. The BOM stated that she could not remember the date, but after the incident on 1/08/25, she followed up with the ADM. She said that Resident #2 had bruises on her arms and a busted blood vessel in her left eye. The BOM said that she took pictures of Resident #1 arms and eyes. She stated the pictures she took have a date of 1/16/25. She said she would provide the pictures to the investigator. She stated that when she spoke with the ADM about the bruising, he stated that the bruising did not coincide with the time of the incident on 1/08/25 but was concerned about the bruising inside the eye. She said that the ADM was looking at the bruising at the time, and no one knew where the bruising came from, but she expressed concern about the cause of the bruising. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 2/5/25 at 8:30 AM, LVN A stated on 1/14/25, she and the ADON were at the nursing station. She stated that she was informed by CNA C that when she (CNA C) showered Resident #2, she noticed the bruising on her (Resident #2's) arms. She (LVN A) stated she assessed Resident #2. She stated Resident #2 had bruising on both of her upper extremities. She stated there was scattered bruising on both arms. She described the bruising as BUE and dark purple with some yellow color. She stated the darker purple was on the inside of her arms. She stated before this stage that the bruising would have had some redness if it had been fresh. She stated she did not see any bruising to her eye at the time. LVN A stated in her nursing experience that bruising of that (dark purple with some yellow) color meant the bruising was about 3-4 days old. She stated the bruising was resolving and not fresh. LVN A stated she had worked the previous Friday (1/10/25), and the bruising was not there as no one brought it to her attention. She stated that she was off over the weekend. She stated she did not report the incident to the ADM because she is familiar with all documented incidents being reviewed by management. She stated that Resident #2 has a behavior of wandering and attempting to transfer herself. LVN A stated that Resident #2 could not say what happened to her and that she (LVN A) had not witnessed what had caused or could have caused the bruising. LVN A stated that regarding the incident that occurred on 1/08/25 with Resident #1 and #2, she did not report it to the ADM. She said similar to the injury of unknown origin, she was familiar with management reviewing the documented incident and had reported the incident to the DON. She stated she did not feel that the behavior she observed regarding Resident #1 was intentional but more of an agitation. She admitted that she reviewed the surveillance with the BOM but did not observe any physical contact with Residents #1 and #2. She stated she had not been interviewed about the incident on 1/08/25, nor was she interviewed or questioned about the bruising on Resident #2, identified on 1/12/25. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 2/5/25 at 9:14 AM, the ADON stated on 1/14/25, she and LVN A were standing at the nurse's station. She stated a certified nurse's aide (unsure who it was) came and requested for LVN A to look at bruising on Resident #2. The ADON stated she also observed the area, and on Resident #2 arm (right), she observed where her muscle was, and there was a bruise. She stated on Resident #2's arm (left), there were multiple bruises. She was unsure how many. She stated she had LVN A write an incident report. The ADON stated she had difficulty remembering that far back as it related to the details of that day. She stated she did observe Resident #2 moving in her wheelchair and believed that was where the bruise could have come from. She stated that Resident #2 would also dig in boxes, and the bruises on her left arm could have come from her digging in boxes. She stated that she felt nothing alarming when she observed the bruising. She stated that the bruising she observed was mixed blue and yellow. She stated that Resident #1 had never had bruising like she had observed before. The ADON stated she did ask around on 1/14/25 but did not document it, nor did she know specifically who and what she asked. She stated she did not observe bruising on Resident #2's eye that day (1/16/25). She stated that on 1/16/25, the ADM did have her look at Resident #2 because of the bruising and potential eye injury. She stated there was no bruising to the eye. She stated she could not remember the ADM's exact wording when he spoke to her, but it was enough for her to take a look at Resident #2 bruising and eye. She stated that when she looked at Resident #2's left eye, it was a little bloodshot, but it appeared red from the moment she woke up. She stated as it related to the bruising on her arms, Resident #2 would look up and say, The Lord Jesus Christ did it when asked what happened. The ADON stated Resident #2 is not cognitive enough to recall. The ADON stated she had been trained when there was an injury of unknown origin to find out if it was an area that was concerning, and that is when they needed to find out what happened. She stated concerning areas such as the face, breast area, back, or groin area are areas they would consider suspicious if bruising appeared in those areas. She stated injuries in those areas would alarm her. She stated that they look at each individual separately, but if they have a history of bruising on their forearms, they try to prevent the bruising. She stated that if the residents cannot tell them what happened, they must continue to find out what happened. She stated that the potential negative outcome of not investigating or thoroughly investigating an injury of unknown origin was the injury could go without treatment and cause further injury. During an interview on 2/4/25 at 9:57 AM, LVN B stated Resident #2 had a history of wandering. She stated that the residents are unhappy when she (Resident #2) wande [TRUNCATED]