STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675358	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/24/2024
NAME OF PROVIDER OR SUPPLIER: Colonial Pines Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 1203 Fm 1277 San Augustine, TX 75972	

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** 43872 Based on observations, interviews, and record reviews, the facility failed to ensure residents were free from verbal abuse for one of twelve residents (Resident #1) reviewed for abuse. 1. The facility failed to prevent verbal abuse for Resident #1 witnessed by CNA A and CNA B to have been told to shut up and you are the one who shit on yourself by CNA C on 03/26/2024 at approximately 1:00 p.m. during incontinence care. The noncompliance was identified as PNC that began on 03/26/2024 and ended on 04/02/2024. The facility had corrected the noncompliance before the survey began. This failure could place residents at risk for psychosocial harm and further abuse. Findings included: Review of a face sheet for Resident #1, dated 04/24/2024, revealed he was an [AGE] year-old male admitted to the facility on [DATE] and had diagnoses including: type 2 diabetes mellitus with hyperglycemia (high blood pressure), non-ketotic hyperglycinemia (metabolic accumulation of large amounts of glycine in blood, urine, and cerebrospinal fluid, acute kidney failure, Chronic kidney disease, stage 3, seizures, Essential (primary) hypertension high blood pressure), Personal history of transient ischemic attack (stroke), and cerebral infarction without residual deficits, Chronic obstructive pulmonary disease (lung disease). Review of Resident #1's Quarterly MDS, dated [DATE], revealed he had a Brief Interview for Mental Status (BIMS) score of 09, indicating moderate cognitive impairment. Resident #1's behavior and functional status revealed he had no physical or verbal behavioral symptoms or decrease in mood or social isolation, had impairment to both upper and lower extremities, and required substantial/maximal assistance with toileting hygiene. (continued on next page)

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

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

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #1's care plan, revised 04/01/2024, revealed he had an anti-anxiety and antidepressant goal in place for resident to be free of any discomfort or adverse side effects within the next 90 days initiated on 3/26/2024 to include the following interventions: monitor behaviors every shift, offer non-pharmacological interventions, and administer medication as ordered, Monitor closely for worsening of depression and/or suicidal behavior or thinking, especially during initiation of therapy and during any changes in dosage, and monitor for interaction/adverse side effects of anxiety, nervousness, insomnia, somnolence, weight gain, anorexia, or increased appetite. Review of incident statement, dated 03/26/2024, signed by Administrator, revealed the following: Reported to me that resident was placed in the bed for incontinent care. When resident was turned by aide [CNA C], the resident hollered out, ouch you hurt me. The aide [CNA C] was overheard by [CNA A] and [CNA B] to say, shut up. You're the one that shit yourself. [CNA A] left the room and reported the incident initially to [LVN D]. [LVN D] brought [CNA C] into my office to discuss allegations. [CNA B] was in turn brought into my office and questioned about the allegations. The incident was in turn reported to the administrator. [CNA C] was questioned regarding the allegations. Review of witness statement, dated 03/26/2024, signed by CNA A, revealed the following: I walked into [Resident #1's] room looking for the other aides. They were in the middle of a bed change, and they were pulling him up in the bed and he said ouch you're hurting me and [CNA C] said shut up you're the one that shit all over yourself. Review of witness statement, dated 03/26/2024, signed by CNA B, revealed the following: I was changing [Resident #1] and he had a huge blowout [bowel movement]. I turned him to pull the brief and noticed he had bowel going up his back and needed new sheets so [CNA C] went [and] got some sheets. She came back and when we were turning him to change sheet and briefs [CNA C] turned [Resident #1] and he said ow because his hip hurt and [CNA C] told him 'Shut up, I don't know why you are complaining you are the one that shit all over his self.' Review of witness statement, dated 03/26/2024, signed by CNA C, revealed the following: CNA walked into room to help other CNA with resident put back into the bed due to needing to be changed. When changing patient, noticed he had poop all the way up his back when lifting [patient] up to change him to get the poop off his back and to take his shirt off. He was complaining of him hurting this CNA said hush we are trying to not get poop on your face and continued to get the poop off resident. Review of witness statement, dated 03/26/2024, signed by LVN D and ADON, revealed the following: [Resident #1]. While I was in resident's room for incontinent care, I asked resident if a CNA talked ugly to him earlier in the day. Resident stated 'yes, she did but I didn't tell the other lady because I didn't want to get her in trouble. People need their jobs.' I told resident no one is allowed to curse at them or talk rudely to them. Resident's roommate stated 'Miss [LVN D] come here.' I approached roommate's bed and he stated, 'I heard it, but I didn't tell because he didn't [Resident #1], and we [Resident #1 and Resident #2] don't want to get anyone in trouble.' (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of notice of warning, dated 03/26/2024, signed by CNA C and ADM revealed CNA C received warning for allegation of verbal abuse of a resident. Review of interview statement by CNA A, dated 03/27/2024, signed by the ADON, revealed the following: I walked into [Resident #1's] room looking for the other aides. They were in the middle of a bed change and they [CNA B and CNA C] we're pulling him up in bed. [Resident #1] stated 'Ouch, you're hurting me. At this time, [CNA C] said 'shut up, you're the one that shit all over yourself.' [Resident #1] said 'I know I did and it stinks'. At this time I stated I'm leaving on that note. I went directly to [LVN D] and reported what was said. [LVN D] then sent me to the ADON/DON office where I reported what I had heard. Review of interview statement by CNA B, dated 03/27/2024, signed by the ADON, revealed the following: I was changing [Resident #1] brief. One that involved a large BM (bowel movement). I turned him to pull the brief and noticed he had feces going up his back and needed new sheets. So [CNA C] went and grabbed sheets. During care of changing his sheeets and brief, [CNA C] turned [Resident #1] at this time he said 'ow' because his hip hurt. [CNA C] told him to 'shut up, I don't know why you are complaining, you are the one that shit all over yourself.' At this time, the peri care was completed. I proceeded to peri care on another resident. When this task was completed, [LVN D] approached me and asked me to speak with [DON]. I give my statement to what I had heard [CNA C] say to [Resident #1] at this time. Review of provider investigation report, a resident interview titled Safe Survey, dated 03/27/2024 and signed by the Social Worker, revealed Resident #1 and his roomate had no concerns or complaints and felt comfortable talking to staff about them if he had them. Additional safe surveys on neighboring residents revealed no concerns. Review of social note, dated 03/28/2024 at 10:40 a.m., signed by the Social Worker, revealed the following: There were witness statements saying an aide, that was helping them change a resident, had made a {vulgar} comment towards the resident. Resident was hollering/moaning due to pain, of being moved around, and the aide told the resident to 'shut up, you are the one who shit yourself.' When I asked the resident did he hear her say that, he said he heard her say something, but could not make it out to what she had said. Resident had also admitted to another nurse, that he in fact did hear her, he just did not want to get her in trouble. Review of witness statement, dated 03/29/2024, signed by LVN D, revealed the following: I entered [Resident #1]'s room to clarify if he heard exactly what [CNA C] said to him on 3/26/2024. Resident stated 'Is she in trouble? I don't want to get anyone in trouble.' I told resident we need to know if he heard what she said since he previously told me she was ugly to him. Resident stated 'she said shut the fuck up.' I thanked resident for speaking with me and left room. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of grievance summary, dated 03/29/2024, signed by the Social Worker, revealed the following concern and conclusion: .Resident was hollering while getting changed, when an aide was helping assist him said 'Shut up, you are the one who shit yourself' .Resident was said he did hear her say something, but does not know exactly what she said. He has not had any mood or behavioral changes. A safe survey (resident interview regarding safety) was conducted and it was found, he was comfortable and safe here. He didn't feel like any harm in his way. The end result of the matter was that, the aide was terminated. RP, [family] was notified about the abuse allegations. Review of personnel record for CNA C, revealed a hire date of 03/05/2024 and received training on abuse with completed post test on 03/05/2024. Review of provider investigation report, dated 04/02/2024, signed by the ADM, revealed the incident ocurred 03/26/2024 at 1:00 p.m. and included the following: Investigation Summary . On 3/26/24 [CNA C] was providing incontinent care to [Resident #1], a resident. Two other staff members were present in the room: [CNA B and CNA A]. While assisting the resident he verbally complained of pain. At that time [CNA C] allegedly stated 'shut up, you are the one who shit all over yourself. This statement was heard by the two staff members that were in the room with [CNA C]. Administrator, DON, Physician, Responsible Party, Corporate Office, and HHSC notified. Alleged perpetrator suspended pending investigation. Staff inserviced regarding abuse/neglect, resident rights, safe transfers. Other residents interviewed in an attempt to discover if similar incidents had ocurred and not been reported. No other incidents or allegations were identified. Resident was interviewed/couseled by the social worker. Resident initially denied hearing what [CNA C] said to him. Administrator spoke to resident and made the same statement, that he had not heard what [CNA C] had said. Resident also told the administrator that he did not wish to get any staff members in trouble. Resident was later interviewed by [LVN D]. During that conversation the resident stated that he had heard [CNA C] tell him to 'shut the fuck up,' but he had not been honest about it because he did not wish to get anyone in trouble. Based on the evidence provided this investigator confirms the incident. Evidence suggests [CNA C] made the statements alleged. Investigation Findings: Confirmed Provider Action Taken Post-Investigation: [Facility] continues to make the safety and well being of its residents top priority. [CNA C]'s employment at [facility] has been terminated and she is not eligible for rehire. [Resident #1] continues to display no lasting effects as a result of the incident and no further incidents have been reported as o the writing of this report. Review of Resident Mood Interview for Resident #1, dated 04/09/02024 at 12:08 p.m., signed by the Social Worker, revealed no symptoms present. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of in-services between March 2024 through April 2024 and employee roster, revealed training was provided to staff on abuse for the following dates: 03/21/2024, 03/26/2024, 03/27/2024, and 04/23/2024. During an interview with the ADM and DON on 04/24/2024 at 11:00 a.m., the ADM said that he was the abuse coordinator and was aware of the self reported incident of verbal abuse related to Resident #1. The ADM said there were multiple staff members in the room providing incontinent care and one of those aides was CNA C. The ADM said during that time, they were turning Resident #1 and he voiced that CNA C was hurting him and she told him to shut up, you are the one who shit yourself and that statement was corroborated by other staff in the room. The ADM said we immediately suspended her pending the investigation and terminated her with no eligibility for rehire. The ADM said the other aides in the room were CNA B and CNA A. The ADM said CNA A and CNA B were not at the facility that day due to CNA A no longer employed by the facility and CNA B works the night shift. The ADM said Resident #1 was doing good and has had no psychosocial harm apparent from the incident. The ADM and DON said they were ensuring residents were free from abuse by reporting, conducting safe surveys, increased monitoring, and in-services with staff. The ADM and DON said it was important to protect residents from verbal abuse to prevent psychocial harm. During an observation and interview on 04/24/2024 at 11:42 a.m., CNA E was walking with a resident down the hall and interaction appeared pleasant. CNA E said that she had worked at the facility for [AGE] years and had received training on abuse recently from in-services and that verbal abuse would be anything from talking down to a resident or cussing. She said she did not suspect any current abuse but was aware of CNA C being let go because of a verbal abuse incident. CNA E said she has had no additional concerns since CNA C was terminated and that she was not working when the incident occurred. CNA E said if she ever witnessed staff cursing at a resident she would immediately report to the ADM, the abuse coordinator. CNA E said it was important to prevent verbal abuse of residents because it could cause psychosocial harm. CNA E said she had never had to report abuse and that she felt residents were safe at the facility. During an interview on 04/24/2024 at 12:09 a.m., the ADON said she had been employed at the facility for 16 months. She said she had received and provided training on abuse and was aware of an abuse allegation and had recently reported alleged abuse on herself from a resident on the secure unit that said she had scratched her during her assessment on 4/23/2024 at around 8:15 a.m The ADON said she reported herself immediately to the ADM, the abuse coordinator, and was suspended until 12:30 p.m. the same day. The ADON said she was out that day when Resident #1 had his incident with the aides and that she has a good relationship with Resident #1 and he will ask for her personally over any issues. The ADON said she asked Resident #1 about the incident with CNA C and he was reluctant to provide any information, but informed him on his safety. The ADON said Resident #1 never told her what CNA C said to him and the DON called her that day with him on the phone so he would feel comortable talking to the ADON since they have a good relationship. The ADON said Resident #2 was his roommate and she asked if he had heard anything and he said no. The ADON said Resident #1 was doing good and has exhibited no signs of psychosocial harm from the incident. The ADON said staff had received training on abuse via in-services and that they did a skills fair recently addressing abuse in March 2024 consisting of a two day event with hands on scenarios and they get the residents involved. The ADON said she felt the incident with CNA C was isolated and that the facility handled the situation appropriately with her termination and felt residents were safe at the facility. The ADON said it was important for residents to remain free from verbal abuse to prevent psychosocial harm. (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 04/24/2024 at 2:08 p.m., LVN F said she had no concerns with staff talking to residents inappropriately and if she did she would report to the ADM. LVN F said she had not worked with CNA C and that if she witnessed staff being verbally abusive to residents she would intervene and make sure both parties are safe before reporting to the ADM. LVN F said she did not suspect any verbal abuse that would consist of talking inappropriately to resident like cursing and that she aware of the incident with CNA C and Resident #1 but did not witness the incident. LVN F said she felt the facility handled that situation appropriately and CNA C was terminated. LVN F said it was important to prevent and protect residents from verbal abuse because it could cause them to become more depressed, socially withdrawn, and could cause psychosocial harm. During an interview on 04/24/2024 at 2:36 p.m. by phone, CNA G said she was PRN. CNA G said she had received training on abuse and verbal abuse would be yelling at a patient, being irate and disrespectful. CNA G said it was important to prevent verbal abuse of residents because it could cause psychosocial harm, that she did not suspect abuse at this facility, and that if she did she would report it to the ADM immediately. During an interview on 04/24/24 at 2:48 PM via phone, CNA C said she and CNA B went to get Resident #1 cleaned up. CNA C said they got him in the bed with the hoyer and he freaks out sometimes because he has arthirits in his back. CNA C said CNA A was coming in the room and when CNA B rolled him over she said it [feces] is up your back we are going to have to take your shirt off and when we sat him up. CNA C said she told Resident #1 to hush, stop, look at me, when we pull it over the top of your head, if you jerk back like that you are going to get poop on your face. CNA C said Resident #1 undesrstood what we were doing and they got him cleaned up and that was it. CNA C said she did not tell him to shut up because she does not talk like that. CNA C said she told him to hush and to look at me. CNA C said she probably did say shit but never told him to shut the fuck up and that the charge nurse said CNA A told her six different stories. CNA C said one story was she said shut up and then it was shut the fuck up and I wanted to ask them questions because if it that was serious why didn't the other aides stop me at the time because the resident's safety was first and they just stood there. CNA C said the facility did not provide training on abuse, but they had in-services on paper at the front and told you to sign them. CNA C said she honestly did not have time to read them when she had 22 residents to take care and was not going to remember what that paper said. CNA C said verbal abuse would be considered belittling and cursing at residents and that it could affect resdidents mentally if they have depression and make them withdrawal. CNA C said she did not curse near any other residents and could not remember if his roommate was in the room at the time of the incident. During an interview on 04/24/2024 at 3:23 p.m., the ADM said verbal abuse was confirmed with Resident #1 and that the resident was truthfully reluctant to provide information that he had overheard what the aide said because he did not wish to get anyone in trouble. The ADM said that Resident #1 was doing fine and has had no negative psychosocial outcomes and that it was important to protect residents from verbal abuse to prevent resident from becoming with more withdrawn and the resident experieincing verbal abuse could experience psychosocial harm. The ADM said to ensure residents are safe from abuse he has provided training, reported to HHSC, and appropriate entities listed in policy, safe surveys were conducted, the incident was QAPI'd (Quality Assurance and Performance Improvement), and alleged perpetrator was terminated. The ADM said there was no concern with her background or licensure check. The ADM said that he did feel this incident caused reason for referral of CNA C. The ADM said that the Social Worker was at the facility and had assessed Reisdent #1's mood and behavior following the incident. (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 04/24/2024 at 3:29 p.m., the Social Worker said she had been employed since October of 2023 and did not suspect abuse. The Social Worker said she had safe surveys to ensure residents are safe and that it was important for residents to be free from verbal abuse to prevent psychocial harm. The Social Worker said Resident #1 was doing good and has not had any complaints with him as far as his care provided. The Social Worker siad there was an incident with CNA C changing him and he never admitted it to me that he heard her say something and could not make out what she said. The Social Worker said Resident #1 has had no mood changes and has been more active in activities.

During an observation on 04/24/2024 at 3:45 p.m., Resident #1 was lying in bed with his head covered. He did not respond to greeting or questions and exhibited no signs of distress. There was no other resident in his room.

During an interview on 04/25/2024 at 11:17 a.m., Resident #1's RP said they were notified of the verbal abuse incident on 3/26/2024 and that the resident had socially improved since the incident and was attending more activities than previously. RP said they had no concerns and that they felt the CNA that told the resident to 'shut up' should not have been fired because the resident can be very difficult and rude to nursing staff and that they believe she should be rehired. RP said they had no concerns with the care and services provided by the facility or staff related to abuse. RP said it has been over a month since she had visited the resident because she was diagnosed with cancer and also because of his rude behavior when RP did visit.

Review of facility policy, titled Abuse, Neglect, and Exploitation and Misappropriation of Resident Property, effective June 23, 2017, revealed the following:

Purpose

The purpose of this policy is to ensure that all healthcare facilities comply with federal and state regulations regarding (i) protecting facility patients and residents from abuse, neglect, exploitation and misappropriation of resident property .

Policy

1.Resident Rights. Each resident has the right to be free from abuse, neglect, exploitation, misappropriation of resident's property, corporal punishment, and involuntary seclusion. Residents must not be subjected to abuse, neglect, exploitation, misappropriation of resident's property by anyone, including, but not limited to, facility staff, other residents, consultants, volunteers, staff of other agencies serving the resident, family members, legal guardians, resident representative, friends, or other individuals.

2 Facility Duty to Protect Resident Rights. The facility must prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's symptoms .

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	b. if the alleged perpetrator is a staff member, the staff member will be suspended from employment and not allowed in the facility, pending the outcome of the investigation, and the Regional Human Resources Consultant will be notified of the suspension; c. the Abuse Coordinator or designee will be assigned throughout the investigation to follow-up with the person and/or persons involved with the concern, incident, or grievance. If allegations of abuse, neglect, exploitation, or misappropriation involve the Administrator's conduct, then the Regional Director of Operations will be assigned to coordinate the investigation; d. the Abuse Coordinator or designee will conduct relevant interviews to determine if any form of retaliation has occurred . Definitions: Abuse: The willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. (42 CFR S488.301). This also includes the deprivation by an individual (including a caretaker), of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well being. This presumes that instances of abuse of all residents, even those in a coma, cause physical harm, or pain or mental anguish . Abuse Coordinator: Licensed Facility Administrator. Adverse event: An adverse event is an untoward, undesirable, and usually unanticipated event that causes death or serious injury. Verbal abuse: The use of oral, written, or gestured language that willfully includes disparaging and derogatory terms to residents or their families, or within their hearing distance, regardless of their age, inability to comprehend, or disability. Examples of verbal abuse include, but are not limited to threats of harm; saying things to frighten a resident, such as telling a resident that he/she will never be able to see his/her family again . The surveyor confirmed PNC had been implemented sufficiently to remove the deficiency by: - Facility implementation of monitoring resident for psychosocial harm. - Facility notification of abuse incident to responsible parties, MD, police, Ombudsman, and HHSC. - Completion of mood assessment on resident/victim. - Completion of in-services on abuse. - Completion of safe surveys on residents. - Suspension of involved staff pending outcome. - Completion of warning notices for involved staff. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Colonial Pines Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1203 Fm 1277 San Augustine, TX 75972	

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Termination of confirmed perpetrator. The noncompliance was identified as PNC. The facility had corrected the noncompliance before the survey began.

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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 - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43872 Based on observations, interviews, and record reviews, the facility failed to implement policies and procedures that prohibit and prevent abuse, neglect, and exploitation of resident to ensure residents were free from verbal abuse for one of twelve residents (Resident #1) reviewed for abuse. 1. The facility failed to prevent verbal abuse for Resident #1 witnessed by CNA A and CNA B to have been told to shut up and you are the one who shit on yourself by CNA C on 03/26/2024 at approximately 1:00 p.m. during incontinence care. The noncompliance was identified as PNC that began on 03/26/2024 and ended on 04/02/2024. The facility had corrected the noncompliance before the survey began. This failure could place residents at risk for psychosocial harm and further abuse. Findings included: Review of a face sheet for Resident #1, dated 04/24/2024, revealed he was an [AGE] year-old male admitted to the facility on [DATE] and had diagnoses including: type 2 diabetes mellitus with hyperglycemia (high blood pressure), non-ketotic hyperglycinemia (metabolic accumulation of large amounts of glycine in blood, urine, and cerebrospinal fluid, acute kidney failure, Chronic kidney disease, stage 3, seizures, Essential (primary) hypertension high blood pressure), Personal history of transient ischemic attack (stroke), and cerebral infarction without residual deficits, Chronic obstructive pulmonary disease (lung disease). Review of Resident #1's Quarterly MDS, dated [DATE], revealed he had a Brief Interview for Mental Status (BIMS) score of 09, indicating moderate cognitive impairment. Resident #1's behavior and functional status revealed he had no physical or verbal behavioral symptoms or decrease in mood or social isolation, had impairment to both upper and lower extremities, and required substantial/maximal assistance with toileting hygiene. Review of Resident #1's care plan, revised 04/01/2024, revealed he had an anti-anxiety and antidepressant goal in place for resident to be free of any discomfort or adverse side effects within the next 90 days initiated on 3/26/2024 to include the following interventions: monitor behaviors every shift, offer non-pharmacological interventions, and administer medication as ordered, Monitor closely for worsening of depression and/or suicidal behavior or thinking, especially during initiation of therapy and during any changes in dosage, and monitor for interaction/adverse side effects of anxiety, nervousness, insomnia, somnolence, weight gain, anorexia, or increased appetite. Review of incident statement, dated 03/26/2024, signed by Administrator, revealed the following: (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reported to me that resident was placed in the bed for incontinent care. When resident was turned by aide [CNA C], the resident hollered out, ouch you hurt me. The aide [CNA C] was overheard by [CNA A] and [CNA B] to say, shut up. You're the one that shit yourself. [CNA A] left the room and reported the incident initially to [LVN D]. [LVN D] brought [CNA C] into my office to discuss allegations. [CNA B] was in turn brought into my office and questioned about the allegations. The incident was in turn reported to the administrator. [CNA C] was questioned regarding the allegations. Review of witness statement, dated 03/26/2024, signed by CNA A, revealed the following: I walked into [Resident #1's] room looking for the other aides. They were in the middle of a bed change, and they were pulling him up in the bed and he said ouch you're hurting me and [CNA C] said shut up you're the one that shit all over yourself. Review of witness statement, dated 03/26/2024, signed by CNA B, revealed the following: I was changing [Resident #1] and he had a huge blowout [bowel movement]. I turned him to pull the brief and noticed he had bowel going up his back and needed new sheets so [CNA C] went [and] got some sheets. She came back and when we were turning him to change sheet and briefs [CNA C] turned [Resident #1] and he said ow because his hip hurt and [CNA C] told him 'Shut up, I don't know why you are complaining you are the one that shit all over his self.' Review of witness statement, dated 03/26/2024, signed by CNA C, revealed the following: CNA walked into room to help other CNA with resident put back into the bed due to needing to be changed. When changing patient, noticed he had poop all the way up his back when lifting [patient] up to change him to get the poop off his back and to take his shirt off. He was complaining of him hurting this CNA said hush we are trying to not get poop on your face and continued to get the poop off resident. Review of witness statement, dated 03/26/2024, signed by LVN D and ADON, revealed the following: [Resident #1]. While I was in resident's room for incontinent care, I asked resident if a CNA talked ugly to him earlier in the day. Resident stated 'yes, she did but I didn't tell the other lady because I didn't want to get her in trouble. People need their jobs.' I told resident no one is allowed to curse at them or talk rudely to them. Resident's roommate stated 'Miss [LVN D] come here.' I approached roommate's bed and he stated, 'I heard it, but I didn't tell because he didn't [Resident #1], and we [Resident #1 and Resident #2] don't want to get anyone in trouble.' Review of notice of warning, dated 03/26/2024, signed by CNA C and ADM revealed CNA C received warning for allegation of verbal abuse of a resident. Review of interview statement by CNA A, dated 03/27/2024, signed by the ADON, revealed the following: (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	I walked into [Resident #1's] room looking for the other aides. They were in the middle of a bed change and they [CNA B and CNA C] we're pulling him up in bed. [Resident #1] stated 'Ouch, you're hurting me. At this time, [CNA C] said 'shut up, you're the one that shit all over yourself.' [Resident #1] said 'I know I did and it stinks'. At this time I stated I'm leaving on that note. I went directly to [LVN D] and reported what was said. [LVN D] then sent me to the ADON/DON office where I reported what I had heard. Review of interview statement by CNA B, dated 03/27/2024, signed by the ADON, revealed the following: I was changing [Resident #1] brief. One that involved a large BM (bowel movement). I turned him to pull the brief and noticed he had feces going up his back and needed new sheets. So [CNA C] went and grabbed sheets. During care of changing his sheeets and brief, [CNA C] turned [Resident #1] at this time he said 'ow' because his hip hurt. [CNA C] told him to 'shut up, I don't know why you are complaining, you are the one that shit all over yourself.' At this time, the peri care was completed. I proceeded to peri care on another resident. When this task was completed, [LVN D] approached me and asked me to speak with [DON]. I give my statement to what I had heard [CNA C] say to [Resident #1] at this time. Review of provider investigation report, a resident inerview titled Safe Survey, dated 03/27/2024 and signed by the Social Worker, revealed Resident #1 and his roomate had no concerns or complaints and felt comfortable talking to staff about them if he had them. Additional safe surveys on neighboring residents revealed no concerns. Review of social note, dated 03/28/2024 at 10:40 a.m., signed by the Social Worker, revealed the following: There were witness statements saying an aide, that was helping them change a resident, had made a {vulgar} comment towards the resident. Resident was hollering/moaning due to pain, of being moved around, and the aide told the resident to 'shut up, you are the one who shit yourself.' When I asked the resident did he hear her say that, he said he heard her say something, but could not make it out to what she had said. Resident had also admitted to another nurse, that he in fact did hear her, he just did not want to get her in trouble. Review of witness statement, dated 03/29/2024, signed by LVN D, revealed the following: I entered [Resident #1]'s room to clarify if he heard exactly what [CNA C] said to him on 3/26/2024. Resident stated 'Is she in trouble? I don't want to get anyone in trouble.' I told resident we need to know if he heard what she said since he previously told me she was ugly to him. Resident stated 'she said shut the fuck up.' I thanked resident for speaking with me and left room. Review of grievance summary, dated 03/29/2024, signed by the Social Worker, revealed the following concern and conclusion: (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	.Resident was hollering while getting changed, when an aide was helping assist him said 'Shut up, you are the one who shit yourself' .Resident was said he did hear her say something, but does not know exactly what she said. He has not had any mood or behavioral changes. A safe survey (resident interview regarding safety) was conducted and it was found, he was comfortable and safe here. He didn't feel like any harm in his way. The end result of the matter was that, the aide was terminated. RP, [family] was notified about the abuse allegations. Review of personnel record for CNA C, revealed a hire date of 03/05/2024 and received training on abuse with completed post test on 03/05/2024. Review of provider investigation report, dated 04/02/2024, signed by the ADM, revealed the incident ocurred 03/26/2024 at 1:00 p.m. and included the following: Investigation Summary . On 3/26/24 [CNA C] was providing incontinent care to [Resident #1], a resident. Two other staff members were present in the room: [CNA B and CNA A]. While assisting the resident he verbally complained of pain. At that time [CNA C] allegedly stated 'shut up, you are the one who shit all over yourself. This statement was heard by the two staff members that were in the room with [CNA C]. Administrator, DON, Physician, Responsible Party, Corporate Office, and HHSC notified. Alleged perpetrator suspended pending investigation. Staff inserviced regarding abuse/neglect, resident rights, safe transfers. Other residents interviewed in an attempt to discover if similar incidents had ocurred and not been reported. No other incidents or allegations were identified. Resident was interviewed/couseled by the social worker. Resident initially denied hearing what [CNA C] said to him. Administrator spoke to resident and made the same statement, that he had not heard what [CNA C] had said. Resident also told the administrator that he did not wish to get any staff members in trouble. Resident was later interviewed by [LVN D]. During that conversation the resident stated that he had heard [CNA C] tell him to 'shut the fuck up,' but he had not been honest about it because he did not wish to get anyone in trouble. Based on the evidence provided this investigator confirms the incident. Evidence suggests [CNA C] made the statements alleged. Investigation Findings: Confirmed Provider Action Taken Post-Investigation: [Facility] continues to make the safety and well being of its residents top priority. [CNA C]'s employment at [facility] has been terminated and she is not eligible for rehire. [Resident #1] continues to display no lasting effects as a result of the incident and no further incidents have been reported as o the writing of this report. Review of Resident Mood Interview for Resident #1, dated 04/09/02024 at 12:08 p.m., signed by the Social Worker, revealed no symptoms present. Review of in-services between March 2024 through April 2024 and employee roster, revealed training was provided to staff on abuse for the following dates: 03/21/2024, 03/26/2024, 03/27/2024, and 04/23/2024. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the ADM and DON on 04/24/2024 at 11:00 a.m., the ADM said that he was the abuse coordinator and was aware of the self reported incident of verbal abuse related to Resident #1. The ADM said there were multiple staff members in the room providing incontinent care and one of those aides was CNA C. The ADM said during that time, they were turning Resident #1 and he voiced that CNA C was hurting him and she told him to shut up, you are the one who shit yourself and that statement was corroborated by other staff in the room. The ADM said we immediately suspended her pending the investigation and terminated her with no eligibility for rehire. The ADM said the other aides in the room were CNA B and CNA A. The ADM said CNA A and CNA B were not at the facility that day due to CNA A no longer employed by the facility and CNA B works the night shift. The ADM said Resident #1 was doing good and has had no psychocial harm apparent from the incident. The ADM and DON said they were ensuring residents were free from abuse by reporting, conducting safe surveys, increased monitoring, and in-services with staff. The ADM and DON said it was important to protect residents from verbal abuse to prevent psychosocial harm. During an observation and interview on 04/24/2024 at 11:42 a.m., CNA E was walking with a resident down the hall and interaction appeared pleasant. CNA E said that she had worked at the facility for [AGE] years and had received training on abuse recently from in-services and that verbal abuse would be anything from talking down to a resident or cussing. She said she did not suspect any current abuse but was aware of CNA C being let go because of a verbal abuse incident. CNA E said she has had no additional concerns since CNA C was terminated and that she was not working when the incident occurred. CNA E said if she ever witnessed staff cursing at a resident she would immediately report to the ADM, the abuse coordinator. CNA E said it was important to prevent verbal abuse of residents because it could cause psychosocial harm. CNA E said she had never had to report abuse and that she felt residents were safe at the facility. During an interview on 04/24/2024 at 12:09 a.m., the ADON said she had been employed at the facility for 16 months. She said she had received and provided training on abuse and was aware of an abuse allegation and had recently reported alleged abuse on herself from a resident on the secure unit that said she had scratched her during her assessment on 4/23/2024 at around 8:15 a.m The ADON said she reported herself immediately to the ADM, the abuse coordinator, and was suspended until 12:30 p.m. the same day. The ADON said she was out that day when Resident #1 had his incident with the aides and that she has a good relationship with Resident #1 and he will ask for her personally over any issues. The ADON said she asked Resident #1 about the incident with CNA C and he was reluctant to provide any information, but informed him on his safety. The ADON said Resident #1 never told her what CNA C said to him and the DON called her that day with him on the phone so he would feel comortable talking to the ADON since they have a good relationship. The ADON said Resident #2 was his roommate and she asked if he had heard anything and he said no. The ADON said Resident #1 was doing good and has exhibited no signs of psychosocial harm from the incident. The ADON said staff had received training on abuse via in-services and that they did a skills fair recently addressing abuse in March 2024 consisting of a two day event with hands on scenarios and they get the residents involved. The ADON said she felt the incident with CNA C was isolated and that the facility handled the situation appropriately with her termination and felt residents were safe at the facility. The ADON said it was important for residents to remain free from verbal abuse to prevent psychosocial harm. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 04/24/2024 at 2:08 p.m., LVN F said she had no concerns with staff talking to residents inappropriately and if she did she would report to the ADM. LVN F said she had not worked with CNA C and that if she witnessed staff being verbally abusive to residents she would intervene and make sure both parties are safe before reporting to the ADM. LVN F said she did not suspect any verbal abuse that would consist of talking inappropriately to resident like cursing and that she aware of the incident with CNA C and Resident #1 but did not witness the incident. LVN F said she felt the facility handled that situation appropriately and CNA C was terminated. LVN F said it was important to prevent and protect residents from verbal abuse because it could cause them to become more depressed, socially withdrawn, and could cause psychosocial harm. During an interview on 04/24/2024 at 2:36 p.m. by phone, CNA G said she was PRN. CNA G said she had received training on abuse and verbal abuse would be yelling at a patient, being irate and disrespectful. CNA G said it was important to prevent verbal abuse of residents because it could cause psychosocial harm, that she did not suspect abuse at this facility, and that if she did she would report it to the ADM immediately. During an interview on 04/24/24 at 2:48 PM via phone, CNA C said she and CNA B went to get Resident #1 cleaned up. CNA C said they got him in the bed with the hoyer and he freaks out sometimes because he has arthirits in his back. CNA C said CNA A was coming in the room and when CNA B rolled him over she said it [feces] is up your back we are going to have to take your shirt off and when we sat him up. CNA C said she told Resident #1 to hush, stop, look at me, when we pull it over the top of your head, if you jerk back like that you are going to get poop on your face. CNA C said Resident #1 undesrstood what we were doing and they got him cleaned up and that was it. CNA C said she did not tell him to shut up because she does not talk like that. CNA C said she told him to hush and to look at me. CNA C said she probably did say shit but never told him to shut the fuck up and that the charge nurse said CNA A told her six different stories. CNA C said one story was she said shut up and then it was shut the fuck up and I wanted to ask them questions because if it that was serious why didn't the other aides stop me at the time because the resident's safety was first and they just stood there. CNA C said the facility did not provide training on abuse, but they had in-services on paper at the front and told you to sign them. CNA C said she honestly did not have time to read them when she had 22 residents to take care and was not going to remember what that paper said. CNA C said verbal abuse would be considered belittling and cursing at residents and that it could affect resdidents mentally if they have depression and make them withdrawal. CNA C said she did not curse near any other residents and could not remember if his roommate was in the room at the time of the incident. During an interview on 04/24/2024 at 3:23 p.m., the ADM said verbal abuse was confirmed with Resident #1 and that the resident was truthfully reluctant to provide information that he had overheard what the aide said because he did not wish to get anyone in trouble. The ADM said that Resident #1 was doing fine and has had no negative psychosocial outcomes and that it was important to protect residents from verbal abuse to prevent resident from becoming with more withdrawn and the resident experieincing verbal abuse could experience psychosocial harm. The ADM said to ensure residents are safe from abuse he has provided training, reported to HHSC, and appropriate entities listed in policy, safe surveys were conducted, the incident was QAPI'd (Quality Assurance and Performance Improvement), and alleged perpetrator was terminated. The ADM said there was no concern with her background or licensure check. The ADM said that he did feel this incident caused reason for referral of CNA C. The ADM said that the Social Worker was at the facility and had assessed Reisdent #1's mood and behavior following the incident. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 04/24/2024 at 3:29 p.m., the Social Worker said she had been employed since October of 2023 and did not suspect abuse. The Social Worker said she had safe surveys to ensure residents are safe and that it was important for residents to be free from verbal abuse to prevent psychocial harm. The Social Worker said Resident #1 was doing good and has not had any complaints with him as far as his care provided. The Social Worker siad there was an incident with CNA C changing him and he never admitted it to me that he heard her say something and could not make out what she said. The Social Worker said Resident #1 has had no mood changes and has been more active in activities. During an observation on 04/24/2024 at 3:45 p.m., Resident #1 was lying in bed with his head covered. He did not respond to greeting or questions and exhibited no signs of distress. There was no other resident in his room. During an interview on 04/25/2024 at 11:17 a.m., Resident #1's RP said they were notified of the verbal abuse incident on 3/26/2024 and that the resident had socially improved since the incident and was attending more activities than previously. RP said they had no concerns and that they felt the CNA that told the resident to 'shut up' should not have been fired because the resident can be very difficult and rude to nursing staff and that they believe she should be rehired. RP said they had no concerns with the care and services provided by the facility or staff related to abuse. RP said it has been over a month since she had visited the resident because she was diagnosed with cancer and also because of his rude behavior when RP did visit. Review of facility policy, titled Abuse, Neglect, and Exploitation and Misappropriation of Resident Property, effective June 23, 2017, revealed the following: Purpose The purpose of this policy is to ensure that all healthcare facilities comply with federal and state regulations regarding (i) protecting facility patients and residents from abuse, neglect, exploitation and misappropriation of resident property . Policy 1.Resident Rights. Each resident has the right to be free from abuse, neglect, exploitation, misappropriation of resident's property, corporal punishment, and involuntary seclusion. Residents must not be subjected to abuse, neglect, exploitation, misappropriation of resident's property by anyone, including, but not limited to, facility staff, other residents, consultants, volunteers, staff of other agencies serving the resident, family members, legal guardians, resident representative, friends, or other individuals. 2 Facility Duty to Protect Resident Rights. The facility must prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's symptoms . (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	5. Training. The facility will conduct staff member training regarding abuse, neglect, and exploitation and the misappropnat1on of resident property, to include prevention, intervention, detection, reporting and employee rights. During each new staff member's orientation and annually thereafter, the facility at a minimum provide training on the following topics: a. Activities that constitute abuse, neglect, exploitation, and misappropriation of resident property b. Procedures for reporting incidents of abuse, neglect, exploitation, or the misappropriation of resident property c. Dementia management and resident abuse prevention. Additional training may be provided in new employee orientation and thereafter in on-going training sessions on the following topics: a. Activities and behaviors that constitute abuse, neglect, and exploitation . d. Working with residents with dementia or cognitive impairment. e. Techniques for management of difficult residents. f. Identification of factors that contribute to, or escalate, hostile behavior. g. Assessment of staff responses to aggressive or hostile behavior h. Identification of employee and resident coping behaviors, and how to reinforce positive and adaptive behaviors. i. How to report any incidence of suspected abuse, who the abuse coordinator is, and how investigations are conducted at the facility. j. How to file a complaint with the state survey agency against any facility that retaliates against an employee who makes a report. k. Appropriate interventions that are implemented to deal with aggressive and/or catastrophic reactions of residents. l. How to recognize signs of burnout, frustration and stress that may lead to abuse. m. Behavioral interventions that can be used for inappropriate resident behaviors . To provide protection to the resident during an investigation, the Facility should apply the following procedures: a. protect residents by removing immediate threats and potential harm; (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675358	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Colonial Pines Healthcare Center	1203 Fm 1277 San Augustine, TX 75972

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	b. if the alleged perpetrator is a staff member, the staff member will be suspended from employment and not allowed in the facility, pending the outcome of the investigation, and the Regional Human Resources Consultant will be notified of the suspension; c. the Abuse Coordinator or designee will be assigned throughout the investigation to follow-up with the person and/or persons involved with the concern, incident, or grievance. If allegations of abuse, neglect, exploitation, or misappropriation involve the Administrator's conduct, then the Regional Director of Operations will be assigned to coordinate the investigation; d. the Abuse Coordinator or designee will conduct relevant interviews to determine if any form of retaliation has occurred . Definitions: Abuse: The willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. (42 CFR S488.301). This also includes the deprivation by an individual (including a caretaker), of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well being. This presumes that instances of abuse of all residents, even those in a coma, cause physical harm, or pain or mental anguish . Abuse Coordinator: Licensed Facility Administrator. Adverse event: An adverse event is an untoward, undesirable, and usually unanticipated event that causes death or serious injury. Verbal abuse: The use of oral, written, or gestured language that willfully includes disparaging and derogatory terms to residents or their families, or within their hearing distance, regardless of their age, inability to comprehend, or disability. Examples of verbal abuse include, but are not limited to threats of harm; saying things to frighten a resident, such as telling a resident that he/she will never be able to see his/her family again . The surveyor confirmed PNC had been implemented sufficiently to remove the deficiency by: - Facility implementation of monitoring resident for psychosocial harm. - Facility notification of abuse incident to responsible parties, MD, police, Ombudsman, and HHSC. - Completion of mood assessment on resident/victim. - Completion of in-services on abuse. - Completion of safe surveys on residents. - Suspension of involved staff pending outcome. - Completion of warning notices for involved staff. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675358	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/24/2024
NAME OF PROVIDER OR SUPPLIER Colonial Pines Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1203 Fm 1277 San Augustine, TX 75972	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Termination of confirmed perpetrator. The noncompliance was identified as PNC. The facility had corrected the noncompliance before the survey began.