

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675374	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/05/2024
NAME OF PROVIDER OR SUPPLIER Irving Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 619 N Britain Rd Irving, TX 75061	

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)
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35489</p> <p>Based on interview, and record review, the facility failed to ensure residents were free from abuse for one of eight residents (Resident #32) reviewed for abuse.</p> <p>The facility failed to ensure Resident #32 was free from physical abuse when the Former Staffing Coordinator grabbed Resident #32's hand hard enough to cause bruising, while attempting to get the resident to allow himself to be taken to the shower.</p> <p>This failure placed residents at risk for abuse.</p> <p>Findings included:</p> <p>Review of Resident #32's face sheet reflected an [AGE] year-old male, admitted on [DATE], with diagnoses of Acute embolism and thrombosis of unspecified deep veins of left lower extremity (a blockage caused by a blood clot in the leg), Urinary tract infection, site not specified, lack of coordination, Spondylolisthesis, lumbar region (a condition in which vertebra slip out of place, and cause pain), and Cauda equina syndrome (a rare condition in which nerve roots at the bottom of the spinal cord are compressed, considered a medical emergency.)</p> <p>Review of Resident #32's care plans reflected the following care plans:</p> <ul style="list-style-type: none"> - Urinary Incontinence and pain, dated 11/27/24 - ADLs re: Non-compliant behavior dated 11/19/24 <p>Review of Resident #32's Admission MDS Assessment, dated 10/04/24, reflected his sight and hearing were adequate, and he was able to express himself, be understood by others, and to understand others. His BIMS score was 12, indicating possible moderate cognitive impairment. He had no indicators of depression, or psychosis, and exhibited no behavioral problems. Resident #32 indicated it was very important to him to take care of his personal belongings or things, and to have a place to keep them safe. He was able to eat with only set-up or clean-up assistance, but was dependent on staff for toileting and bathing.</p> <p>(continued on next page)</p>

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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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the facility investigation documentation for a self-reported allegation of abuse by a resident, submitted to HHSC by the Former Administrator on 10/31/24, reflected Resident #32's allegation that some female staff members had entered his room, and tried to get him to take a shower on 10/29/24, which he refused. The document reflected that he stated one of the women (thought to be the Former Staffing Coordinator) handled him roughly and bruised his hand. In the investigation materials provided, a statement by CNA I, dated 11/04/24, (appearing to be a text message) reflected that the CNA had been in the room during this incident, and observed the (Former) Staffing Coordinator was asked to come into the room to assist. The facility investigation reflected the resident was observed to have a small bruise on his left hand, where he was allegedly grabbed.</p> <p>An interview with Resident #32 on 12/03/24 at 3:04 PM, with his friend, Visitor K, present, revealed him to be alert, and oriented, with some forgetfulness. He said that some women came into his room, and told him he had to take a shower. He said that he told them he would do it the following day, and they said no and that he always said that, but he would not do it, so they wanted him to do it right then. He said they removed his clothing and stripped his bed, and he did not remember when he ended up in the chair to go to the shower. He said he did not remember their names, but one of them was a huge woman who was tall, and very strong, and he could not remember if he had seen her before that, but did not think he had seen her since. He thought someone told him she was no longer working there. He said during the disagreement the large woman grabbed his left hand so hard he could not pry her hand off, and she left a bruise. He said they hauled him out of his room. He could not remember when he got into the chair, but he said the abuse happened in the room, and down to the shower room. He said that two male staff then showered him, and were very nice, and repeatedly apologized, though it was not their fault. He said that the staff were all very nice, and he liked them, except for the woman who grabbed his hand. He did not feel afraid of anyone. Observed at the time of this interview was an assortment of disposable plastic cups on his bedside table with items like sugar and salt packets, and margarine packets. He explained there were usually more things on the table and when he left the room the staff took advantage of his absence, and cleaned his room, getting rid of his things, which was why he insisted on having his showers when one of his friends was there, to make sure that did not happen. The surveyor confirmed with the resident that the items on his table were the belongings he was referring to. He said he did not report the incident to anyone when it happened, because he did not know that he could, so they did not know about it right away. He said the staff now knew he wanted to take showers only when his friend was there to watch his things.</p> <p>An interview on 12/04/24 at 12:43 PM with CNA I revealed Resident #32 was very aware of what was happening, during the incident. He said the resident often refused showers, and he thought it had been about a week since he allowed them to shower him. CNA I said the DON and LVN G seemed stuck on doing it (showering the resident), and he kept refusing. He said the Former Staffing Coordinator came into the room, and he thought he remembered her holding the resident down so they could try to clean him, while he tried to push them off, and she held his arm down. He said the Former Staffing Coordinator quit soon after the incident. He said Resident #32 did allow him, another male CNA (CNA J) to take him down to the shower room.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An interview on 12/04/24 at 1:27 PM with the Former Staffing Coordinator revealed she had been called into Resident #32's room, and when she got there, CNA I, the DON, and LVN G were in the room. She said she did not know what they wanted her to do, because Resident #32 did not want to shower, so there was nothing she could have done. She said the resident was new to the facility, and she did not really know him well. She said she talked to him, and said it was his shower day, but the resident said he wanted no ladies so she was trying to leave the room. She said she did not remember if she touched him, but she denied ever grabbing him. She said the resident said he would take a shower if all the women left, and CNA I showered him, and she left the room. She said she was not suspended as a result of the incident, and she was never made aware that anyone thought she hurt his arm. While she was in the room, she said, she never saw anyone be rough, or grab at him or his bedding, and everyone was being nice.</p> <p>An interview on 12/04/2024 at 3:16 PM with the Former Administrator revealed on 10/31/24 the SW told her there was a potential abuse report by Resident #32, who said large black ladies went into his room, hurt him, mistreated him, grabbed his arm, and made him take a shower. The SW told her that the DON was in the room during the incident. The Former Administrator went to Resident #32's room, and he told her that it was three, large, black women who came into his room, and asked him about taking a shower. He said he refused and one of them grabbed his arm so tight he had to pry her fingers off his wrist. The Former Administrator said she saw he had about an inch and a half bruise, with a small skin tear in the middle of it. The resident did not know names, and could only describe them as three large, black women and he could not tell her which one grabbed his arm, and could not say an exact time it happened, only the day. She interviewed staff to see who was there. She said someone told her a male CNA entered the room at one point, but Resident #32 did not say anything about any males in the room. She self-reported it and did what she could to protect the resident, not knowing who had been in the room. She said she suspended the Former Staffing Coordinator, who fit the description of the one who hurt his arm, but was not able to get a statement from her, because she left before she could speak to her, and quit and would not return her calls. They had one nurse who was African American, but she was slender, and the resident insisted the one who hurt him was larger, and had been in the room, pulling at his blankets, and trying to get him to take a shower. She had the Social Worker do safe resident surveys, and talked to any staff who were there and might have observed anything. She had some trouble getting CNA I's statement, but later in the investigation, when she got it she found the statement kind of disturbing, but she turned it in with the rest and considered that part of the original self-report. When she finally got his statement, she saw that he said it was the DON, LVN G, and the Former Staffing Coordinator (who was already gone at the time she received the statement.) As part of the investigation she got statements from everyone else, and suspended the perpetrator if one was confirmed or someone fit the description. She said she put the Former Staffing Coordinator on suspension, but she never returned back to work, and even though she tried several times to get her to give a statement, she was never able to get one.</p> <p>An interview on 12/04/2024 at 4:08 PM with the VP revealed it was their protocol to suspend anyone with an allegation. She said when the Former Administrator called her with the original allegation she told her to immediately suspend the Former Staffing Coordinator, who was the staff member who fit the description the resident gave them. The Former Administrator said the Former Staffing Coordinator had left early because she was sick, but she would suspend her, but they never got to suspend her because she never came back to the facility and would not return phone calls. She told the Former Administrator to call the police, and to get statements from anyone who was there, and talk to the DON and other residents.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An interview on 12/04/2024 at 4:33 PM with the DSM revealed she was notified to go investigate the incident with Resident #32. Resident #32 had alleged that a larger African American woman had grabbed his wrist, and that there were 3-4 ladies trying to get him to take a shower, and the lady who grabbed him left a bruise. He said everyone there had been professional, and friendly, and that the woman who had grabbed his arm was no longer there and he had never seen her again. He said women had looked at his bottom due to an abscess he had, and tried to get him to take a shower, but they were not the one who grabbed him. He said he felt safe, and comfortable, and this had been an isolated incident. She said she talked to him and learned that he preferred to be showered by males, and that he wanted his friend to be there to watch his things while he was out of the room. The DON was inserviced.</p> <p>An interview on 12/05/2024 at 5:10 PM with LVN G revealed she and the DON had not originally gone to Resident #32's room to get him to shower. She said he had an abscess on his bottom they needed to check on. She said when he rolled to his side to let them look they could see that his bed was filthy with urine, BM, food, and they could see flakes of skin, and he and his bed needed to be cleaned up. She said it had been a while, but she remembered that they talked him into taking a shower. She said they told him he hadn't taken one the day before, she thought. He didn't want to, because he had for a friend, or family member, she thought, but she was having trouble remembering. They told him that they could make sure that someone told his visitor that he would be right back from the shower soon. She thought he said he would consider it if males could shower him. She thought that the Former Staffing Coordinator had also been in the room part of the time, and a male CNA, but she did not know when they came into or left the room. Someone assisted him into the shower chair and took him to the shower room, and while he was gone she and the DON, and the other person she thought was the Former Staffing Coordinator, washed the bed with a basin of water, sanitized it, and wiped down the whole room. They did not throw away anything, just cleaned everything. She said she did not see anyone grab him, or be abusive in any way. If she had, she said she would have reported it to the (former) Administrator immediately. She said that residents had a right to refuse care.</p> <p>An interview on 12/05/2024 at 5:45 PM with the DON revealed she went with LVN G and the Former Staffing Coordinator because they needed to look at Resident #32's abscess. She said the abscess was healed, but his bed was filthy and his brief was soaking wet and had BM on him. He said not right now because he had family coming, and they told him they could tell his family he would be right back when they arrived. He said that was OK, and he wanted male CNAs so they called two male CNAs, and they took him to shower. She and LVN G washed and sanitized the bed, and put clean linen on. She was normally part of the investigations of self-reports, but she was never shown that one. She was informed that there had been an allegation a heavy-set black woman going into his room, and making him take a shower. She remembered the bruise on the back of his hand, and he told her it was from scratching himself when he took his watch off. She said the lady who fit the resident's description was no longer working there when the corporate person came.</p> <p>Review of a skin assessment done on 11/08/24 at revealed Resident #32 refused the assessment.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the facility Abuse Prevention Program policy, dated 04/08/21, reflected: 1) Prevention Component: Abuse Policy Requirement: It is the policy of this facility to prevent abuse by providing residents, families and staff information and education on how, when, and to whom to report concerns, incidents, and grievances without the fear of reprisal. The facility will then provide feedback regarding those concerns or complaints. The facility administrative staff will consistently reinforce this information to residents, families and staff. Procedures: There are policies and procedures written in this program on detecting and preventing abuse, neglect and exploitation. The facility will monitor activities to identify indicators for abuse, neglect and exploitation. Organizational practices that influence quality of care and quality of life including staffing levels, certified nursing assistant involvement in planning and evaluating care, and environmental considerations are monitored. Basic problem-solving components include periodic reviewing and revising policies and procedures for State and Federal compliance, analyzing all incidents, reviewing incident reports, reviewing reports on abuse, neglect, and exploitation and assessing for trends and analyzing satisfaction surveys.</p>		

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<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement policies and procedures to prevent abuse, neglect, and theft.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35489</p> <p>Based on interview and record review the facility failed to implement the facility's own written abuse and neglect prevention policy and procedure for one (Resident #32) of eight residents reviewed for abuse and neglect.</p> <p>The Former Administrator and corporate staff failed to immediately suspend two staff members (the DON and LVN G) pending investigation when an allegation of physical and emotional abuse of Resident #32 was made in a statement by CNA I on 11/04/24 during the investigation of a self-reported allegation by Resident #32 of physical abuse by the Former Staffing Coordinator (who was suspended). The DON and LVN G were also not suspended immediately when corporate staff became aware on 11/17/24 the DON and LVN G staff had not been suspended by the Former Administrator (the day before their re-investigation of the self-report and allegation by CNA I on 11/18/24).</p> <p>This failure could place residents at risk of a lack of protection from being abused pending the investigation of an allegation of abuse.</p> <p>Findings included:</p> <p>Review of the facility Abuse Prevention Program policy, dated 04/08/21, reflected:</p> <p>5) Protection Component: Abuse Policy Requirement: It is the policy of this facility that rights will be protected of alleged victims of abuse, neglect, misappropriation or mistreatment, as well as the rights of staff who are accused of abuse, neglect, misappropriation or mistreatment- as well as those who report it. Procedures: The alleged perpetrator will immediately be removed from the resident and the resident will be protected.</p> <p>Review of Resident #32's face sheet reflected an [AGE] year-old male, admitted on [DATE], with diagnoses of Acute embolism and thrombosis of unspecified deep veins of left lower extremity (a blockage caused by a blood clot in the leg), Urinary tract infection, site not specified, lack of coordination, Spondylolisthesis, lumbar region (a condition in which vertebra slip out of place, and cause pain), and Cauda equina syndrome (a rare condition in which nerve roots at the bottom of the spinal cord are compressed, considered a medical emergency.)</p> <p>Review of Resident #32's care plans reflected the following care plans:</p> <ul style="list-style-type: none"> - Urinary Incontinence and pain, dated 11/27/24 - ADLs re: Non-compliant behavior dated 11/19/24 <p>(continued on next page)</p>

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<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident #32's Admission MDS Assessment, dated 10/04/24, reflected his sight and hearing were adequate, and he was able to express himself, be understood by others, and to understand others. His BIMS score was 12, indicating possible moderate cognitive impairment. He had no indicators of depression, or psychosis, and exhibited no behavioral problems. Resident #32 indicated it was very important to him to take care of his personal belongings or things, and to have a place to keep them safe. He was able to eat with only set-up or clean-up assistance, but was dependent on staff for toileting and bathing.</p> <p>Review of the facility investigation documentation for a self-reported allegation of abuse by a resident, submitted to HHSC by the Former Administrator on 10/31/24, reflected Resident #32's allegation that some female staff members had entered his room, and tried to get him to take a shower on 10/29/24, which he refused. The document reflected that he stated one of the women (thought to be the Former Staffing Coordinator) handled him roughly and bruised his hand. In the investigation materials provided, a statement by CNA I, dated 11/04/24, (appearing to be a text message) reflected that the CNA had been in the room during this incident, and observed the DON and LVN G refusing to honor the resident's refusal, telling the resident he had scabies and demanding in a harsh way that he had to be bathed in spite of his refusals, and pulling the bedlinens off the resident while he tried to pull them back. The statement also reflected the (Former) Staffing Coordinator was asked to come into the room to assist, and because the resident continued to refuse, he was informed he would have to have a bed bath. CNA I's statement reflected the DON and the Former Staffing Coordinator asked CNA I to get basins of water, with which they proceeded to pour water onto the resident in his bed while he was still wearing a gown, and wiped him between the legs, and on other parts of his body. The statement reflected that CNA J entered the room and made the women leave, after which CNA I and CNA J were able to shower the resident with his consent, as he preferred showers by male staff. The facility investigation reflected the resident was observed to have a small bruise on his left hand, where he was allegedly grabbed.</p> <p>(continued on next page)</p>		

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<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An interview with Resident #32 on 12/03/24 at 3:04 PM, with his friend, Visitor K, present, revealed him to be alert, and oriented, with some forgetfulness. He said that some women came into his room, and told him he had to take a shower. He said that he told them he would do it the following day, and they said no and that he always said that, but he would not do it, so they wanted him to do it right then. He said they removed his clothing and stripped his bed, and he did not remember when he ended up in the chair to go to the shower. He said he did not remember their names, but one of them was a huge woman who was tall, and very strong, and he could not remember if he had seen her before that, but did not think he had seen her since. He thought someone told him she was no longer working there. He said during the disagreement the large woman grabbed his left hand so hard he could not pry her hand off, and she left a bruise. He said they hauled him out of his room. He could not remember when he got into the chair, but he said the abuse happened in the room, and down to the shower room. He said that two male staff then showered him, and were very nice, and repeatedly apologized, though it was not their fault. Twice during the conversation with the surveyor he denied the women attempting to give him a bed bath, saying that never happened, and he would remember that because he was given bed baths in the hospital, and he did not like them, and did not want them. He said that the staff were all very nice, and he liked them, except for the woman who grabbed his hand. He did not feel afraid of anyone. Observed at the time of this interview was an assortment of disposable plastic cups on his bedside table with items like sugar and salt packets, and margarine packets. He explained there were usually more things on the table and when he left the room the staff took advantage of his absence, and cleaned his room, getting rid of his things, which was why he insisted on having his showers when one of his friends was there, to make sure that did not happen. The surveyor confirmed with the resident that the items on his table were the belongings he was referring to. He said he did not report the incident to anyone when it happened, because he did not know that he could, so they did not know about it right away. He said the staff now knew he wanted to take showers only when his friend was there to watch his things.</p> <p>An interview on 12/04/24 at 12:43 PM with CNA I revealed Resident #32 was very aware of what was happening, during the incident. He said the resident often refused showers, and he thought it had been about a week since he allowed them to shower him. CNA I said the DON and LVN G seemed stuck on doing it (showering the resident), and he kept refusing. He said the Former Staffing Coordinator came into the room, and he thought he remembered her holding the resident down so they could try to clean him, while he tried to push them off, and she held his arm down. He said the Former Staffing Coordinator quit soon after the incident. CNA I said he felt uncomfortable about it, because the resident had a right to refuse care, and he did. He said the DON kept saying Resident #32 had scabies, as a reason that they needed to bathe him, and the resident did not have scabies. He said she was just saying that to try to get him to have a bath, but he continued to refuse, and was completely capable of making his own decisions. CNA I said the resident only wanted to take a shower when one of his trusted friends was there to watch his stuff, because the housekeeper took his things off the table, and he was upset about that. He said Resident #32 did allow him, another male CNA (CNA J) to take him down to the shower room. CNA I said the reason he did not immediately report was because the Administrator was gone that day, and the DON was part of it, so he did not know who to tell, but he did tell the Administrator when he could. He was aware at the time of this interview that the Administrator was to be immediately informed of anything thought to be abuse or neglect. He said the resident preferred to be bathed by men, so he was not going to go for a bunch of women coming in to give him a shower.</p> <p>(continued on next page)</p>		

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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)		
<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An interview on 12/04/2024 at 3:16 PM with the Former Administrator revealed on 10/31/24 the SW told her there was a potential abuse report by Resident #32, who said large black ladies went into his room, hurt him, mistreated him, grabbed his arm, and made him take a shower. The SW told her that the DON was in the room during the incident. The Former Administrator went to Resident #32's room, and he told her that it was three, large, black women who came into his room, and asked him about taking a shower. He said he refused and one of them grabbed his arm so tight he had to pry her fingers off his wrist. The Former Administrator said she saw he had about an inch and a half bruise, with a small skin tear in the middle of it. The resident did not know names, and could only describe them as three large, black women and he could not tell her which one grabbed his arm, and could not say an exact time it happened, only the day. She interviewed staff to see who was there. She said someone told her a male CNA entered the room at one point, but Resident #32 did not say anything about any males in the room. She self-reported it and did what she could to protect the resident, not knowing who had been in the room. She said she suspended the Former Staffing Coordinator, who fit the description of the one who hurt his arm, but was not able to get a statement from her, because she left before she could speak to her, and quit and would not return her calls. They had one nurse who was African American, but she was slender, and the resident insisted the one who hurt him was larger, and had been in the room, pulling at his blankets, and trying to get him to take a shower. She had the Social Worker do safe resident surveys, and talked to any staff who were there and might have observed anything. She had some trouble getting CNA I's statement, but later in the investigation, when she got it she found the statement kind of disturbing, but she turned it in with the rest and considered that part of the original self-report. She said the resident did not say anything about anyone pouring water on him. She said that CNA I had come to her confidentially, and said he felt threatened, and did not want to speak to anyone about it, but she told him she needed the statement. When she finally got his statement, she saw that he said it was the DON, LVN G, and the Former Staffing Coordinator (who was already gone at the time she received the statement.) She said CNA I said the DON and LVN G were jerking the resident's blankets, roughhousing him, and he said he witnessed them pouring water on the resident while he was in the bed, and coaxing him to turn over so they could look at his bottom, saying he had scabies, something like that. She said she sent the self-report to the regional staff, and was told that CNA I had been written up several times, and that what he said he witnessed did not happen. She said she went back to Resident #32, and asked him about the water, and he said he did not remember all of it, but he was fine. She said what CNA I said was not consistent with any of the other statements, and the DON and LVN G were not suspended. She said that she was not allowed to suspend them, and she was told by the VP that the resident did not say any of that (the DON and LVN G abusing him) happened. She clarified that they did not specifically say she could not suspend the DON and LVN G, but she was told that the DON was a very good DON and that CNA I's statement was more about being upset and falsely saying things in his statement. She said she had not been at the facility very long, and this had happened in the first week or two, and she was going on what the resident told her. As part of the investigation she got statements from everyone else, and suspended the perpetrator if one was confirmed or someone fit the description. She said she put the Former Staffing Coordinator on suspension, but she never returned back to work, and even though she tried several times to get her to give a statement, she was never able to get one. She said LVN G was suspended the day before she left (11/14/24).</p> <p>(continued on next page)</p>		

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<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An interview on 12/04/2024 at 3:41 PM with the SW revealed she had spoken with Resident #32 about the allegation of abuse. She said he told her that some people were rough with him, and he was not able to identify them or give a clear enough description of them for her to identify them. She said when she asked what they did, he told her that they demanded he take a shower. She asked him if he took a shower and he said that a very nice male staff had given him one. The Former Administrator told her to go back and get a written statement, and to return to her office. She was not aware of the statement involving the DON and LVN G, but she said if a staff member was trying to remove blankets that someone did not want removed, or trying to make a resident do something against their will, she would consider that an abuse. She said if a staff member made a statement that named staff member involved in it, those staff members would be investigated immediately. She said it did not matter if it was true, or if they were the Medical Director, Administrator, or DON, they would have to follow their policy the same they would with anyone.</p> <p>(continued on next page)</p>

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<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An interview on 12/04/2024 at 4:08 PM with the VP revealed that she did not say, and in no way implied, that the Former Administrator could not suspend someone when there was an alleged abuse by them. She said it was their protocol to suspend anyone with an allegation, and it did not matter who it was. She said when the Former Administrator called her with the original allegation she told her to immediately suspend the Former Staffing Coordinator, who was the staff member who fit the description the resident gave them. The Former Administrator said the Former Staffing Coordinator had left early because she was sick, but she would suspend her, but they never got to suspend her because she never came back to the facility and would not return phone calls. She told the Former Administrator to call the police, and to get statements from anyone who was there, and talk to the DON and other residents. She said they use an electronic meeting and messaging app for communication, and they had a system in place to use it for any high risk event. She said the event gets entered into the facility's events in the app, and the corporate administrative staff would give direction and advice about how to handle the investigation. They would tell the Administrator actions they needed to take, like head-to-to assessments, initial self-report statements and in-service, and they could review the reports and investigation. She said the only thing the Former Administrator reported to her was that there was a disgruntled CNA who was going to write a bad statement against the DON because they were upset with her, and she needed to know what to do from there. The VP said she told the Former Administrator that she needed to see the self-report and investigation to review it, but she never sent her what she sent to the state. She said when the Former Administrator started there was so much chaos and fighting among the department heads, and she described how the Former Administrator appeared to be deliberately trying to turn people against each other, and she had to terminate her employment because of it. She said when the Former Administrator left, she took a lot of original paperwork with her, including the self-report. The VP said after she was gone, they had to get an IT person to retrieve what they could, and they were able to get the investigation documents that way. She said on 11/18/24, the day after they saw the statement by CNA I, she had their DSM, who helps them with clinical issues, and is also a Social Worker, go to the facility and investigate more. She said they called the police to go to the facility, as well. She said they wanted confirmation that it was not the DON who had grabbed his wrist, and the resident told the DSM that it was not her, and that she checked on him all the time, and was nice. They had the resident assessed for scabies, to make sure that was not true, and he did not have scabies. She said that the DSM got everyone's statements again, and they did not think what they found warranted abuse. She said CNA I did speak with the DSM, but she did not have the notes, and he had been written up before. She said when the DON was hired, she started holding staff accountable, and CNA I was probably upset, so his statement did not match anyone else's. She said the resident's statement, and all the other staff statements matched, but CNA I's statement did not. She said the resident's biggest complaint was that they grabbed his wrist. He said he did not have water poured on him, and he did not want females to bathe him. She said they did an inservice on approach with the DON, and told her we know you want everyone to be clean, but when they say no, it's no. She said the DSM had investigated a little further and learned why Resident #32 did not want to go to the shower room. She said if the Former Administrator thought it was abuse, she should have called it in, and followed the policy.</p> <p>(continued on next page)</p>		

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<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An interview on 12/04/2024 at 4:33 PM with the DSM revealed she was notified to go investigate the incident with Resident #32. They had not seen the statement by CNA I until after it had already been reported to the state, and the Former Administrator was gone. Once they saw it, they went back immediately (the following day, 11/18/24), and Resident #32 denied it happened. Resident #32 had alleged that a larger African American woman had grabbed his wrist, and that there were 3-4 ladies trying to get him to take a shower, and the lady who grabbed him left a bruise. She spoke with the resident numerous times, and he said he did not get a bed bath or have water poured on him, and the only problem was that the lady grabbed his arm. She took the DON and LVN G (separately) into his room, and they chit-chatted with him, and she went back each time and made sure that neither of them had harmed or threatened him in any way. He said everyone there had been professional, and friendly, and that the woman who had grabbed his arm was no longer there and he had never seen her again. He said women had looked at his bottom due to an abscess he had, and tried to get him to take a shower, but they were not the one who grabbed him. He said he felt safe, and comfortable, and this had been an isolated incident. She said she talked to him and learned that he preferred to be showered by males, and that he wanted his friend to be there to watch his things while he was out of the room. The DON was inserviced.</p> <p>An interview on 12/05/2024 at 5:10 PM with LVN G revealed she and the DON had not originally gone to Resident #32's room to get him to shower. She said he had an abscess on his bottom they needed to check on. She said when he rolled to his side to let them look they could see that his bed was filthy with urine, BM, food, and they could see flakes of skin, and he and his bed needed to be cleaned up. She said it had been a while, but she remembered that they talked him into taking a shower. She said they told him he hadn't taken one the day before, she thought. He didn't want to, because he had for a friend, or family member, she thought, but she was having trouble remembering. They told him that they could make sure that someone told his visitor that he would be right back from the shower soon. She thought he said he would consider it if males could shower him. She thought that the Former Staffing Coordinator had also been in the room part of the time, and a male CNA, but she did not know when they came into or left the room. Someone assisted him into the shower chair and took him to the shower room, and while he was gone she and the DON, and the other person she thought was the Former Staffing Coordinator, washed the bed with a basin of water, sanitized it, and wiped down the whole room. They did not throw away anything, just cleaned everything. She said she was not aware anyone had made an allegation of abuse about her, and she was never suspended. She did receive an inservice about customer service and the right of residents to say no after that. She said she did not see anyone grab him, or be abusive in any way. If she had, she said she would have reported it to the (former) Administrator immediately. She said that residents had a right to refuse care.</p> <p>(continued on next page)</p>		

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<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An interview on 12/05/2024 at 5:45 PM with the DON revealed she went with LVN G and the Former Staffing Coordinator because they needed to look at Resident #32's abscess. She said the abscess was healed, but his bed was filthy and his brief was soaking wet and had BM on him. He said not right now because he had family coming, and they told him they could tell his family he would be right back when they arrived. He said that was OK, and he wanted male CNAs so they called two male CNAs, and they took him to shower. She and LVN G washed and sanitized the bed, and put clean linen on. She was normally part of the investigations of self-reports, but she was never shown that one. She was informed that there had been an allegation a heavy-set black women going into his room, and making him take a shower. She remembered the bruise on the back of his hand, and he told her it was from scratching himself when he took his watch off. A corporate person came after the Former Administrator left, and said that she and LVN G were mentioned in the self-report. They were in-serviced on approach. She said the lady who fit the resident's description was no longer working there when the corporate person came. The corporate lady said the statement said they poured water on the resident, and that LVN G was rough with him. The corporate came out and did investigation, and said it was something that was blown way out of proportion.</p> <p>An interview on 12/05/2024 at 6:13 PM with the Administrator revealed he had only been at the facility for two weeks, but had been an Administrator for a long time, and the allegation the surveyor described (coercing a resident to shower when they said no, pulling bedding off of them, and pouring water on them in bed) would definitely be considered an allegation of abuse. He said the staff involved should have been suspended, and it did not matter who they were. He said he had once been suspended pending investigation, because he matched a vague description given, and it was not personal. He said if someone made a new allegation during an investigation of another allegation, that would still be investigated. He said if something happened a long time ago, and someone made a new allegation about it, they would still follow the policy, and investigate and suspend.</p> <p>Review of a skin assessment done on 11/08/24 at revealed Resident #32 refused the assessment.</p>		